1. Introduction to peer education

1.1 What is peer education?

Similar people learning informally together

A peer is a person who is of equal standing or rank with another person. A peer educator is a member of a group of people sharing the same background, experience and values. The peer educator is trained to facilitate discussions on HIV/AIDS risk-taking behaviour and lead his or her peers in the examination of solutions. The peer educators are the link between the programme and the target population. The peer educators, who usually share the same age, gender or status as their peers, can:

- facilitate discussions
- answer questions
- present information
- conduct advocacy
- provide counselling
- lead dramas
- distribute materials
- make referrals to services
- sell or give out condoms.

Peer education or peer leadership

In a uniformed services setting, the term "peer leader" is sometimes considered more appropriate than "peer educator". Leadership implies setting a positive example and inspiring others to follow. The peer leaders are expected to help others from their peer group to go through the process of examining and, ultimately, changing behaviour that puts them at risk of HIV infection. Peer education or peer leadership is a form of non-formal education that can be established at little cost. It has also proved to be good for delivering culturally sensitive messages that come from, as well as work for, the benefit of a specific group.

1.2 What do peer educators do?

Diverse levels of intervention

Different ways in which peer educators work:

- facilitate discussions on risk-taking behaviour and settings that encourage it
- disseminate basic facts on STIs (sexually transmitted infections)/HIV/AIDS
- train peers in safer sex practices
- train peers in condom use and condom negotiation with a sexual partner
- motivate condom use among peers
- help in social marketing of condoms
- identify those with STIs and motivate them to take early and complete treatment
- identify cases of repeated infections of STIs and/or treatment failure and refer them to appropriate health centres
- participate in broader project activities.

1.3 Why use peer education?

Advantages include:

- low cost
- breaks barriers to help sensitive matters to be discussed without fear
- brings about sustainable behaviour change
- helps maintain confidentiality
- most effective, informal way of sending the correct message to a specific target group
- less time-consuming than more formal methods.

Peer educator the key

The success or failure of a peer education programme depends largely on the characteristics of the peer educator. The main characteristics that are desirable in a peer educator include:

- available and accessible to the target group at all times
- motivated by concern for the health of the target group
- has effective interpersonal communication skills
- known to or part of the uniformed services community
- respected by the uniformed services community
- able to listen to others without bias or assumptions
- confident about his/her ability to work with the uniformed services community
- able to speak the language(s) of the target groups.

1.4 How do groups and individuals learn?

Information not enough

Hearing facts about HIV and AIDS does not usually result in people changing their risk-taking behaviour. People change their behaviour when they understand the consequences of it and decide for themselves that they should change. People can be told over and over again to do something but they do not usually do so until they see that the change is worthwhile and want to do it themselves.

Learning through experience

Peer educators who ask questions rather than give talks are more effective. Peer beneficiaries prefer peer education exercises that encourage them to think about their own lives and discuss the behaviour choices they face. In other words, rather than telling them that drinking alcohol increases risk-taking behaviour, it is more effective to get them to reflect on what happens personally when they drink and what effect it has on their behaviour.

Personalize issues

Sometimes those with risk-taking behaviour deny that they have a problem. The more peer educators can get each peer beneficiary to see that HIV and AIDS is not someone else's problem, the better it is. Getting peer beneficiaries to talk about how they would feel if their children did not have enough money to attend school or had their house taken from them because no will had been prepared is one way of personalizing the potential impact of the virus.

Touch emotionally

It is easy for peer beneficiaries to ignore the advice of peer educators who only talk about the facts of HIV and AIDS. What is more effective is getting them to become concerned about what being infected with HIV would mean to them and their families. For example, peer beneficiaries can be asked to describe how they would feel if, after wishing for a son, their wife gives birth to a beautiful boy who looks just like them, but who then starts to become sick from AIDS and dies before reaching his fifth birthday.

Understand link between behaviour choices and future

Those who pay women to have sex without condoms are often thinking only of the pleasure of the moment. This is especially true after drinking alcohol and/or taking drugs. Peer beneficiaries can be asked to talk about their dreams for the future and imagine themselves realizing those dreams. They can also be asked how they feel about their current behaviour choices reducing the chances of making dreams come true.

1.5 How do people change their behaviour?

Inspiring behaviour change

People have to decide themselves to change behaviour that puts them at risk of HIV infection. They can be persuaded to examine their behaviour and consider the consequences. However, ordering them to change or simply telling them about the risk is not usually enough to get people to make changes. Behaviour change is a process that involves several steps.

Unaware to aware

Initially a person is unaware that particular behaviour may be dangerous. The first step in a behaviour change programme is to make people aware. For example, to promote safer sex practices, people first need basic information on STIs and HIV/AIDS. This could be provided through various channels using mass and group media and through interpersonal communication, including peer education.

Concerned

Individuals who are aware of an issue may not be concerned about it. Information must be given in such a way that the audience feels it applies to them, i.e. people become concerned and are motivated to evaluate their own behaviour. Targeted communication and interpersonal approaches are more useful than mass media approaches.

Knowledgeable and skilled

Once individuals are concerned, they may acquire more knowledge by talking to friends, social workers or health-care providers about the dangers of STIs and HIV/AIDS and methods of protection. More interpersonal communication approaches, including peer education, are needed at this stage, especially training programmes to build skills in discussing sex and sexuality and in negotiating responsible sexual behaviour.

Motivated and ready to change

Individuals might now begin to think seriously about the need to protect themselves and their loved ones from HIV/AIDS or other STIs. This is when they might become motivated

and ready to change. They may think about this for a long time and decide not to have multiple sexual partners or perhaps go out and buy condoms. At this stage, condoms need to be easily available and individuals need to feel capable of using condoms and negotiating safer sex. Both mass and group media can help provide a supportive environment by showing role models promoting a positive view of safer sexual behaviour. Positive messages from peers are particularly effective.

Trial change of behaviour

At a later stage, individuals may find themselves in a situation where a sexual encounter could take place, and where they have access to condoms. They could then decide to try the new behaviour. The results of any trial will be evaluated. If the experience has been too difficult or embarrassing due to lack of experience or skills, then they may not repeat the behaviour for a long time. Therefore, skills to negotiate condom use, and to use condoms correctly, are essential.

Maintenance/adoption of new behaviour

Avoiding relapses to past behaviour that put the person at risk in the first place is a challenge. Peer educators have a role to play in reinforcing positive behaviour and encouraging its continuation. New risks may present themselves and, as a result, new behaviour will need to be adopted.

2. Training peer educators

2.1 How are peer educators trained?

Training of trainers

A team of trainers must be established for training the future peer educators. The larger the team, the more quickly the programme can be established. The team needs to have a solid overview of peer education including:

- need for peer education programme
- purpose of peer education programme
- roles and responsibilities of the peer educators
- motivating peer educators and incentives.

2.2 How is training organized?

Training continuous

Training of peer educators needs to be an ongoing process. Main activities for initiating the training after the peer educators have been selected or recruited include the following.

- Assess learning needs of the beneficiaries of peer education through rapid assessment surveys and focus group discussions.
- Assess existing knowledge and attitudes within each category of peer educators (a rapid assessment through surveys may be done for this purpose).
- Prepare a training plan based on the findings of training needs assessment and beneficiary needs assessment.
- Plan the number of peer educators to be trained in each batch. The quality of the training is often related to the size of the group. In other words, training 20 at a time will be more effective than training 100 at a time.

2.3 Why carry out a training needs assessment?

- Ensures that the training plan is based on the learning needs of the participants.
- Increases the commitment of the participants for learning, as they are involved in preparation of the training plan.
- Makes learning a joint responsibility of the participants and the facilitator.
- Helps to develop rapport between the facilitators and the participants before the actual training begins.
- Helps identify the strengths and limitations of the group.
- Helps define learning objectives.
- Helps assess the impact of training on the performance level of the participants.

2.4 How is a training needs assessment carried out?

- Talk to the peer educators individually or collectively to tell them about the possible topics and objectives of the training programme.
- Assess the peer educators' interests and what they would like to learn.
- Ask the peer educators to rank or rate the relative importance of each topic.

- Ask a number of probing questions to assess the existing knowledge of each peer educator within each of the topics.
- Assign priorities for the topics based on the peer educators' rankings and assessment of their existing knowledge and the essential knowledge and skills that they require as peer educators.

2.5 What are the training objectives?

Each of the training sessions should be participatory in design and try to meet as many as possible of the following objectives. Peer educators need to understand:

- the principles of adult learning
- how to use communication skills with their peers or target group
- how to use communication skills to facilitate group discussion
- how to explain the dynamic of HIV/AIDS and its impact
- how to discuss basic facts on HIV/AIDS/STIs
- how to discuss basic STI symptoms and care services in their area
- how to discuss gender issues related to HIV/AIDS infection
- peer education and outreach strategies for HIV/AIDS/STI prevention
- how to discuss human sexuality in a confident way
- how to use condoms in a correct way
- how to discuss issues around HIV testing
- the behaviour change process
- how to assess risk-taking behaviour of their peer or target group
- how to use decision-making or problem-solving processes to reduce risk
- how to use negotiation skills related to HIV/AIDS prevention
- how to discuss the advantages of safer sex services with the local authorities
- how to discuss the advantages of safer sex services with owners of sex establishments
- access to health-care services for sex workers
- the living conditions and rights of sex workers
- the process of creating an effective communication project.

2.6 How are peer educators supervised?

It is necessary to:

- identify the number of supervisors needed
- identify the supervisors
- determine the method of supervision: individually or as a group
- determine the frequency of supervision
- prepare a checklist of tools for supervisors
- train supervisors.

2.7 What are the characteristics of effective supervision?

- Supervisors should be knowledgeable about HIV and the peer education programme and be in close contact with peer educators.
- Two-way communication is needed between peer educators and the supervisors.
- Peer educators should understand that they are not being judged individually; the supervisors are there to support them, and their experience is contributing

to a fuller understanding of how well the whole programme is working overall.

- Ideally, the peer educator should be contacted every week, preferably by the same supervisor.
- The supervisor needs to meet all the participants about once a month to assess the effectiveness of the programme.
- The supervisors should be able to identify and recruit additional or alternative peer educators if required, especially if existing ones are found to be ineffective.
- Supervisors need to motivate the peer educators by making them understand the value of their contribution and how much it is appreciated by the programme.
- The supervisors' reports should be analysed and reviewed quarterly to determine what changes need to be made to the programme.

2.8 Why organize refresher training?

Revitalizes and renews

It is a common practice to train peer educators at the start but offer little support afterwards. Refresher training has good value in revitalizing peer educators and reorienting their work. The content of the refresher training should be based on feedback from the supervision and monitoring. These elements should be considered when planning refresher training:

- obstacles to effective peer education based on feedback from peer educators and beneficiaries
- need for reinforcement of previous learning
- identifying additional knowledge and required skills.

3. Organizing peer education

3.1 How do you get support for sessions?

Coordinate with other peer educators

Discussing approaches to peer education and reviewing what was learned during the training with other peer educators is a good way to get started. If the way ahead is not clear the peer education trainer should be available to offer help in getting started or unstuck. Superior officers can be approached together to get permission to organize sessions during work time.

Convince superior officers

Not all superior officers are convinced that peer education is a good thing. It might be up to you to explain what peer education is and why it is important. You might point out that officers want their forces to be protected in battle so why not protect them from an even more powerful menace? Point out that you have the support of the commander to organize peer education sessions but you are depending on the superior officer to provide inspiring leadership and encourage personnel to participate.

3.2 Why write a work plan?

A work plan sets the stage

A work plan simply states what each peer educator intends to do, when they intend to do it, and with whom and where. Peer education sessions which are regularly scheduled, even if they are informal, work better than unscheduled ones. Once a work plan is prepared and approved by the commander or immediate supervisor it is more likely that the sessions will be held as planned and peer beneficiaries will participate. This is especially the case if the commander orders personnel to participate and allows sessions to be held during work time.

3.3 How do you identify peer beneficiaries?

Identify those most at risk

Not all people in the uniformed services are at equal risk of being infected and infecting others. Many men already use condoms when they visit brothels and others remain faithful to their wives. Younger personnel who like to drink alcohol and go to brothels are the most important group to engage in peer education.

Work with commanders or other officers to identify participants

Commanders can arrange for peer education sessions to be organized during work time and even order peer beneficiaries to attend. Lists can be made of unmarried or younger personnel to ensure that they are involved from the start.

Go to where personnel congregate

Men potentially at risk can be found in places where alcohol is served. Younger men can often be found playing sports or cards. Where personnel live in barracks they will be easy to find.

Use public ceremonies for announcements

A public ceremony or meeting of the company is good for making announcements and reaching large numbers with basic information but it is not so useful for interactive participatory sessions: for these small groups of 6–10 are recommended.

Be sensitive when seeking particular groups

The clients of sex workers, men who have sex with men, and injecting drug users are all groups who have special peer education needs because of their vulnerability to infection. It is best when peer educators themselves share the same characteristics as those they are approaching and practise safe sex. It can be expected that those who are most at risk may be afraid of discrimination against them if they are associated with a group known to have risk-taking behaviour. Meeting them discreetly in places where they congregate, individually or in small groups, may be necessary to gain their confidence.

3.4 How do you attract peer beneficiaries?

Make peer education fun and interesting

The more formal and dull peer education sessions are, the harder it is to get peer beneficiaries interested and to keep their interest. The more dynamic and amusing the peer education is, the more likely peer beneficiaries will want to participate. If they are going to get a long moralistic lecture you can be sure they will head the other way when they see the peer educator walking in their direction.

Use exercises learned in training

Most peer educators enjoyed the games, role-playing and participatory discussions that were part of their training. Peer beneficiaries can be expected to like those kinds of activities as well. Make sessions attractive by encouraging animated discussion with provocative questions.

3.5 How do you promote yourself as a peer educator?

Identify yourself as a peer educator

If given a peer education poster put it up in a prominent place outside your barracks or near where you work. If given a special peer educator shirt, wear it whenever possible. If the topic of HIV comes up in casual conversation point out that you are a peer educator and like to talk about the subject and answer questions.

Introduce yourself at gatherings of personnel

Let it be known at company ceremonies or other assemblies that you are a peer educator and are willing to meet with colleagues one to one or with small groups who would like to talk about HIV and AIDS.

3.6 How do you choose a location for sessions?

Go to where the people are

It is always more effective when the peer educator goes to where personnel are rather than having them come to him or her. The more convenient the location is for peer beneficiaries, the more likely they will participate. Meet them where they are already congregated such as in barracks, recreation areas or clubs. The workplace during

working hours is definitely the best location if commanders agree that sessions can be held then.

For sensitive topics discreet locations are best
If the topic is condom use in brothels, meeting in front of the barracks with wives walking by might not be the best idea. The use of discreet locations with few passers-by and out of earshot of senior officers or family members is recommended.

3.7 How do you prepare a session?

Being well prepared is important
The better prepared the peer educator is, the more smoothly the session will flow. Make sure you know exactly what topics you would like to cover, what exercises you would like to conduct and what you expect to accomplish.

Read background information before session
Nothing is more distracting than a peer educator who is not prepared and who reads the reference material during a session. It is better to read it a short time before the session and have it fresh in your mind.

Practise sessions with friends first
Getting practice explaining exercises with a couple of friends before the session increases the chances they will work when you conduct the session.

Arrive on time
When sessions are scheduled, it is best to arrive a little early to greet the participants. Make sure you are not late. Do not keep them waiting: they may be gone by the time you get there. Arriving early allows you to get some feedback on previous sessions by talking to the first who arrive.

3.8 How do you introduce a session?

Introduce yourself and session goals
If the peer beneficiaries do not already know you, identify yourself and explain what your role is. Tell them that you will be asking questions to stimulate discussion and introducing games and exercises. Explain the purpose of the particular session and emphasize that everyone's participation is desired and that everyone's opinion and experience are equally important.

Create an environment of trust
Let peer beneficiaries know that you are there to help them and want to encourage free and open discussion in order to better understand what puts people at risk and how to reduce risk. Reassure them that anything said in the session will be kept confidential by you and encourage all the participants to be discreet and respect each other.

3.9 How do you conduct a session?

Keep relaxed and informal
Peer beneficiaries generally prefer sessions which are held in an informal atmosphere with peer educators who lead but act informally rather than like a superior officer or a teacher.

Allow peer beneficiaries to have fun
Role-playing, playing games and discussing sex can be fun and cause laughter. It is up to the peer educator to create an informal atmosphere that allows this to happen.

Do not be judgemental or moralistic
Making peer beneficiaries feel guilty when they are talking about risk-taking behaviour can result in communication being cut off and is unlikely to result in positive behaviour change. Try to respect everyone's opinions even if you do not agree with them. A peer educator who is faithful to his wife or girlfriend may find it hard to understand why other men visit sex workers or turn to sex with other men. However, it is essential to focus on protecting your peers from infection, not changing moral and social behaviours to resemble your own.

Ensure that everyone participates
Try to get everyone to contribute equally to discussions. There will always be a few people who will want to dominate and a few quiet ones who prefer not to say too much. It is up to the peer educator to try to get everyone to participate. Ask questions directly to individuals rather than to the whole group and ask the same question to several different people, especially the quieter ones.

Try not to tell people what to do
Remember peer beneficiaries have to conduct their own risk assessment and then decide for themselves that it is to their advantage to change their behaviour. Simply being told to change does not usually work.

Ask probing questions or follow-up questions
To get the peer beneficiaries to offer more details about their experiences and what they were thinking and feeling, ask additional questions based on what they say. For example ask people how they feel and not just what they think or know. Find out if they were happy, guilty, sad, worried, afraid or indifferent about specific situations.

Get peer beneficiaries to move and stretch
If the attention level is waning and people are getting a bit restless, try getting them to stand up and stretch, touch their toes or jog on the spot.

4. Making peer education participative

TIPS FOR THE READER

This section is designed to improve the ability of peer educators to actively involve peer beneficiaries in peer education sessions. Reasons for making peer education participative are offered as well as recommendations on how do it. Emphasis is placed on the types of questions peer educators can ask to encourage participation. Two exercises that allow peer educators to increase their skills for organizing and conducting participatory sessions are included.

BASIC FACTS ON MAKING PEER EDUCATION PARTICIPATIVE

4.1 Why make peer education participative?

Information alone does not usually change behaviour

Experience shows that interactive and participatory methods are more effective in motivating participants to think through their behavioural choices and inspire change than simply providing facts.

Formal lectures tend to be dry and dull

Reading directly from documents or reciting facts about HIV and AIDS is usually not appreciated by peer beneficiaries. They would much prefer the peer educator to introduce discussion topics such as sexually transmitted infections or stigma and discrimination, and provide information or answer their questions in the course of the discussion.

Some information needed

There may very well be information gaps to be filled but as a rule a lack of knowledge is not the problem faced by uniformed services personnel. People know how HIV is transmitted and how to prevent its transmission. The problem is that risk-taking behaviour such as having sex without using condoms is still practised despite knowledge that condoms should be used.

4.2 Why should participation be encouraged?

- Peer beneficiaries enjoy sessions more when they are talking, laughing and actively involved.

- Instead of dealing with abstract facts on HIV and AIDS, participation helps personalize the issues and makes them relevant to the lives of the peer beneficiaries.
- Peer beneficiaries tend to remember details better if they are discussed and personalized rather than presented as fact.
- Active participation allows immediate feedback on what peer beneficiaries are thinking and feeling, and provides peer educators with the opportunity to correct misinformation and identify problem areas that need attention.
- Encouraging participation results in peer beneficiaries reflecting on their own situation and behaviour choices.
- Hearing about the experiences of others helps peer beneficiaries realize that others are facing the same challenges. They can be encouraged by those who have successfully changed risk-taking behaviours.
- Participation improves the quality of contact between peer educators and peer beneficiaries.
- Encouraging participation is actually easier for peer educators because they are not doing all the talking and they do not have to spend time preparing lectures.

4.3 How do you get peer beneficiaries to talk?

Asking questions is the key

The more peer beneficiaries are talking and the less peer educators are talking, the better the job the peer educator is doing. In other words, a peer educator should ask a question to start a discussion such as "Can you describe what happens when you arrive in a brothel?". When the group runs out of things to say the peer educator should ask another question, perhaps sending them in a specific direction: "What happens if the brothel runs out of condoms?".

Ensure two-way communication channels are open

A good peer educator should listen more than talk. The trick is to ask a question, listen to the answer and ask another question based on what was said. Ask questions that find out "why" things happened or "how" people feel about certain situations. The idea is not to provide facts but to find out what each peer beneficiary thinks and feels about risk-taking behaviour and behaviour choices.

People naturally want to answer questions

Peer beneficiaries generally like to contribute to a discussion by talking about their own experiences. The challenge for peer educators is creating a positive environment that makes the peer beneficiaries feel comfortable enough to start talking. It may seem difficult at first but once peer educators find out how easy it is to initiate a discussion they enjoy their work much more.

Smaller groups are easier than big ones

Between 6 and 10 is the best number of peer beneficiaries for a peer education session. If there are more the group becomes unwieldy, harder to control and it is less likely that all peer beneficiaries will get the chance to participate actively. If the group is smaller, too much attention is focused on a few individuals which may make them feel more uncomfortable, especially when talking about intimate details of their sex lives.

4.4 What are probing questions?

Go beyond surface comments

Probing questions are used to obtain information that is needed to communicate effectively. Peer beneficiaries often provide short answers or even try to give you the answers they think you want to hear. A peer educator who is skilled at asking probing questions is more likely to get to the reality of a situation and encourage open and frank discussion. Developing skills for asking probing questions is important. Some examples of probing questions are:

- Could you tell me more about that?
- What made you do that?
- How did you feel when that happened?
- Why do you think that is important?

4.5 What are open-ended questions?

Look for more than "yes" or "no" answers

An open-ended question is a question that cannot just be answered by "yes" or "no". Open-ended questions are useful to peers to get discussions started. Open-ended questions cannot be answered in a few words and usually begin with "how", "why" or "could". A closed-ended question asks for only a simple answer that does not require any reflection on the listener's part. Answers to such questions are usually brief ("yes" or "no") and they usually begin with "is", "are" or "do". Open-ended questions are more valuable than closed-ended ones because they increase participants' involvement in peer education sessions.

Examples of closed-ended questions

- Do you like rice?
- Do you drink beer?
- Are you enjoying this training?

Examples of open-ended questions

- What are your favourite foods?
- What do you think of beer drinking?
- How could this training be improved?
- Why do you think men are different from women?

4.6 Why examine behaviour choices?

Get peer beneficiaries to understand the consequences of their behaviour

Create a relaxed and informal atmosphere that encourages peer beneficiaries to describe their risk-taking behaviour and reflect on what the possible consequences of their behaviour choices might be. These might be feeling guilty, fear of infecting their wives, fear of a premature death or suffering from stigma and discrimination.

Get peer beneficiaries to pinpoint their decision-making process

Peer educators can encourage peer beneficiaries to pinpoint exactly when decisions were made that put them at risk. Questions like the following can be asked.

- When was the decision made to go to the brothel?
- When was the decision made to obtain or not obtain a condom?

- When was the decision made to use or not use a condom?
- Did they imagine their sexual partner was not infected because she was beautiful?

The idea is that if those with risk-taking behaviour understand why they made certain decisions and when, they can make a different decision the next time they find themselves in the same situation and avoid the risk-taking behaviour.

Get peer beneficiaries to consider influences on their behaviour

Peer educators can help peer beneficiaries figure out the external influences on the behaviour choices they make. Peer pressure to go out to brothels with other men, alcohol consumption which clouds decision-making or partners who are insulted by the idea of condom use are the kinds of things that can influence behaviour choices.

Get peer beneficiaries to confront their defences

Some peer beneficiaries have a tendency to deny that their risk-taking behaviour is a problem or even blame others for it. Peer beneficiaries can sometimes give a long list of reasons why they do not use condoms. It is up to the peer educators to get peer beneficiaries to think through the realities of HIV/AIDS, examine the behaviour choices they make and not hide behind misinformation or wishful thinking. This can be done by getting other peer beneficiaries to comment on the excuses offered or what they think the real risks are.

4.7 How do you use support materials?

Support materials enhance peer education

Support materials are usually printed documents with illustrations or photographs that can be used by peer educators to convey ideas and stimulate discussion. Peer educators like them because they make their job easier by providing questions to ask. Some suggestions on how to use support materials:

- Don't tell peer beneficiaries what is happening in the photographs or illustrations: ask them to tell you.
- Let the peer beneficiaries comment extensively before offering information yourself.
- Make sure everyone has a good view of the materials by moving the peer beneficiaries in closer or passing the materials around for each to have a good look.
- Ask open-ended questions: avoid questions that get "yes" and "no" answers.
- Create a relaxed atmosphere by placing participants in a circle without desks in front of them.
- Ask follow-up questions based on what is said like: "Could you expand on that?" "What does that mean to you exactly?" "Does anyone have anything to add?".
- Ask the same question to different peer beneficiaries.
- Re-pose questions asked by peer beneficiaries to the other peer beneficiaries to answer.
- Avoid letting the same peer beneficiaries answer all questions.
- Try asking every question to a specific individual rather than letting anyone answer because the same people will usually respond.

- Ask simple questions like: "What do you think?" "What do you see?" "How do you think the person feels?" "What do you think they will do?".

4.8 How do you engage peer beneficiaries?

Make sure all peer beneficiaries participate

The more peer beneficiaries are active and involved in the peer education, the more they like it. Some suggestions on how to engage them:

- Ask peer beneficiaries what kinds of activities and topics they prefer, and offer them.
- Involve peer beneficiaries in the decisions on the times and locations for sessions.
- Use the more dynamic peer beneficiaries as helpers and subgroup leaders.
- Break into small groups or pairs for more intimate discussions and get the groups to report back.
- Suggest the buddy system be used to help the peer beneficiaries keep an eye on each other outside the sessions.

EXERCISE 4.1

How to lead a peer education session

OBJECTIVE
To improve skills for peer education.

BACKGROUND
The more the peer educators develop their skills, the more effective they will be in their work. This session allows them to practise conducting a peer education session.

MATERIALS
Flip chart and paper or blackboard (optional)

TIME
1 hour

INSTRUCTIONS

STEP 1
Ask participants to divide into groups of 5–10.

STEP 2
Have each group choose one person to act as the peer educator.

STEP 3
Ask the chosen peer educators of the groups to role-play how they would approach a group of uniformed services personnel. They can choose any topic related to HIV/AIDS they want. The others in the group will act as the peers. Some suggestions for topics:

- the importance of condoms to HIV/AIDS prevention
- how HIV is spread from one person to another
- why uniformed services personnel are vulnerable to HIV/AIDS.

STEP 4
Let each group come forward and enact the situations they have created.

STEP 5
Discuss with participants and remind them of the factors that they must bear in mind when meeting a group for the first time:

- greet the group
- introduce themselves
- explain why they have come.

STEP 6

Write out and explain to participants some of the things they should remember when facilitating a group of peers:

- Be punctual at sessions.
- Have fun playing the games in a relaxed manner.
- Do not be judgemental and remember that everyone has his/her own views and beliefs.
- Try not to tell the group/person what to do. Rather, ask them questions so that they can deduce their own answers.
- If your group is tired or loses attention during the session, then exercise or sing a song before you continue, or reschedule the meeting.

STEP 7

Review the important points and ask for feedback from the participants. Ask if they have any questions.

EXERCISE 4.2

Skills for asking questions

OBJECTIVE
To increase skills in leading discussions through effective question-asking.

BACKGROUND
Probing questions are used to obtain information that is needed to communicate effectively. Often participants in peer education sessions will provide short answers or even try to give you the answer they think you want to hear. A peer educator who is skilled at asking probing questions is more able to get to the reality of a situation and encourage frank and open discussion.

MATERIALS
None

TIME
20 minutes

INSTRUCTIONS

STEP 1
Tell the peer educators why developing skills for asking probing questions is important. Ask them to provide some examples of probing questions such as:

- Could you tell me more about that?
- What made you do that?
- How did you feel when that happened?
- Why do you think that is important?

STEP 2
Explain to peer educators that an open-ended question is a question that does not require a "yes" or "no" answer. Open-ended questions are useful to peers to get discussions started. Open-ended questions cannot be answered in a few words and usually begin with "how", "why" or "could".

STEP 3
Point out that closed-ended questions ask for only a simple answer that does not require any reflection on the listener's part. Answers to such questions are usually brief ("yes" or "no") and questions usually begin with "is", "are" or "do". Ask each peer educator in turn to answer the following questions:

- Do you like rice?
- Do you drink beer?
- Are you enjoying this training?

STEP 4

Now ask each peer educator in turn to answer the following open-ended questions:

- What are your favourite foods?
- What do you think of beer drinking?
- How could this training be improved?
- Why do you think men are different from women?

STEP 5

Remind participants that open-ended questions are more valuable than closed-ended ones because they increase participants' involvement in peer education sessions.

5. Overcoming barriers

TIPS FOR THE READER

This section focuses on several things that can make sessions difficult to conduct. Suggestions are made on how to overcome barriers such as poor communication and reluctance to deal frankly and openly with sexual issues. One of the exercises included has peer educators consider common obstacles faced and think about how to overcome them. The other has them consider their own personal obstacles that may inhibit them in their peer education work.

BASIC FACTS ON OVERCOMING BARRIERS

5.1 How do you overcome barriers to effective communication?

Talk less and ask more questions

If peer educators are talking too much then they are not doing their job. Most peer beneficiaries find lectures dull and boring. Peer educators who get discussions started by asking questions find that approach much more effective than preparing talks. Peer beneficiaries are more interested in talking about their lives than listening to a peer educator talk in technical language about HIV and AIDS in a way that they do not understand or really care about.

Ask questions and then listen

To be effective, a peer educator should encourage peer beneficiaries to think and talk about their own situations. They would much rather talk about what is happening in their own lives. Peer educators should listen to what peer beneficiaries have to say and then ask more questions until everyone has had a chance to add to the discussion.

Find out what is happening in the lives of peer beneficiaries

The more peer educators understand the lifestyles of peer beneficiaries, the better they will be able to help them think through their behaviour choices. If a peer educator is talking too much then he or she is not listening. For example, rather than give facts about voluntary counselling and testing, peer educators can ask the peer beneficiaries if they have ever thought about going for a test or ask those who were tested to describe how they felt about the experience.

5.2 How do you keep informed?

Read reference materials

An informed peer educator is a confident peer educator. Reading reference materials several times increases the chances of remembering the content. Reading the materials every six months helps to refresh your memory.

Offer to answer tough questions later

Pretending to know the answer to a question to save face is never a good idea. A good peer educator writes down a question he or she cannot answer and either looks up the answer in a reference book or asks another peer educator or supervisor. The correct answer is then offered at the next session.

Seek advice and counsel

Part of the job of the peer education supervisor is to provide peer educators with the information they need. They are also available to offer advice on problems organizing or conducting peer education. They will also be glad to meet with peer beneficiaries who have particular problems that the peer educator cannot handle.

5.3 How do you get comfortable with sexual issues?

Keep peer education focused on sex

Most HIV infection is transmitted through sexual relations, the majority of them heterosexual. Even in the case of the second most important mode of transmission, mother-to-child transmission, the mothers were almost always first infected by their sexual partners before passing the virus to their babies. Despite this reality, there is often a reluctance on the part of peer educators and participants to deal frankly and openly with human sexual relations. In order for HIV/AIDS prevention to be effective, there has to be an understanding of the sexual behaviour of uniformed services personnel that puts them at risk.

Be bold when discussing sex

Talking about sex is taboo for many people, especially when it involves details of sexual behaviour that may be socially unacceptable, such as relations outside marriage or sex for money. It requires special skills on the part of peer educators to become comfortable with dealing with sexual questions themselves and then getting their peers to feel comfortable as well. Some suggestions for making talking about sexual issues easier:

- Be at ease in talking about sex. If you are embarrassed, participants will be too.
- Provide a comfortable and quiet place where people will not be interrupted so that participants feel safe in revealing sexual information honestly.
- Ask direct questions about sex to encourage peer beneficiaries to offer concrete detailed information about their sexual choices.
- Get people to talk about "someone just like them" or "someone they know very well" if they are too shy to talk about their own sexual habits. This sometimes allows them to speak more freely than if they have to reveal things about themselves.

5.4 How do you get others talking about sexual issues?

Think about your own sexual values

Peer educators should start by looking at their own sexual behaviour and examine their personal opinions and moral values as well as their feelings about sexuality. Next they should learn to use sexual words without embarrassment. Learn the type of questions to ask that will elicit sexual information without unduly embarrassing the participants. In cases where people may be reluctant to discuss sexual issues openly and frankly, peer educators can use a variety of techniques, including the following.

- Start with more indirect questions which are easier to answer, such as asking peer beneficiaries to describe their family situations, and talk about their siblings or children.
- Ask specific questions about sexual relations but if the peer beneficiaries are reluctant to discuss their own experiences ask them to talk about "people they know" or what "people nowadays" might do.
- Do not be judgemental or take a moralistic attitude when sexual issues are being discussed.
- Encourage discussion by asking follow-up questions such as "How did you feel then?" or "Why do you think that happened?". Or ask others to comment on what happened and if they have had similar or different experiences.

Admit that talking about sex is not always easy

Indicate that you realize people do not usually discuss sex and that it can be embarrassing to do so. However, we all have sex and the questions and problems facing us demand that we are able to talk openly about it. Other suggestions:

- Use humour. Nothing reduces embarrassment like a good laugh.
- Begin questions with a general statement about different types of sexual behaviour. Do so in an accepting manner and then proceed to ask them to describe their own sexual behaviour or that of people they know well. For example: "Someone told me that some men want to use condoms but get so drunk they forget. Do you know anyone to whom this has happened?".
- Start from general questioning and become more specific as the peer beneficiaries relax and get talking. For example, get them to describe where they go to drink alcohol, who they go with, who they meet there; and then ask them to describe sexual encounters.
- Use words that are understandable and acceptable to peer beneficiaries. Develop a vocabulary of terms that are commonly used. Do not be afraid to use them even if they sound vulgar. Words include: sexual intercourse, penis, vagina, sperm, oral sex, anal sex, sex worker, words pertaining to various STIs, etc.
- Be aware of cultural attitudes and values concerning sexual behaviour that affect a person's risk of being infected by HIV.

5.5 How are personal blocks overcome?

Condoms cannot be ignored

It is impossible to reduce HIV infection without condoms. Some peer educators may be personally against condoms or feel uncomfortable talking about them. However, peer

educators cannot do their job effectively without getting peer beneficiaries to consider consistent condom use.

Moral judgements counter-productive

Peer educators can set a good example by avoiding brothel visits and excessive alcohol consumption. But criticizing others who do not practise the same positive behaviour can end up alienating those you are trying to work with. More often than not, morally judging the behaviour of a peer beneficiary will lead to communication being cut off and the person hiding their risk-taking behaviour. The idea is to create strong lines of communication and get the peer beneficiary to understand behaviour choices better.

EXERCISE 5.1

Understanding barriers to effective communication

OBJECTIVE
To promote understanding of common barriers to effective communication and increase knowledge on how to overcome them.

BACKGROUND
There are a number of common barriers to effective communication that greatly handicap peer education. They might involve the peer educators themselves (personal), the greater society (socio-cultural) or poor organization (logistical). It is important for peer educators to understand what the challenges are and how they can be effectively overcome.

MATERIALS
Sheets of typing paper or flip chart paper (optional)

TIME
1 hour

INSTRUCTIONS

STEP 1
What follows is a description of different barriers to effective communication. Read each one to the peer educators and ask them to think of ways peer educators could respond.

STEP 2
Share the strategies listed after each barrier if they have not already been mentioned by the peer educators. The barriers and the strategies may be written on flip chart paper, typed out and printed on sheets of paper, or written on a blackboard. Make sure the barriers and strategies are presented separately.

Personal barriers

BARRIER 1
The peer educator has difficulty communicating effectively, does not understand the subject, or has poor understanding of his/her peers and how they see the subject.

Strategies
Make sure your knowledge is up to date. If you do not know something, inform your peers of that and return later with the information they need.

BARRIER 2
A peer educator's negative attitude can affect the impact of the message on others.

Strategies
Be keenly observant and aware of your attitudes and biases, and try to set them aside when you work with your peers. Never impose your own opinions on controversial topics.

BARRIER 3
Some young people do not feel comfortable with people much older than themselves, and some older people may not be comfortable discussing certain subjects with younger persons.

Strategies
Show respect to all participants. Identify yourself as a responsible person who deals sensitively with difficult topics.

Socio-cultural barriers

BARRIER 4
Sometimes religious and cultural backgrounds may differ and may interfere with communication.

Strategies
It helps to have background information on the religious and cultural beliefs of the people with whom you are working. Try to acknowledge when religious and cultural values might interfere with communication and deal with them head on. Do not ignore them. Respect people's values even when you do not agree with them.

BARRIER 5
Some people prefer to communicate with people of the same sex, especially on sensitive subjects.

Strategies
Acknowledge that the discussion might be embarrassing, but explain that sometimes it is necessary to discuss sensitive topics. Acknowledging embarrassment sometimes helps one to overcome it.

BARRIER 6
Some people may misunderstand technical language. They may be polite and pretend to understand but there may be a lot of blank faces among those listening.

Strategies
It is important to speak in terms that the participants will understand and to use acceptable terminology. Keep language as simple as possible. Find out whether terms

are familiar or if they require an explanation. If you have to work with people who speak a different language, find a reliable person to translate.

BARRIER 7
Younger recruits might find it hard to relate to a person who appears to be of another economic status or a much higher rank.

Strategies
Show respect, no matter what the rank or age of the person might be. Sit among the group members instead of standing over them or sitting apart. Wearing informal dress can also help to break down barriers.

Logistical barriers

BARRIER 8
If the meeting time is inconvenient, peers may not be able to listen effectively (or they may not attend).

Strategies
Allow the peers to choose the time.

BARRIER 9
Noise, high temperatures and inadequate seating facilities can interfere with effective communication.

Strategies
Make sure the venue is comfortable, quiet and accessible.

EXERCISE 5.2

Overcoming personal blocks to condoms

OBJECTIVE
To encourage participants to feel more comfortable discussing sexual issues.

BACKGROUND
Discussing intimate subjects such as sex and condoms can make people feel uncomfortable. This is as true of those working in HIV/AIDS prevention as it is of target groups and community leaders. There are different ways to "desensitize" them so that condom promotion can be undertaken more freely.

MATERIALS
Condoms, bananas or wooden models, sheets of paper or a short questionnaire (optional)

TIME
30 minutes

INSTRUCTIONS

STEP 1
Some people in the uniformed services have never seen, touched or used a condom. Pass condoms out. Have people open the packages and examine them. Ask them to stretch them and even blow them up into balloons. Demonstrate how to put them on, using a banana or a wooden model.

STEP 2
The following short questionnaire measures people's personal comfort level when dealing with sex and condoms. The questionnaire may include the following points that people are asked to rate, on a scale of 1–4, in terms of how comfortable they would be with each one. For example, marking "1" beside the first statement would mean the person was very comfortable "discussing condoms with teenage children" and marking "4" would mean they were uncomfortable.

- Discussing condoms with your teenage children or nieces and nephews.
- Putting up a poster promoting condoms in your sleeping quarters.
- Recommending condom use to a friend you know is taking risks.
- Demonstrating how to put a condom on a banana.
- Handing out condoms to others.
- Answering questions about your own experience with condoms.

- Going into a shop and buying condoms.
- Having your wife find condoms in your kit.
- Talking about condoms in a place of worship.
- Talking to your in-laws about condoms.
- Talking to a senior officer about condoms.
- Meeting for the first time with a group of men who have sex with men.
- Talking about ways to clean equipment used to inject heroin.

STEP 3

After getting participants to consider the ranking of 1–4, ask those who chose 3 or 4 on the scale for any point to describe what makes them uncomfortable. Ask them if they think their embarrassment might prove to be an obstacle to conducting their peer education work effectively. How might they eventually get over their embarrassment?

6. Monitoring and evaluation

TIPS FOR THE READER

Two main topics are covered in this section. The first focuses on reporting to the peer education supervisor, holding meetings with focal persons such as decision-makers, programme planners and high-ranking supervisors, and the use of diaries and notebooks. The second topic discusses collecting information: types of data (qualitative and quantitative) and quarterly report monitoring. The exercise has participants look at sample monitoring forms and provide feedback on their comprehension of what would be required of them when filling them out and its importance.

BASIC FACTS ON MONITORING AND EVALUATION

6.1 What are monitoring and evaluation?

One of the biggest challenges with peer education programmes is determining whether they are working or not. There is a wide array of methods and approaches for collecting information to determine whether the peer education programme is working and risk-taking behaviour is being reduced. For example, the following steps can be followed:

1. Define the types of information to be collected.

2. Design a reporting system.

3. Define indicators to monitor the progress and assess the actual impact of the programme such as:

- number of individuals referred by the peer educators to a nearby health facility for treatment of sexually transmitted infections (STIs) and opportunistic infections or for voluntary counselling and testing (VCT)
- number of condoms sold or supplied by the peer educators and used by the peers
- amount of educational material distributed by peer educators to their peers
- anecdotal experiences narrated by the peer educators
- acknowledgement/recognition of the peer educators' services by randomly selected peers.

4. Develop informal approaches to supervision and monitoring including:
   - observation (simply watching peer educators in action)
   - interaction with participants and feedback from peer educators
   - focus group discussions
   - system for providing feedback to peer educators.

5. Develop formal approaches including:
   - feedback from site visits and key informant interviews
   - weekly peer educators' meetings
   - routine refresher training for the peer educators
   - structured interviews with high-risk groups in their places of work or residence.

6. Develop impact indicators for the peer education programme including:
   - number of STI cases treated by qualified medical practitioners
   - number of socially marketed condoms sold by peer educators
   - number of attendees to STI services from the target group
   - percentage of individuals within the target population that used a condom in the last casual sexual relationship.

7. Develop a means of verification:
   - referral slips
   - information on STI cases treated, as collected from private and government medical practitioners
   - reports from social marketing condom outlets and peer educators.

6.2 How can the quality of monitoring be improved?

Train peer educators well in monitoring

Peer educators have the responsibility of keeping track of their own activities and reporting to supervisors and, ultimately, programme planners. Because they are on the front lines they have the responsibility of monitoring the changes in behaviour of the peer beneficiaries and reporting them. In order to get good results they must be aware of their role and motivated to carry it out.

Start by collecting preliminary data

The collection of baseline data is essential before starting any peer education programme. A survey should be conducted with personnel to gain an accurate picture of what their needs are. Questions should revolve around knowledge levels and understanding of HIV/AIDS and related topics.

Keep reporting forms simple

Reporting formats for peer educators should be simple so it is easy to collect and interpret results. There are three sample forms in the exercise which show: a) the monthly activity record; b) the monthly data collection form; c) the condom stock card. In addition, each peer educator can keep a small pocket-size notebook and diary that provides more details on each session and lists appointments. Peer educators are encouraged to initially organize five meetings per month in the workplace and increase gradually.

Hold monthly supervision meetings

Peer educators should hold monthly meetings with the peer education coordinator or amongst themselves, depending on the structure in place. The peer educator is responsible for reviewing the impact of the process and should identify and invite pertinent personnel to attend meetings where this information can be shared. This identification process should be at the discretion of the peer educator but should include decision-makers, programme planners and high-ranking supervisors. The forum is used to share experiences, events, problems, progress, causes of problems and potential solutions. Issues on the agenda might include a review of HIV/AIDS activities, submission of monthly reports and drawing up an action plan. The peer educator collects the data, and if possible compiles them into meaningful statistics.

Regular meetings necessary

Supervision and monitoring of peer educators is best achieved through regular meetings to take note of any new changes as well as reviewing progress to identify weaknesses/ strengths and check performance. Ongoing training based on areas that need improvement may also be arranged.

Supervisors compile report

The supervisor should compile a quarterly report for monitoring. Implementation of the HIV/AIDS programme must be monitored to highlight progress of STI/VCT assessments, condom promotion/distribution, and health talks and counselling sessions with peers.

Promote record-keeping

Record-keeping is an important tool as it helps to gauge the performance of peer educators and also assess the progress of the programme.

Collect information at monthly meetings

Peer educators should hold monthly meetings with supervisors to focus on the following:

- share experiences and learn from each other
- update peers with HIV/AIDS information and events
- highlight problems and seek ways to solve them
- practise role-plays/presentations.

Points when holding a meeting

- Collect reports as required before the meeting.
- Appoint someone to take the notes or minutes.
- Make announcements.
- Review the last meeting notes and correct as needed.
- State the purpose of this meeting and read the agenda items.
- Ask if anyone wants to add agenda items.
- Go through agenda items for discussion and/or decisions as needed.
- Share successes or accomplishments since the last meeting.
- Raise problems and other issues.
- Discuss training or other needs.
- Go over work schedules as needed.

- Talk about the next meeting before closing.
- Close on a positive note (sharing a story or experience observed among those in the group and recognizing those who performed well).

Reasons to monitor peer educators

- Helps motivate the peer educators.
- Identifies any performance gaps.
- Reviews how the peer educators respond to difficulties encountered.
- Assures the objectives and practices followed by the peer educators are in line with the project's objectives.

6.3 How are peer educators monitored?

- Field support visits. The project coordinator lists the uniformed services to be visited, taking note of their schedule, and arranges for a visit by appointment.
- Regular visits to take note of any new changes.
- Record review to identify weaknesses/strengths and check performance.
- Spot checks are done randomly without planning in order to follow up and check activities. This helps peer educators to be alert and active. Ongoing training in the field based on areas that need improvement is also arranged.
- Quarterly reports: These reports are compiled by the project coordinator against four key tasks:
  a) Implementation of HIV/AIDS programme: this highlights progress of STI/VCT assessments and condom promotion/distribution.
  b) Training programme: in accordance with the performance guidelines.
  c) Supervision: monitoring visits to focal persons/peer educators.
  d) Monitoring and evaluation: position data collection for the baseline survey.

6.4 Why is baseline research important?

The best evaluations compare what a situation was like before peer education occurred with what it was like afterwards. In order to do this it is important to collect reliable data in the beginning. Some examples of information to be collected:

Quantitative assessment

- Situation of the HIV/AIDS epidemic and the potential spread of HIV/AIDS in the selected country.
- Identification of national guiding principles and strategic planning.
- Do these national guiding principles include and integrate uniformed services, especially youths and new recruits?
- Identification of service: armed forces, police, border/customs officials, etc.
- Policies related to recruitment.
- Size of eligible population to be recruited and actual recruited population.
- Quantification of uniformed personnel in service (including by sex and age).
- Structure of service, i.e. training cell, medical unit, etc.
- STI/HIV/AIDS prevalence or incidence among the uniformed services.
- Referral systems available (where do they seek treatment for STIs?).
- Availability of epidemiological surveillance within the uniformed services.

- Other links to relevant civilian systems or activities (i.e. health and education).
- Policies and activities related to HIV/AIDS prevention among uniformed services.
- Readiness of uniformed services to introduce HIV/AIDS interventions.
- Mapping, identification of institutions interested and implementation readiness.
- Identification of basic monitoring and evaluation indicators.
- Access to condoms; information, education and communication (IEC); STI voluntary counselling and testing.
- Availability of educational materials, programmes and activities in the areas of prevention, counselling and care.
- Access to information: IEC, media, educational and internal communication.

Qualitative assessment

What are the main factors determining the spread of HIV/AIDS among the uniformed services, particularly new recruits? The general factors outlined in the above section on uniformed services vary depending on each country and context. For example, the determining factors such as injecting drug use and forced commercial sex work (trafficking in women) in Eastern Europe and Central Asia are much different from the determining factors in many African countries which are often linked with poverty and lack of access to education.

More specifically, the qualitative assessment should address the following issues:

- How do officers and the rank and file, especially new recruits, perceive risk and risk-taking behaviour?
- Do they use condoms (access and use)?
- What do they do for recreation?
- Who do they listen to for information about STIs/HIV/AIDS?
- What are the cultural background and values?
- What is the level of education?
- How are issues linked to sexual behaviour (e.g. gender-based violence and drug use) being addressed?
- How good is the quality of the relevant training (e.g. is it gender sensitive)?

Evaluations should answer questions such as:

- Did the intervention reach all the individuals?
- How many peers were trained?
- To what extent are people living with HIV/AIDS involved in training?
- Were training activities implemented the way they had been intended?
- Which specific interventions work best? Under what circumstances?
- What components did not work? What went wrong?
- Where should more efforts be placed?
- What can be improved?

EXERCISE 6.1

Evaluating monitoring forms

OBJECTIVE
To learn more about what is required of peer educators in terms of monitoring and evaluation and become familiar with sample reporting forms. Peer educators should have a better understanding of what information it is important to collect, how to plan their activities and the importance of coordination.

BACKGROUND
The peer educators have an important role in providing the eyes and ears for the progress the peer education effort is making since they are on the front lines.

MATERIALS
Sample reporting forms, flip chart and paper or blackboard (optional)

TIME
45 minutes

INSTRUCTIONS

STEP 1
Distribute the sample evaluation forms to participants and briefly explain how to record the following information:

- Monthly activity record: provides details on and tracks peer education activities.
- Monthly data collection form: elicits feedback on condom distribution, numbers referred for STI treatment and VCT.
- Condom stock card: source of information for monitoring flow of condoms through the system.
- Peer educator's diary: assists the peer educator in keeping his/her own individual records and in recording promptly.

STEP TWO
Ask participants the following questions and write their responses on a flip chart or blackboard if possible:

- What do you think of the evaluation forms?
- Was there anything confusing about the forms?
- Why do you think it is important to fill out forms like these?
- What do you think the information collected on the forms would be used for?

- Why do you think it is important to provide correct information on the forms?

STEP THREE

Provide a summing-up of the points made by the participants.

SAMPLE EVALUATION FORMS

Monthly activity record

Name of company . . . . . .
Name of peer educator . . . . . .
Month/year . . . . . .

Topic	Presentation method	Number of males reached	Number of females reached	Comments

Presentation method: Role-play – RP Video – VO Group discussion – GD
Slide show – SS Dance troupe – DT Demonstration – DN

Monthly data collection form

Name of company . . . . . .
Name of peer educator . . . . . .
Month/year . . . . . .

Number provided with male condoms Males Females	Number supplied with female condoms Males Females	Number of referrals Males Females	Reason for referral Males Females

Condom stock card

Name of company . . . . . .
Year . . . . . .
Opening balance . . . . . .

Month	Number issued	BALANCE
Week 1		
Week 2		
Week 3		
Week 4		
	Total	Total

Peer educator's diary

Name of company . . . . . .
Name of peer educator . . . . . .

Date	
Type (group or one to one)	
Place of meeting	
Time of meeting	
Number of peer beneficiaries present	
Number of female participants present	
Method of presentation	
Topic(s)	
Number of people provided with condoms	
Number referred for STI treatment	
Number referred for VCT	

7. Basic information on HIV and AIDS

TIPS FOR THE READER

It is necessary for peer educators to have a basic knowledge of HIV and AIDS as they need to be prepared to answer questions that arise. Having basic information about HIV, AIDS, STIs and condoms increases confidence. What follows is a detailed description of how HIV spreads between people and the different stages of infection. There are three exercises. The first helps people distinguish between different levels of risk for infection. The two others are games to illustrate how easily HIV can be spread throughout a group of people.

BASIC FACTS ON HIV AND AIDS

7.1 What is the cause of AIDS?

AIDS is caused by:

H = Human
I = Immunodeficiency
V = Virus

which is also referred to as the AIDS virus. HIV is an extremely small virus; you cannot see it with your eye. It likes to be in dark, wet places like body fluids (blood, semen, vaginal fluid, breast milk). It is a fragile virus and when exposed to air it dies in seconds. It can be quickly killed with soap.

7.2 What is the definition of AIDS?

A stands for **acquired**. It means that HIV is passed from one person who is infected to another person.

I is for **immune** and refers to the body's immune system. The immune system is made up of cells that protect the body from disease. HIV is a problem because, once it gets into a person's body, it attacks and kills cells of the immune system.

D is for **deficiency**, which means not having enough of something. In this case the body does not have enough of certain kinds of cells, called immune cells, that it needs to protect against infections. HIV enters the body and acts like a patient sniper, hidden for as long as it takes to do its job to weaken the immune

system. Over time HIV kills more and more immune cells, the body's immune system becomes too weak to do its job and the person living with HIV becomes sick.

S means that AIDS is a **syndrome.** A syndrome is a group of signs and symptoms associated with a particular disease or condition that occur together. AIDS is a syndrome because people with AIDS have symptoms and diseases that occur together only when someone has AIDS.

7.3 How is HIV spread?

Body fluids that can spread HIV are:

- semen
- vaginal fluid
- blood
- breast milk.

Most HIV is spread by having unprotected vaginal, anal or oral sex with a person already infected with HIV.

Vaginal sex

This means a man inserting his penis into a woman's vagina. Vaginal sex can let HIV into your body through any cuts or tears inside the vagina or on the penis. HIV is contained in both semen and vaginal fluid, so a man can give HIV to a woman and a woman can pass HIV to a man. When a man is aroused, his penis stretches. Likewise, when a woman is aroused, her vagina stretches. This stretching makes the membranes in the penis and vagina more porous and causes very tiny cuts and breaks that you cannot see.

Anal sex

This refers to a man putting his penis into the rectum, or anus, of a woman or a man. Anal sex can let HIV into your body through cuts or tears in the rectum, or anus. The rectum does not stretch readily (unlike the vagina) and because of this can tear and bleed more easily. A woman can contract HIV through semen when a man ejaculates in her rectum. A man can contract HIV through semen when a man ejaculates in his rectum. Men who have sex with men are more vulnerable to HIV infection because of anal sex. A penis can irritate and cut the anal lining increasing the opportunity for the virus to enter the body.

Oral sex

This means sucking or licking of the genitals. A man can suck or lick a woman's genitals or a man's penis; a woman can suck or lick a man's penis or a woman's genitals. Oral sex can let HIV into your body through any cuts or tears inside the mouth due to injury or gum disease. People taking semen into their mouths are more vulnerable than those ejaculating. Oral sex is a much lower risk for infection than vaginal or anal sex, especially if semen is not taken into the mouth.

By sharing needles with a person living with HIV/AIDS

Those who share needles can transfer infected blood from one person to another. This is particularly the case with those who inject drugs such as heroin.

During pregnancy, birth or breastfeeding from a mother with HIV/AIDS to her baby

During pregnancy, HIV can be passed from mother to baby through the placenta. At birth, HIV can be transmitted through blood from the birthing process. HIV is present in breast milk and can be transmitted to a baby during breastfeeding. Current statistics say there is a one in three chance an infected mother can transmit HIV to her baby by breastfeeding.

By receiving a blood transfusion that is contaminated with HIV

Not all blood is routinely tested for HIV. Some blood is transferred directly from a donor, who is usually a relative, to someone needing a transfusion.

7.4 What are the stages of HIV infection?

Window period

Once a person becomes infected with HIV, that person does not immediately become "HIV-positive". There is a period of usually three to six weeks (sometimes as long as three to six months) before the body reacts to the presence of this virus and produces antibodies that can be found in the blood by laboratory tests. If these antibodies are found, the test result is "positive". The period of time that passes while the test is still negative is called the "window period". It is important to understand this, since the person can pass on the virus in these weeks, even though the HIV test is still negative.

Asymptomatic period

After a person is infected with HIV, there is usually no change in that person's health for quite a few years. The person feels well, is able to work as before and shows no signs or symptoms of being sick (this is what is meant by "asymptomatic"). With the exception of having HIV in the body, the person is "fit for work". This asymptomatic period varies from a few years to up to as many as 12 years. The average range is between eight and 12 years. However, individuals can begin to become sick from as little as a few to five years after infection.

The symptomatic period when the person is sick with AIDS-related illnesses

Remember, AIDS is a "syndrome", a collection of conditions that, taken together, allow us to make a diagnosis of AIDS. Most of the conditions that start to appear are called "opportunistic infections". Opportunistic infections are caused by bacteria or viruses that normally do not cause illness in a person with a strong immune system, but do cause illness in a person with a weakened immune system. Opportunistic infections are infections such as diarrhoea, tuberculosis and pneumonia, and they repeatedly make the person sick. When a person is diagnosed with AIDS, the length of time until death can be very individual depending on the number and type of opportunistic infections and the availability of treatment and drugs. Individuals can live for one to two years or much longer (if receiving treatment with drugs).

Window period and HIV testing

If a couple wants to stop using condoms or have a family, both individuals can be tested for HIV at the same time and then use condoms with every sexual act (vaginal, oral or anal intercourse) for the "window period" of three to six months. This is presuming they both

test negative. They must agree to only have sex with each other and not have sex with anyone else. When the six months are over, the couple can again get tested for HIV at the same time. If both still test HIV-negative, then they can start having sex without using a condom or try to get pregnant. Again, both individuals must agree to have sex only with each other and not see anyone else or use condoms if they do.

7.5 How is HIV not spread?

- Through casual (non-sexual) social contact like shaking hands, touching or hugging, from toilet seats or from eating food prepared by someone living with HIV/AIDS.
- Sharing eating and cooking utensils like cups, plates, pots, or forks and spoons.
- By kissing, even tongue kissing (French or deep kissing). HIV has been found in saliva, but the amount of HIV in saliva is extremely small. No one has ever contracted HIV by kissing.
- By mosquitoes. Mosquitoes are a problem and cause other diseases, but do not transmit HIV. You cannot get HIV from a mosquito, as you can malaria. Mosquitoes bite people for blood, which is their food. With malaria, a mosquito bites a person then goes into a two-week life cycle to incubate the parasite. After this two-week period, the mosquito then goes and bites someone else, infecting them with malaria. This same situation does not happen with HIV because HIV cannot live within the mosquito for two weeks: it dies and the mosquito cannot transmit HIV when it bites another person.

7.6 Can a person be infected with one exposure?

Anyone can become infected with HIV from one single unsafe sexual act or from using drugs by injection even just once. The vast majority of all HIV infection is caused by having unprotected intercourse with a woman or man who is already infected with HIV (80% of infections). Having sex with an infected person does not mean, however, that every time an infected person has unprotected sex they infect their sexual partners. An infected man could have sex with his wife for two years before infecting her or it could happen the first night they have sex. People are more infectious right after being infected themselves.

7.7 What is the most common way to get infected?

Almost all transmission of HIV is through sexual intercourse between two people who do not use condoms, either heterosexual relations or as a result of men who have sex with men. There is a rapidly growing number of mothers who are infected with HIV who pass the virus to their babies during or after their birth. These women were often infected by their husbands who were often infected by sex workers. There are some cases when blood taken from a person infected with HIV is transfused to another person. Those who inject drugs like heroin and share their needles also risk infection. All other modes of transmission are almost insignificant. It is impossible to become infected with HIV through casual contact with people living with HIV/AIDS. There is no problem touching or sharing eating utensils or combs and brushes.

7.8 Is there a cure for AIDS?

There is no cure for AIDS at present. A combination of drugs called antiretroviral drugs (ARVs) can result in controlling the virus so it does not weaken the immune system and

make it vulnerable to AIDS-related illnesses. At present, the cost of ARVs makes them unaffordable for most people in the world infected with HIV. Progress is being made in reducing the cost of the drugs, which will potentially increase their availability.

7.9 Do traditional healer cures for HIV/AIDS work?

Traditional healers around the world are selling cures for HIV/AIDS. Many have been examined by scientists but none so far has proved to eliminate HIV. There would be great joy in the world if traditional healers did come up with something that cured AIDS. Traditional healers can ease some of the symptoms of AIDS-related illnesses and opportunistic infections. Unfortunately, many with HIV/AIDS turn to traditional healers with false hope and waste their money.

7.10 Is it easier for women to get infected than men?

Women are about four times more vulnerable than men to sexually transmitted diseases, including HIV. This is largely because of anatomy: the area of the female genitals exposed to semen and other sexual fluids during sex is four times larger than that of men. Women are also at more risk of getting infected because semen contains greater amounts of the virus than vaginal fluids. Women can also be vulnerable to infection as a result of rape or coercion. They can be driven to selling sex for financial reasons. Female sex workers who do not use condoms are vulnerable to contracting HIV and other STIs which increase their likelihood of infecting their many partners.

7.11 What is the impact of STIs on HIV infection?

The presence of an untreated STI like syphilis or gonorrhoea facilitates the transmission of HIV from one person to another. Open sores and blisters provide an easy entrance into the body for STIs, including HIV. Having an STI is already a sign of risk-taking behaviour. Prevention and treatment of STIs is another way to protect against HIV infection.

7.12 How do alcohol and drug use increase the chances of infection?

Drinking alcohol or using illegal drugs will reduce your judgement and your ability to act within the bounds of safe behaviour. When you are under the influence of alcohol and/or drugs, you are more likely to indulge in risky sexual contacts. Consumption of alcohol also tends to increase the libido and make people feel like having sex. Sex workers can often be found at places where alcohol is served. Men who serve in the uniformed services and are restricted to barracks may look forward to getting their monthly pay, going on leave, getting drunk and finding women to have sex with. They may intend to use condoms but are less concerned about HIV infection when they are drunk. Injecting drug users face direct risks of infection if they share equipment (see Section 11).

7.13 What is safer sex?

Safer sex is a means of preventing the sexual transmission of HIV. The easiest form of safer sex for those who are sexually active to adopt is the use of latex condoms every time they engage in vaginal, oral or anal sex. Safer sex also includes not having sex, fidelity between uninfected partners, and practising non-penetrative sex such as hugging, kissing, masturbation, mutual masturbation and simulating sex between a partner's thighs or breasts. The reason it is called "safer" rather than "safe" sex is because a condom might

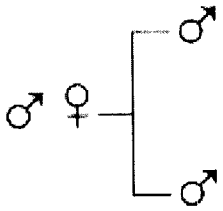
break or those intending to practise non-penetrative sex might end up having penetrative sex without a condom in the heat of the moment.

7.14 What is the HIV and STI transmission butterfly?

The HIV/AIDS/STI butterfly consists of a series of illustrations that demonstrates how a person does not only have sex with one person, but with every person that person has ever had sex with.

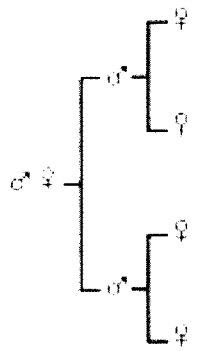
To demonstrate how STIs, including HIV, are transmitted from one person to another, imagine the following situation.

Imagine that you are at a bar. You're out with some of your friends from your unit. It was a difficult week at work and you and your friends just want to relax and have a good time. You're sitting at a bar when a group of beautiful young women comes in. You and your friends start talking to them and before you know it you're all coupled off. You start talking and dancing with one of these young women and eventually decide to leave the bar with her. You go with her to her home and, as things work out, decide to have sex. Because you weren't planning for this to happen, you didn't grab a condom when you left home. But you think to yourself "just this one time" nothing can happen. Besides, she's so lovely she cannot possibly have anything. So, you have sex without using condoms. As you lie in bed, you think what a romantic evening it has been ... just the two of you. But, let's imagine for a second that your new friend had made an exception and had unprotected sex "just this one time" at least twice before.

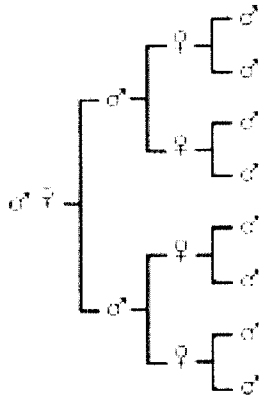


What your new friend didn't know was that the guy she picked up at the bar a couple of months ago had got drunk at a party and had sex with a total stranger "just once". She didn't know that on another occasion he had made an exception "just this one time" and had unprotected sex with someone he had been dating for only a week. She didn't know

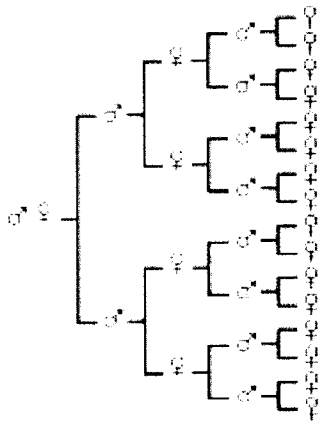
that the other guy she had unprotected sex with had also made an exception "just this one time" with at least two different sexual partners.



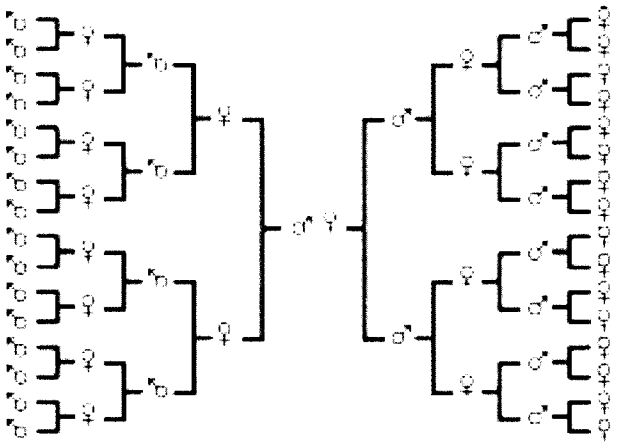
Each of these people had also put themselves at risk "just this one time" at least twice before.



And imagine if their sexual partners made exceptions and had unprotected sex "just this one time" at least twice before. Now let's think about who's in the bed ... you think it is just the two of you ... there are at least 30 people in bed with you and your beautiful new friend and any one of them could have an STI. Regrettably, you don't know which one. It could be anyone ...



Now let's take a look at you and your other sexual partners. The pattern is repeated on the other side of the butterfly's "wings".



Think about this: if this woman were a commercial sex worker, how big would the bed have to be to hold all the people you were having unprotected sex with? It could be as large as a football field! If you think this is an exaggeration, consider this: any time two people on the butterfly have unprotected sex, you are potentially at risk of getting an STI, including HIV. What if one of those people on your side had herpes? Or if one of them had HIV? It's that easy for you to get HIV or any other STI as well.

EXERCISE 7.1

High risk, low risk, almost no risk, no risk

OBJECTIVE
To clear up misunderstandings on how HIV is spread and not spread.

BACKGROUND
Different behaviour carries different levels of risk of HIV infection. There is also often an unwarranted fear of HIV infection through casual contact like sharing cups or razors. The point of this exercise is to get participants to understand better what puts them most at risk of infection and what carries little or no risk of infection.

MATERIALS
Sheets of paper or flip chart paper, index cards or sheets of paper cut in half with the points written on them

TIME
1 hour

INSTRUCTIONS

STEP 1
On a large sheet of paper or flip chart paper, write in big letters "High risk". On other sheets write "Low risk", "Almost no risk" and "No risk". Write each of the following points on index cards or on half sheets of paper before starting the exercise, then mix them up:

High risk
- Vaginal sex without a condom
- Having sex without a condom with a sex worker
- Anal sex without a condom
- Many sexual partners without using condoms
- Having sex when infected with an STI without a condom
- Having sex with a person infected with an STI without a condom
- Having sex while drunk without a condom
- HIV-infected person wanting to have a child
- Using petroleum jelly or hair oil to lubricate a condom
- Sharing needles with intravenous drug users
- A transfusion of untested blood

Low risk

- Oral sex without a condom
- Sex with a condom
- Sex for money with a condom
- Touching the blood of an injured person

Almost no risk

- Injection of medicines
- Scarification (tribal marking)
- Female genital cutting
- Sharing razors

No risk

- Abstinence
- Kissing, hugging, massaging and mutual masturbation
- Sex between mutually faithful, uninfected partners
- Sharing eating, drinking and cooking utensils with an infected person
- Donating blood
- Deep kissing with tongues
- Sharing a toothbrush or hairbrush
- Being bitten by mosquitoes
- Touching a person with HIV/AIDS
- Sharing a bathroom or latrine
- Hugging a person with HIV/AIDS
- Caring for a person with HIV/AIDS

STEP 2

Present the following points to participants to explain the relative risks they face of being infected with HIV/AIDS:

High risk

- High risk means doing something with a good chance of getting infected with HIV.
- HIV, the virus that causes AIDS, can be found in bodily fluids including blood, semen and vaginal fluids.
- More than 90% of HIV is transferred by penetrative sexual intercourse (a penis in a vagina or anus).

Low risk

- Low risk means that an activity presents a small chance of getting infected with HIV.
- A condom may break allowing for infection.
- A person who has cuts on the hands handling a bleeding person has a small chance of being infected – if in doubt wear gloves.

Almost no risk

- Almost no risk means that there have been no cases of people being infected in this way but it is a remote possibility.
- Small amounts of HIV can be found in saliva, sweat and tears but not enough to infect another person.
- Sharing razors presents little or no risk.

No risk

- No risk means that it is impossible to get HIV in this way.
- All casual contact, touching, kissing, hugging, massaging and masturbating.
- Since HIV is primarily a blood disease, sharing everyday utensils for eating and cooking is not a risk at all.

STEP 3

Have participants pick a card and then judge whether it should be categorized as "High risk", "Low risk", "Almost no risk" or "No risk" and place the card in the proper group. They should also say why they think it should be placed there.

STEP 4

After all the cards are placed, ask the whole group if they would like to change any of the cards from one group category to another.

STEP 5

Make sure that all the cards are in the right category and offer the following explanations for any errors in placing the cards:

High risk

- Vaginal sex without a condom
  (Semen and vaginal fluids can contain HIV.)
- Having sex without a condom with a sex worker
  (Sex workers have multiple partners increasing their chances of being infected.)
- Anal sex without a condom
  (A rectum is not designed for sex and a penis can cause rips and tears inside allowing exchange of blood and semen.)
- Many sexual partners without using condoms
  (The greater the number of sexual partners, the greater the chance of engaging in sex with one who is infected.)
- Having sex when infected with an STI without a condom
  (STIs bring blood to the surface of the skin increasing the opportunity for infection.)
- Having sex with a person infected with an STI without a condom
  (STIs bring blood to the surface of the skin increasing the opportunity for infection.)
- Having sex while drunk without a condom
  (Too much alcohol can reduce the desire to use a condom.)

- HIV-infected person wanting to have a child
  (*A pregnant woman with HIV has one chance in three of infecting her child at birth or through breastfeeding.*)
- Using petroleum jelly or hair oil to lubricate a condom
  (*Oil-based products weaken condoms and can cause them to break.*)
- Sharing needles with injecting drug users
  (*Injecting drug users who share needles inject other people's blood into their veins.*)
- A transfusion of untested blood
  (*Unless the blood has been tested, there is no way of knowing if the person donating it is infected or not.*)

Low risk

- Oral sex without a condom
  (Unless the person has cuts in their mouth there is only a small chance of getting infected.)
- Sex with a condom
  (A condom is good protection against HIV unless it breaks.)
- Sex for money with a condom
  (A condom is good protection against HIV unless it breaks.)
- Touching the blood of an injured person
  (The skin surface is a good seal against HIV unless cuts or sores are present.)

Almost no risk

- Injection of medicines
  (Since it is medicine and not blood being injected, the risk is extremely low.)
- Scarification or tribal marking
  (If this were a risk, many more children would be found to be infected before they became sexually active. It is very rare to find an HIV-positive child who was not infected by their infected mother at birth or through breastfeeding.)
- Female genital cutting
  (If this were a risk many more girls would be found to be infected before they became sexually active. It is rare to find an HIV-positive child who was not infected by their infected mother at birth or through breastfeeding.)
- Sharing razors
  (HIV in infected blood is very fragile outside the body and is easily killed by soap and water. We would find more old men who are infected if this were a common means of transmission.)

No risk

- Abstinence
  (Having no sex at all prevents sexual transmission.)
- Kissing, hugging, massaging and mutual masturbation
  (The small amount of HIV in saliva or sweat is not enough to transmit to someone else.)
- Sex between mutually faithful, uninfected partners

(Two people who have been tested and remain mutually faithful.)

- Sharing eating, drinking and cooking utensils with an infected person
  (HIV is a very weak virus outside the body. It dies in the air very quickly and is killed by soap and water.)
- Donating blood
  (Those collecting blood are careful to use new or sterilized needles.)
- Deep kissing with tongues
  (HIV can be found in saliva but not enough to transfer the virus from one person to another.)
- Sharing a toothbrush or hairbrush
  (Sharing brushes may not be hygienic but HIV transmission is not a problem.)
- Being bitten by mosquitoes
  (If mosquitoes transmitted HIV then many more people of all ages would be infected.)
- Touching a person with HIV/AIDS
  (The skin is a good protective coating. HIV doesn't go through it unless there is an open sore or cut.)
- Sharing a bathroom or latrine
- Feeding a person with HIV/AIDS
- Hugging a person with HIV/AIDS
- Caring for a person who has HIV/AIDS
  (Those who are caring for women living with HIV/AIDS should be extra careful handling menstrual blood, but other contact is not a risk.)

EXERCISE 7.2

The glove game

OBJECTIVE
To create a better understanding of how HIV is spread and of the impact of protection and abstinence, as well as to get participants to reflect on voluntary counselling and testing.

BACKGROUND
This game is more complex than the others and requires equipment in the form of gloves. It is important to explain the rules slowly and clearly.

MATERIALS
Small pieces of paper (sheets of paper torn into quarters) and two gloves

TIME
45 minutes

INSTRUCTIONS

STEP 1
Prepare small slips of paper so that you have a number equal to three less than the total number of participants. (For example, if you have 20 participants, prepare 17 slips of paper.) Write an "X" on one of the slips. Put the slips into a hat or bowl. Prepare three additional slips of paper with the following instructions:

- G Wear a glove on your right hand during rounds 1 and 2 of the activity.
- G Wear a glove on your right hand during rounds 3 and 4 of the activity.
- A During the game, if somebody tries to shake your hand, apologize and explain to them that you do not shake hands.

STEP 2
Before the game begins, and without other participants seeing you, take aside three participants and give each of them one of the slips of paper with special instructions. Provide gloves to the two participants with the "G" slips of paper. Instruct them that when you come around with the hat or bowl, they should pretend to pick a slip of paper, but not actually pick one. Caution the participants not to let anybody else know you have spoken to them.

STEP 3
Instruct participants to number a second sheet of paper vertically from 1 to 4. Ask each

participant to choose a slip of paper from the bowl or hat and put it in their pocket. Emphasize that no one should look at their slip of paper until the end of the exercise.

STEP 4

Ask the participants to find a partner (if there are an odd number of participants, the facilitator can join the game). They should greet their partner, shake hands, and write the partner's name on the first line of their piece of paper.

STEP 5

Now instruct them to move around and find another partner. Again, they should greet their partner, shake hands, and then write the partner's name on the second line of their paper. Repeat until everybody has shaken hands with four different people, and has written the four names on their paper.

STEP 6

Ask everybody to take their seats. Ask if anyone wants to have an HIV test to find out if they are HIV-positive or not, and why. Ask others who don't why they don't.

STEP 7

Everyone should now take out their slips of paper and look at them. Ask the person with the "X" to come forward. Explain that, in this game, this person is infected with HIV. Ask everybody to look at the first line of their paper. If the infected person's name is written there they should come forward. Ask each person who comes forward if they were wearing a glove when they shook hands with the infected person. If they were not wearing a glove, they should join the "infected person" and stand in the middle. If they were wearing a glove they should return to their seats.

STEP 8

Now ask everybody to look at the second line of their paper. Anybody who has the name of any of the people standing in the middle written there should come forward. Unless they were wearing a glove, they should join the people (standing or sitting) in the middle.

STEP 9

Now ask everybody to look at the third line of their paper. Anybody who has the name of any of the people standing in the middle should come forward and join them, unless they were wearing a glove when they shook hands.

STEP 10

Now ask everybody to look at the fourth line of their paper. Anybody who has the name of any of the people standing in the middle should come forward and join them, unless they were wearing a glove when they shook hands.

STEP 11

Ask participants what the handshake represented (answer: sexual intercourse). Ask them to take note of the number of participants who became "infected" from only one

person with HIV. This demonstrates how rapidly the disease can spread, and the multiplier effect. How did they feel when they saw the number of people who ended up in the middle?

STEP 12

Ask the person who had the "A" on their sheet to come forward. Explain that the "A" represented abstinence. Ask this participant how they felt when they could not join in the hand shaking. Was it difficult? How did others feel when this person refused to shake hands?

STEP 13

Ask what the glove represented (answer: condom). Find out if either of the people with the gloves became infected. If so, use this to make the point that people must use condoms every time they have sex in order to be protected from infection with STIs and HIV. Ask the two participants who wore the gloves how they felt when they shook hands. How did their partners feel?

STEP 14

Ask the people who were not infected:

- How was your behaviour different from those who became infected?
- How did you end up not becoming infected?
- How did you feel about those who became infected?

STEP 15

Ask the people who were infected:

- What are you thinking now that you realize you may be infected?
- What could you have done differently to protect yourself?
- Would you tell anybody that you might be infected? Who?
- Would you tell your sexual partner(s)?
- What support would you need at this stage and to whom would you turn?

STEP 16

Be sure to mention that this has only been a game and that the person with the "X" is, of course, not infected with HIV. Also be sure to emphasize that HIV/AIDS cannot be transmitted by a handshake or prevented by wearing a glove. The selection of slips from the bowl or hat was random. Each handshake represented a round of unprotected sex. You are at risk from even one instance of unprotected sex.

EXERCISE 7.3

Wildfire

OBJECTIVE
To decrease the perceived distance between uniformed services personnel and the HIV/AIDS epidemic. It also aims to instil a sense of empathy with and understanding for people living with HIV/AIDS.

BACKGROUND
This exercise can be very emotional. The peer educator should allow time for individuals to share their feelings and experiences. The exercise should close with reinforcement that you cannot get HIV/AIDS from shaking hands and a presentation on the basic facts of HIV/AIDS.

MATERIALS
None

TIME
45 minutes

INSTRUCTIONS

STEP 1
Have the participants sit in one circle. Ask them to close their eyes. Explain that you will be going around the circle and will tap two or three people on the shoulder. The person who is tapped will be considered HIV-positive for the purpose of the exercise. (If you have participants who are HIV-positive, you should consult with them and ask them to help to facilitate the exercise.)

STEP 2
Ask participants to stand up and walk around. They should shake hands with three people each.

STEP 3
Once seated again, ask those individuals whose shoulders you tapped to raise their hands. Ask those individuals who shook hands with the tapped individuals to raise their hands. Ask the next level to raise their hands (those who shook hands with an individual who shook hands with the first people tapped).

STEP 4

Explain to the group that you cannot get HIV from shaking hands but that, for this exercise, we will assume that high-risk-taking behaviour took place and that each of the individuals whose hands were raised were exposed to the virus. Ask those who were tapped how they felt.

STEP 5

Ask those who have been exposed whether or not they would like to go for an HIV test. Those who do not want to go should explain why.

STEP 6

Those who opt for a test should come forward and collect a folded piece of paper. (These will be prepared ahead of time.) The paper will have either "HIV-negative" or "HIV-positive" on it.

STEP 7

Ask each individual how they feel about their test result and how the result will impact on their lives.

8. Risk assessment

TIPS FOR THE READER

There remains much denial on the part of uniformed services personnel that their risk-taking behaviour makes them vulnerable to HIV infection. There is a tendency to focus on the momentary sexual pleasure and not think about the risk. This section explores some of the myths and denial related to assessing risk. Information is also provided on men who have sex with men. The exercises help participants better understand how certain behaviour puts them at risk of HIV infection. Several exercises are particularly good at getting participants to appreciate how easily HIV is spread. They explain that when you have unprotected sex with someone it is like having sex with all their previous sexual partners as well. In one exercise, each participant can conduct a personal risk assessment. Finally, an illustrated story helps people make the link between behaviour choices and consequences.

BASIC FACTS ON RISK ASSESSMENT

8.1 Why is HIV infection so well hidden?

Cannot see HIV infection by looking

An analogy can be made between safe weapons and safer sex. There is a common misperception that one can "tell" if someone is likely to have HIV or an STI just by looking at him or her. In studies with United States uniformed services, many individuals felt they could tell if someone had an STI/HIV if they had dirty hair and blemished skin. It is important to understand that you cannot tell someone's HIV/STI status simply by looking at them. Most people infected with HIV do not know they are infected and can live for 10 years or more showing no signs of being infected at all. All that time they risk infecting every person they have unprotected sexual relations with.

Young, attractive-looking, healthy women can be infected

Some men make the mistake of thinking that the younger the woman the less likely she will be infected. In fact, in many countries young women between the ages of 15 and 25 have the fastest growing rate of infection. Some men mistakenly think that if they use condoms with sex workers and not with other women they will be safe. The sex workers may have five sexual partners in a night and the other women five in a year. But all it takes is for one of those five to infect her and her future partners risk infection if condoms are not used.

More than three-quarters of people infected with HIV do not know they are

It is not possible to tell if someone has HIV or another STI simply by looking at them. They do not have a particular smell or look sick. The symptoms that people who are starting to become sick with AIDS-related illnesses and opportunistic infections have are similar to many other common illnesses, like fever, coughs and diarrhoea. Even people who have started to show symptoms can go through periods when they are sick and others when they are perfectly healthy.

Putting a gun to your head

If you pick up a gun how do you know if it is loaded or unloaded? Keeping your training in weapon safety in mind, what must you assume? Would you just pick up a gun, point it at your head and pull the trigger? You would not place yourself at risk by not thoroughly checking it out and making sure that it is safe.

Impossible to tell HIV status by looking

The same safety issues hold true for people, especially strangers, when you are "sizing up" a potential sexual partner. You cannot tell by looking at them if they are infected with HIV or an STI. It is possible that a woman is unknowingly infected with gonorrhoea or HIV, however beautiful she is. For all you know, she may have made an exception "just one time" that has unfortunately resulted in an HIV infection. She is still beautiful, but now she is as deadly as a loaded gun. Is it worth risking your good health or life to have unprotected sex with this stranger?

And what about a fine-looking man in uniform? Perhaps he is a peacekeeper or a soldier. Would you be able to tell what his HIV status is just by looking at him?

So, how can you tell if someone is possibly infected with HIV/STIs? It is impossible to tell if someone has HIV or another STI just by looking at them.

BASIC FACTS ABOUT MEN WHO HAVE SEX WITH MEN

8.2 What does "men who have sex with men (MSM)" mean?

Oral and anal sex

Men who have sex with men refers to men who have oral or anal sex with other men. These men may be homosexual and only have sex with men or they may be bisexual, which means they have sex with both women and men. Some men are married to women but occasionally have sex with men. One study found that half of the men who had sex with men also had sex with women. Some men, such as those restricted to military barracks or prisons, have sex with men on a temporary basis only because they do not have access to women. The men can come from any social, cultural or economic group. Most men who have sex with men have no characteristics that distinguish them from other men. Some may have adapted certain looks or mannerisms which identify them as being gay. Men who have sex with men in the uniformed services usually prefer to be secretive about their sexual preferences because they fear negative repercussions if they are found out.

8.3 Are there men who have sex with men in the uniformed services?

MSM in all walks of life

In many countries it is estimated that 10% of men have sex with other men. It can be expected that the percentage of male uniformed services personnel having sex with other men will be about the same. The percentage may be smaller in countries with no tradition of homosexuality or very strong social and cultural taboos against it. For example, men are having sex with other men in sub-Saharan Africa, but it is less prevalent than in many other parts of the world. By and large, there is much more sex between men occurring among uniformed services personnel than is acknowledged because of the secretive, hidden nature of it.

8.4 Why are men who have sex with men important?

MSM vulnerable to HIV infection

Outside the industrialized world, most HIV/AIDS prevention campaigns have been targeted at heterosexuals (men and women who have sex together). As a result, many men mistakenly think they are not at risk of being infected with HIV when they have sex with other men. The truth is they can be very vulnerable if they engage in anal intercourse. In the industrialized countries, where HIV prevention campaigns have been targeted at men who have sex with men, 1 in 10 men is infected. Men who have sex with both men and women can become infected through anal intercourse with their male partners and then transmit the virus to their wives and girlfriends.

8.5 Why is sex between men in the uniformed services hidden?

In many countries sex between men is illegal. Two men caught having sex could be arrested and sent to jail. Men in the uniformed services could be court-martialled or demoted if found to be having sex with other men. Heterosexual men can also be cruel to men who have sex with men and ridicule and even attack them. Sex between men occurs in all societies but, because it is stigmatized and often legally prohibited, many believe that same-sex sexual behaviour does not exist when it is, in fact, simply hidden.

8.6 Are there male commercial sex workers?

Young men exist who have sex with other men who are willing to pay for it. Some of these young men are not attracted to men but only do it for the money. They have recreational sex with women and risk infecting them. Like female sex workers the male sex workers have higher levels of HIV infection because they have many different sexual partners and are often offered more money to have anal sex without a condom. They are also more vulnerable to infection because they are more likely to be the partner who is penetrated during anal intercourse.

8.7 What are the challenges for preventing HIV infection among men who have sex with men?

- Because of the hidden nature of sex between men it can be hard to find men and organize peer education sessions. Information about the risks to MSM and preventive action should therefore be included in all programmes.
- Many men who have sex with men resent being associated with "homosexuality" and deny that they have sex with men. This is especially true among men who have sex with both men and women.
- Because they are afraid of being caught, men who have sex with men often have sex in dark public places with partners they do not know. This makes accessing condoms and negotiating condom use a potential problem.
- When officials deny that sex between men exists, it is difficult to get approval to conduct peer education with the men.

8.8 What can be done to lower the risk of HIV transmission among men who have sex with men?

- Increase the awareness of men who have sex with men that unprotected sex can result in HIV infection.
- Promote condom use to men who have sex with men.
- Recommend alternatives to penetrative sex such as mutual masturbation and intercural sex (putting the penis between the thighs and simulating sex).
- Recommend engaging only in oral sex rather than anal sex and avoid having partners ejaculate inside the mouth.
- Recommend using a non-oil-based lubricant, like the white of an egg, when having anal sex with a condom to reduce the chance of it breaking.
- Carry condoms when going to locations where men go to meet other men for casual sex.

EXERCISE 8.1

Musical partners

OBJECTIVE
To create a better understanding of the risk of STI infection from unprotected sexual relations with different sexual partners.

BACKGROUND
This game is designed to demonstrate graphically how quickly an STI can be spread through a group of people.

MATERIALS
Two index cards or pieces of paper, condoms, drum (optional)

TIME
30 minutes

INSTRUCTIONS

STEP 1
The peer educator writes "STI" and "Clinic" on two index cards or pieces of paper. He or she also gets five condoms and a drum (or an object that can be banged like a drum). The peer educator assigns a small area as the location of the "clinic" and places the sign there. Another area of around 3 metres by 3 metres (9 feet by 9 feet) is marked off by using chairs or other objects placed at the four corners.

STEP 2
The peer educator asks for about nine volunteers and gives the "STI" card to one of them and tells them they have an STI. The condoms are given randomly to half of the participants. The game can be played with more or fewer people but condoms should always be given to half of them.

STEP 3
The facilitator then explains that people must circulate in the square while the drum is played. As soon as the drum stops, the person with the STI card grabs the nearest person. (Recorded music can be used instead of a drum.) If they have a condom, they do not contract the STI and are released to continue the game. If they do not have a condom, they contract the STI and must retire to the "clinic" for treatment. The game continues until only those with condoms are left in the square and the STI is powerless.

STEP 4

Following the exercise, ask those without condoms what they were thinking when the drum was beating. Did they feel vulnerable and nervous that they might be caught? Then ask those with the condoms how they felt.

EXERCISE 8.2

HIV scratch chain

OBJECTIVE
To increase understanding of how quickly HIV can spread.

BACKGROUND
This is a simple exercise that requires no equipment; it illustrates the risk taken by engaging in unprotected sexual relations with many partners.

MATERIALS
None

TIME
20 minutes

INSTRUCTIONS

STEP 1
Have participants stand in a circle with their eyes closed. Tell them that one person will be designated by the peer educator to be infected with HIV. That person will be given a tap on the shoulder.

STEP 2
Get the participants to shake hands with three different people and tell the infected person to scratch the palm of the three people he or she shakes hands with.

STEP 3
After all the hand-shaking is complete ask the person who was tapped on the shoulder to step into the middle of the circle and say how it felt to be the one infected with HIV. Ask them how they felt about infecting others. Ask those who had their hands scratched by that person to step into the middle of the circle. Ask them how it felt when they realized that they had been infected.

EXERCISE 8.3

Personal risk assessment

OBJECTIVE
To increase awareness of an individual's personal risk of HIV infection.

BACKGROUND
The purpose of this exercise is to get participants to reflect on how the behaviour choices they make may result in making them vulnerable to HIV infection.

MATERIALS
Sheets of paper

TIME
45 minutes

INSTRUCTIONS

STEP 1
Get participants to mark one point on a piece of paper for each of the following questions to which they answer "yes".

1. Have you ever had sex without a condom?
2. Have you had sex without a condom with someone who was not a mutually faithful partner?
3. While you were married, have you ever had sex without a condom with a woman who was not your wife (or a man who was not your husband)?
4. Have you ever engaged in unprotected sex in exchange for letting someone who broke a law go free?
5. Have you ever had a sexually transmitted infection (such as gonorrhoea, syphilis or others?)
6. Have you ever been so drunk you do not remember having sex?
7. Have you ever treated an STI without consulting a health professional?
8. Have you had sex without a condom with more than 15 people during your lifetime?
9. Have you ever had a blood transfusion?
10. Did you ever have sex without a condom with someone you just met?
11. Have you ever had one or more new sexual partners in the period of a month and not used a condom in each case?
12. Have you ever paid money for sex?

13. Have you ever had anal sex without a condom?
14. Did your spouse ever have sex with another person before you were married?
15. Do you desire sex more after drinking alcohol?
16. Have you ever had sex with a schoolgirl and not used a condom?
17. Have you ever forced a woman to have sex against her will?
18. If you are a man, have you ever had sex with another man without using a condom?

STEP 2

Have the participants add up their scores and explain the consequences of the following categories that their point totals place them in.

Between 12 and 18 points

Extremely high risk. Consideration should be given to having an HIV test.

Between 6 and 12 points

High risk. Serious consideration should be given to increased condom use and reflecting on behaviour choices.

Between 0 and 6 points

You are less at risk but still at risk.

STEP 3

Ask participants to each make a list of things they do that put them at risk of HIV infection and actions they personally can take to change this behaviour. (For example: one risk is having sex with a sex worker. The behaviour change might be to use a condom in those relationships.)

EXERCISE 8.4

Picture story on risk

OBJECTIVE
To create an understanding of how making different behaviour choices impacts on the sexual health of individuals and their families.

BACKGROUND
Denial of the reality of risk for HIV infection exists among uniformed services personnel. This story allows participants to think about their attitudes towards "risky behaviours" and their vulnerability to STIs including HIV. The story about a policeman named John and his wife Mary tells how they deal with having an STI.

MATERIALS
Picture cards (see Annex for full size cards)

TIME
1 hour

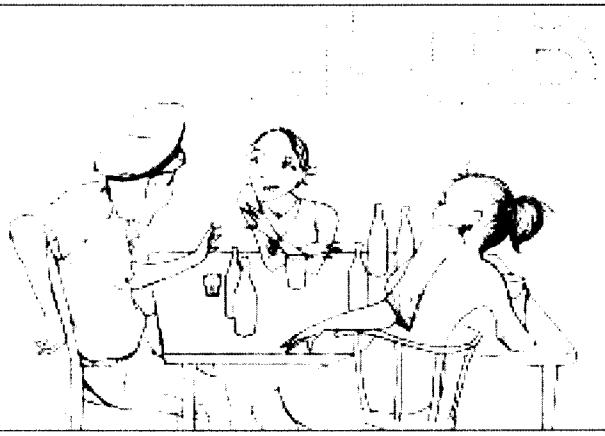
INSTRUCTIONS

STEP 1
Explain that you will be telling the story of John and Mary. If appropriate, remind participants about storytelling traditions around the world and how we learn from these stories.

STEP 2
Show the pictures and tell the whole story without asking questions. Then go back to the beginning of the story and ask discussion questions as the story is retold. Encourage everyone to talk and to give his or her views during the second telling. The participants should be asked to put themselves in the place of the people in the story and ask themselves how they would have behaved in the various situations.

STEP 3
At the end of the story, try to get everyone to understand that we are responsible for ourselves. Each of us must protect ourselves from HIV/AIDS. Go around the group, asking everyone to state the most important thing they learned from the story.

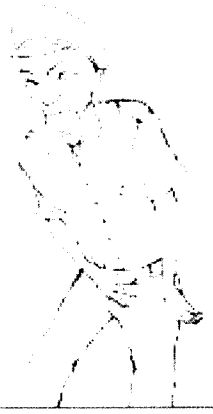
CARD 1
A night out



Visual
John, a policeman, is out on the town one Saturday night drinking beer and visiting the ladies.

Text
John ends up having sex without a condom.

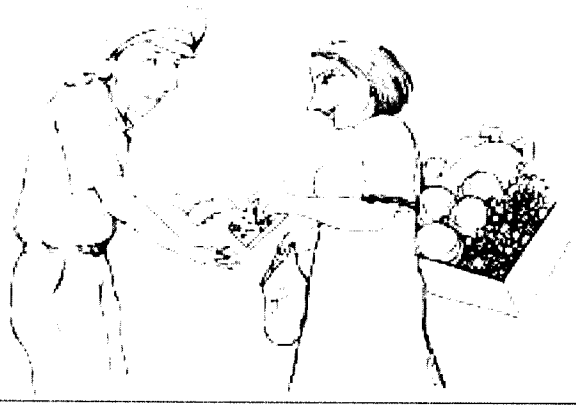
CARD 2
Signs and symptoms of STIs



Visual
A few days later, John is holding his genital area and grimacing.

Text
After a few days John feels an itching and burning which are signs of gonorrhoea.

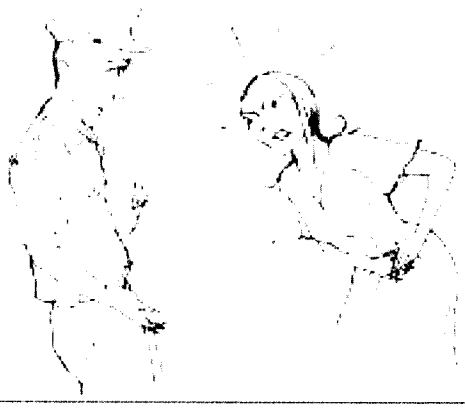
CARD 3
At the market



Visual
John purchases antibiotics from a woman who takes them out of a plastic bag in a market.

Text
Antibiotics bought from a woman in the market turn out not to be the right treatment because a white puss discharge persists. John considers this a minor irritation and ignores it. He does not tell his wife.

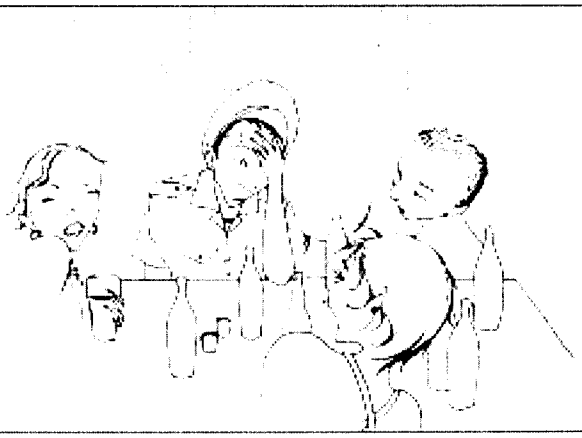
CARD 4
John's wife complains of discharge and irritation



Visual
Mary holding her side and complaining to John.

Text
Mary contracts an STI from her husband but does not seek treatment.

CARD 5
John's symptoms return and so do his bar visits



Visual
John with women at the bar with a worried look on his face.

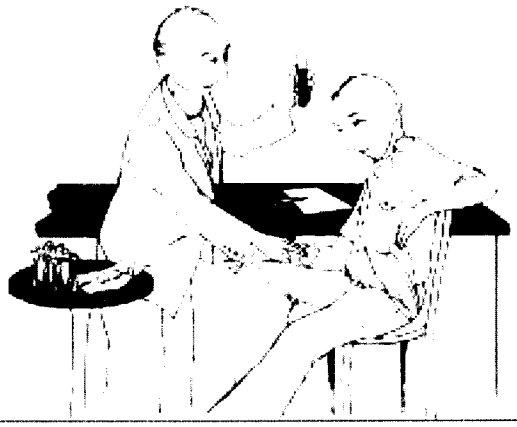
Text
John does not consider having an STI to be serious and continues his habits without using protection.

CARD 6
John discusses the symptoms with another policeman

Visual
John talking to another policeman.

Text
As the symptoms do not go away this time, John listens to the advice of his friend to go to the clinic.

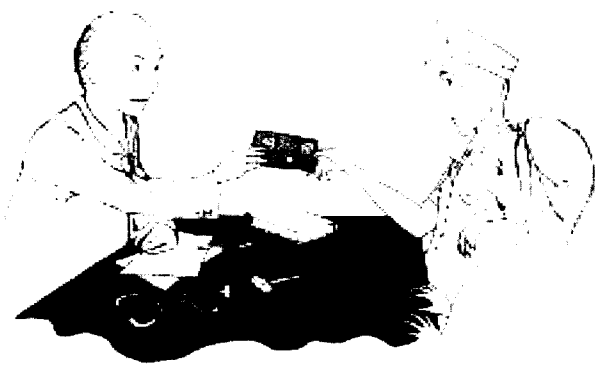
CARD 7
The doctor diagnoses an STI



Visual
John being examined by a doctor.

Text
The doctor tells John that he has a sexually transmitted infection and praises him for seeking treatment in the clinic. He tells John to bring his wife in for treatment.

CARD 8
Condoms key to prevention



Visual
Doctor giving John condoms.

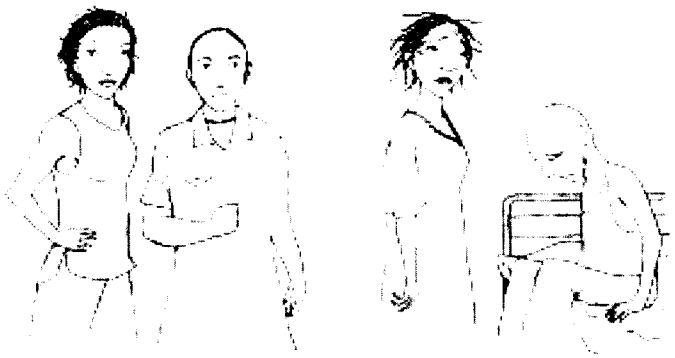
Text
Condoms prevent the transmission of STIs during sexual relations.

CARD 9
STIs contribute to HIV transmission

Visual
John in bed with his wife in one image and with another women in a second image.

Text
HIV is spread in the same way as STIs. If you have an irritation caused by an STI, it creates an opportunity for HIV to enter your body. If you have an STI you could already have contracted HIV.

CARD 10
What happens to your body over time



Visual
People looking healthy to start with and beginning to get sick after eight or nine years.

Text
The HIV multiplies slowly in your body over time as it takes over your immune system. Eventually your body succumbs to various diseases and infections.

CARD 11
Transmission from mother to child

Visual
John with Mary who is visibly pregnant.

Text
You can pass on HIV to many partners without knowing it, even though you have no signs of HIV infection and feel perfectly healthy. It is possible you could pass on HIV to your wife and for her then to pass it on to your unborn child.

CARD 12
Why police officers are vulnerable

Visual
Two policemen on patrol at night arresting a woman.

Text
Policemen may have many risk-taking types of behaviour. They may be offered and accept sexual favours while on patrol or in operations away from home, they may drink heavily, many do not use condoms and they may self-treat for STIs.

CARD 13
Policemen need protection

Visual
Strong and fit policeman buying condoms at a shop.

Text
Stay fit and strong and protect yourself from STIs by sticking to your faithful partner or using condoms. Protect yourself and your family.

CARD 14
Wives should accept that their husbands need condoms

Visual
A woman gives her husband condoms as he leaves on a mission.

Text
Wives and regular girlfriends should ensure that their whole family is protected from HIV by giving their husbands condoms when they leave on mission.

9. Condom use

TIPS FOR THE READER

Condoms are the front line of defence against infection with HIV and STIs. The basic facts explore obstacles to condom use and how to overcome them. There are more exercises on the topic of condoms than other subjects. This is because condoms are considered a key element in the prevention of HIV infection and STIs among uniformed services personnel. It is much easier to get people to use condoms in their casual sexual relations outside marriage than it is to get them to stop having those relations. Remaining mutually faithful to an uninfected partner is a prevention method that works for many and it should be encouraged. But to make a difference, condoms need to be front and centre in the battle against HIV/AIDS among uniformed services. These exercises teach people how to use condoms correctly and help participants overcome some common obstacles to condom use.

BASIC FACTS ON CONDOM USE

9.1 How can obstacles to condom use be overcome?

Obstacles are defined here as "conditions or attitudes that present a handicap to conducting condom promotion". These conditions or attitudes may apply to the rank and file, officers, the general public or religious leaders. Because HIV is primarily transmitted through sexual relations and condoms are the primary defence against HIV transmission, peer educators can often experience resistance from those who:

- oppose condoms for religious or moral reasons
- deny the reliability of condoms in preventing HIV
- are embarrassed by condoms and sexual matters
- deny the risk presented by sexual activity and the need for condoms
- think condom promotion will encourage sexual activity.

9.2 Why do some people oppose condom use?

Human beings tend to be particularly shy about sex. They may be sexually active but, at the same time, they can be reluctant to talk about it even in intimate situations. They are even less enthusiastic about doing so publicly or professionally. Uniformed services personnel tend to engage in a substantial amount of unprotected sex, putting them at risk

of HIV infection. Regrettably, there are those who are reluctant to accept this reality and would prefer to not hear anything about sex or condoms.

9.3 Why overcome obstacles to condom use?

If obstacles to condom use are not overcome, its effectiveness as a tool for prevention will be compromised. To prevent the sexual transmission of HIV/AIDS and other STIs, it is necessary to deal openly and honestly with human sexuality and condom use. If the promotion of condoms is not made a priority by peer education planners and peer educators, little progress can be made. The result of not overcoming obstacles to condom promotion and use is increased death from HIV/AIDS.

9.4 How can obstacles be overcome?

There are no set ways for overcoming obstacles and there are no guarantees that they will be overcome. Here are some suggestions.

Identify the obstacles as soon as possible

The earlier the obstacles are identified, the easier it is to overcome them. No matter how well intentioned peer educators are in promoting condom use, unforeseen obstacles can sabotage their efforts. Rather than guessing what the obstacles might be, find out what they actually are by asking uniformed personnel, opinion leaders in the uniformed services community and uniformed services religious leaders.

Find out what is acceptable

One way to find out to what degree condom promotion is acceptable is to speak with a few individuals about condoms before speaking to a larger group. Perceptions of what may be offensive are not always accurate. At times, personnel are more accepting of challenges to convention than peer educators give them credit for.

Get those involved to understand the obstacles that exist

Sometimes, just pointing out that an obstacle exists and talking about it is enough to eliminate it. It may also require a special effort and take time to get people to appreciate that they harbour prejudices, that their attitudes are closed, or to accept a reality that they deny exists or that makes them feel uncomfortable.

Deal openly and honestly with the obstacle

Discussing the reasons behind the obstacles and looking at possible compromises for overcoming them are important. Role-playing, group exercises, games and other techniques can help people come to grips with the obstacles.

Be bold, firm and convincing

Peer educators have to be strong in their conviction that the approach they are taking is correct, and they should not be afraid of breaking with convention and pushing currently accepted limits. It might be easier to avoid all discussion of sexual questions and ignore the fact that obstacles exist, but that will not slow the spread of HIV infection. Those conducting condom promotion have to be subtle in their approach so as not to offend people unnecessarily but also determined to ensure that obstacles are confronted and dealt with. Uniformed services

personnel, just like people in civilian society, are in flux in terms of their attitudes towards condoms and condom use. The challenge presented by the AIDS crisis has broken down barriers that prevent open discussion of sexual health. The environment for condom promotion is changing.

Make condom promotion fun

One of the best ways for overcoming shyness and discomfort when it comes to condoms is to get fun out of them. Just the mention of the word "condom" can get a giggle out of people. People usually find it very humorous when condoms are blown up into balloons. The blown-up balloons can be batted around or attached to walls as decorations. Bars and night clubs are particularly good places for "playing" with condoms. Condom balloon-blowing contests can be held where prizes are given to the largest balloon or the first one blown up and tied. Dance contests can be held in which couples dance with a blown-up condom between them. Passing condoms around or showing how to put them on over bananas or wooden models can also help to desensitize the situation and help people overcome their discomfort with condoms.

Promote condoms without mentioning AIDS

HIV/AIDS is often not perceived as a problem by individuals who, in fact, are potentially at risk. This is especially true in countries where there have been relatively few AIDS deaths. Also the public and different target groups in some countries have been oversaturated with HIV/AIDS prevention messages, particularly those with a negative tone. One solution is to promote condom use without mentioning AIDS. Preventing STIs and unwanted pregnancies are often more pressing problems for sexually active people. Linking condoms with AIDS and a sombre, negative mood can also contribute to people "tuning out" the promotion.

Avoid using the word condom if it is offensive

Use a socially marketed brand name that is widely available when referring to condoms. A popular word in a local or vernacular language can also be used if it is more acceptable.

9.5 What responses are there to obstacles to condom use?

Condoms are not seen as reliable, the quality of condoms available locally is poor, or condoms are believed to be porous and therefore not resistant to HIV

- Point out that the chances of HIV being transmitted when condoms are properly stored and used is almost zero and they are as reliable as any other man-made objects such as cars or antibiotics.
- Emphasize that they are electronically tested and that it is better to be as close as possible to being perfectly safe than to take the risk of being entirely unsafe without a condom when having sexual intercourse.
- Refer to studies that prove that HIV, STIs and sperm (which are much larger) cannot pass through a latex (rubber) condom.

Condoms reduce the pleasure of sex

- Point out that although a condom may be felt when the penis is first inserted into a vagina, once it warms up to body temperature it is rarely felt and quickly

forgotten. For example, users cannot usually tell that condoms have broken or slipped off while they are having sex.
- People get accustomed to using condoms and the disadvantage of any reduced sensation is small when compared to the satisfaction of not having to worry about HIV and STI transmission.

Fear that condoms get lost in a woman's womb
- Provide instructions on condom use, including the suggestion that the man holds on to it when withdrawing from the woman after ejaculation, especially if the penis is no longer erect.
- Explain that condoms cannot get into the womb or other parts of a woman's body. If a man has left the condom inside her vagina, the woman simply pulls it out with her fingers.

Rejection of condoms because people do not see any benefit in using them
- Point out that using condoms reduces worry and anxiety about contracting AIDS and STIs and unwanted pregnancy; protects the user's family and future family; permits a man or woman to control his or her destiny; is an expression of love and caring for partners; and, in the case of women, reduces the chances of becoming infertile or developing cervical cancer.

Opposition on the part of people with strong religious beliefs
- Encourage the promotion of delaying the start of sexual behaviour among young people, abstinence and fidelity. Suggest that until those strategies begin to have an impact, those who are presently engaged in sexual behaviour that puts them at risk need condoms to protect themselves.
- Ask those with strong religious beliefs to agree to disagree and, at least, agree not to actively oppose condom promotion to those who are at risk.

Opposition on the part of bar owners to condom promotion with uniformed services clients and bar girls
- Point out that the goal is not to discourage sexual contact between the bar girls and their clients but to encourage condom use.
- Discuss with the bar owners when activities might take place so they do not interfere with business.
- Convince the bar owners that it is to their long-term advantage to protect the girls and their customers.

9.6 How can condom use be made more enjoyable?

Finding pleasure in condom use

There is no doubt that many people in the uniformed services do not use condoms because they feel that they reduce their sexual pleasure. What follows is a list of suggestions on how to get more pleasure out of using condoms.

Experiment with condoms
Play with them with your partner. Blow them up. Stretch them. Snap them like rubber bands.

See them as part of the pleasure
Condoms will never feel like naked skin. Simply accepting this and exploring the sensations of latex can increase the pleasure of condoms. If condoms are seen as part of the pleasurable process of love-making instead of a hygiene device, much of the resistance to them is eliminated.

Have partners put condoms on
Condoms can be put on by sexual partners and become an exciting part of sex, instead of an interruption. They can be put on with the mouth or along with affectionate caressing and kissing.

Use one condom after another
Men often make the mistake of thinking that once they have put a condom on they have to ejaculate. This puts added pressure on their sexual performance. Condoms can be taken off and a new one put on during sex before ejaculation.

Lubricants increase sensation
Use of additional water-soluble lubricant can enhance sensation when using condoms. The lubrication on the surface of condoms helps but is not usually enough. Putting a small amount of lubricant in the reservoir tip before putting a condom on can heighten pleasure. This helps keep air out of the tip and greatly increases the sensation when the lubricant seeps around the top of the penis. It takes a little practice before the right amount is determined. Even the best water-soluble lubricants dry out during use. Either add more lubrication or add saliva or water to the exterior of the condom. Lubricants are especially necessary for men engaging in anal sex with women or men. A condom is more likely to break in the anus than a vagina without lubrication.

Condoms make sex last longer
Condoms reduce friction and, as a result, can prolong sex before ejaculation. This is an advantage for many men and women but a problem for others. For those for whom it is a problem, other non-penetrative love-making techniques can be used until the man is close to ejaculation and then a condom can be put on.

Try different condoms
If possible, keep several types and colours of condoms around so that you can experiment to find the ones your partner and you like best. Choosing a condom can be like choosing a type of soap. Some people like to try different brands and some people always like to use the same one because they are used to it and it makes them feel secure.

Fantasize about sex with condoms
Involve images of condoms in sexual fantasies. If the fantasy involves a movie star, imagine the star making love with a condom. Men who experience difficulty because they

lose their erections when putting on condoms can even experiment with their fantasies and masturbate while wearing a condom.

Talk with partners about condoms
Talk about how to make condom use more pleasurable with your partners and friends.

Try female condoms
Using the female condom is one way of increasing the pleasure of sex. Both men and women prefer the sensation of the female as opposed to the male condom and find it less of a distraction.

EXERCISE 9.1

Demonstrating correct condom use

OBJECTIVE
To provide participants with the opportunity to practise manipulating condoms.

BACKGROUND
It is more likely a condom will break because it is not properly handled or put on by the user than because of a problem with storage or manufacture. Therefore, it is vitally important for peer educators to help participants learn how to use a condom.

MATERIALS
Condoms, wooden models of a penis, broom handles or bananas

TIME
30 minutes

INSTRUCTIONS

STEP 1
Find a suitable model. Ideally a wooden model of a penis is used to demonstrate how a condom is put on. If such models are not available, other similarly shaped objects like a banana or the end of a broom handle can be used. If this is not possible the condom can be rolled by one hand down one or two fingers on the other hand.

STEP 2
Explain that uniformed services personnel need to protect themselves and, if used correctly, condoms provide excellent protection.

STEP 3
Using your model, demonstrate how to place a condom on it, highlighting the following points:

1. Check the expiry date and look for signs of wear such as discoloured, torn or brittle wrappers. Do not use condoms that have passed the expiry date or seem old.
2. Tear the package carefully along one side. It is better not to do this using teeth or fingernails to avoid damaging the condom.
3. Place the rolled-up condom on the top of the wooden model.

4. Hold the tip of the condom between a finger and thumb of one hand (leaving space at the tip to collect the sperm or semen).
5. Place the condom on the end of the penis and unroll the condom down the length of the penis by pushing down on the round rim of the condom. (If this is difficult, the condom is "inside-out". Turn the condom the other way around, take hold of the other side of the tip and unroll it.
6. When the rim of the condom is at the base of the penis (near the pubic hair) penetration can begin.
7. After intercourse and ejaculation, hold the rim of the condom and pull the penis out before it gets soft. Tie the condom in a knot sealing in the semen or sperm. Dispose of the condom in a safe place. Use a new condom next time.

STEP 4

Hand out condoms to each of the participants. Have each participant practise putting the condom on the model and recite aloud each of the steps as they go. Ask the participants who are observing to point out any difficulties or omitted steps. If the group of participants is very large, they can be divided up into groups of five or so to practise, then report back.

STEP 5

List the most common difficulties encountered. Ask the participants to suggest how these problems might be solved. Some common problems include:

- trying to roll the condom down when it is "inside-out"
- the condom is not rolled down all the way
- the condom is placed crookedly on the model
- the user is too rough when opening the package or uses teeth to open it
- the air in the tip is not squeezed out.

EXERCISE 9.2

Correct and consistent use

OBJECTIVE
To practise manipulating condoms.

BACKGROUND
This exercise is similar to the previous one on demonstrating correct condom use. However, it is a bit more interactive and forces participants to think through the steps more thoroughly.

MATERIALS
Sheets of paper or index cards

TIME
45 minutes

INSTRUCTIONS

STEP 1
Beforehand, prepare sheets of paper or index cards. Write one of the following phrases on each sheet or card:

- Check expiry date.
- Discuss condom use with partner.
- Have condoms with you.
- Have an erection.
- Open the condom wrapper carefully.
- Squeeze out air from tip of condom.
- Roll condom on erect penis all the way down to the base.
- Intercourse.
- Ejaculation.
- Withdraw penis from partner, holding onto condom at base.
- Be careful not to spill semen.
- Remove condom from penis.
- Penis gets soft.
- Tie up the condom and throw it away in a place where children will not find it.
- If you have sex again open another condom.

STEP 2
Mix the cards up in a random order and have each participant, in turn, choose a card

then read their card and show it to the group. Ask the participants to then tape it on a wall or lay it out on the floor in the correct order so that the cards describe the step-by-step use of a condom.

STEP 3

When all the cards are placed, ask the participants to comment on the order. Make any necessary changes. Be sure that the final line-up is correct.

STEP 4

Ask the participants the following questions. What might happen when condoms are not used correctly? What are the consequences of this? What was it like using condoms for the first time? What is it like now?