REFERENCE MANUAL FOR "PEER TRAINERS" WITH PEP/NAMIBIA - 2006

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This Reference Manual describes the details of the exercises and vital information that is provided in the shorter version of the Manual presented to the PEP/Namibia - Namibia participants. PEP/Namibia directors in Rundu, Grootfontein, Rehoboth and Windhoek will now have an expansion of each topic and discussion! Please feel free to add culturally appropriate revisions as you wish.

Once again, I thank our friends with PEPFAR, the American Embassy in Namibia and the US State Department in Washington for this opportunity to share PEP/LA strategies in international HIV/AIDS prevention.

With this training, we happily welcome you into the PEP/International family of more than 11,500 YOUTH Peer educators (85 teen PEPs) and 5,500 "Trainers" (55 PEPs) in 25 countries. With Namibia, we are in 26 countries! ***(Russia, Siberia, Hungary, France, Israel, Philippines, Nepal, Thailand, China, Armenia, Belize, Suriname, Guyana, Puerto Rico, Zimbabwe, Uganda, Tanzania, South Africa, India, Kenya, Cameroon, Ghana, Congo-Brazzaville, Congo-DRC and throughout the USA!!! ☺).***

With respect and hope,

Wendy Arnold, M.P.H.
President
PEP/LA and PEP/International

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REFERENCE MANUAL FOR HIV/AIDS PREVENTION WITH PEP/Namibia

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I. INTRODUCTION:

A. **Personal <u>experiences</u>** *(since 1982)* of Wendy Arnold, M.P.H. in HIV/AIDS education, prevention and caring for people with HIV disease.

B. **<u>Why are we working in Namibia</u>:**

1. Since the beginning of the epidemic, there have been many mistakes in HIV/AIDS prevention through education; **can we help you avoid some of these mistakes?**
2. There is **no cure** - *<u>sharing</u>* educational strategies in prevention is vital. Regretfully - *<u>we</u> do **not** have <u>all</u> the answers but have found some techniques that have been culturally adapted and successful in other countries.*
3. **Our hearts go to the good people of Namibia – "HIV/AIDS has become the leading cause of death in Africa."** ***(UNAIDS, May 2003)***

➔ We must stop the new infections! ←

D. The **<u>goal of PEP/LA, PEP/International and PEP/Namibia</u>:**

1. To help decrease the number of <u>HIV infections</u>, particularly in <u>youth</u> *("Last year more than 50% of reported new HIV infections worldwide occurred in people between 15 and 24 years of age" - World Health Organization).*
2. To help elevate the care, compassion, respect and hope for men, women and children who are <u>living with HIV/AIDS</u>. **The discrimination must stop!**

E. **<u>Key components of this workshop</u>**:

1. <u>Open discussion</u> for the participants *(so we <u>all</u> get to know each other!).*
2. <u>Why adolescents</u> are effective as educators, counselors, advocates and helpers.
3. <u>Initial considerations</u> for establishing HIV/AIDS programs *(Who is your population? Who are the educators? Can we talk openly and honestly about sexuality? **The success of the program will be <u>your</u> success.***
4. <u>Active participation</u> exercises and situational role-plays *(we will work through some of <u>your</u> problems and difficult situations).*
5. The promotion of <u>collaboration</u> among HIV/AIDS education and service agencies throughout the country of Africa**.**
6. What is ***"Peer Education"*** and why does it work *(for teens, clinicians, teachers, medical care providers, etc.)*?

II. EXERCISE: Who are <u>we</u>?? (Do you like M&Ms ☺) ?)

A. Your name, something about your self *(<u>fun stuff</u> like hobbies and family life).*

<u>Wendy</u> loves her family in Boston; I play tennis, ski and love all sports; I have a 3 Yellow labrador dogs ***(The Mum's name is "Muzungu" and the two little pups are called "Kinshasa" and "Eupe Mbwa, which is "white dog" in Swahili ☺)*** and a miniature lop-eared rabbit named "Uganda"; my hobby is collecting penguins!

B. Please give us a 'brief' description of your <u>expertise</u>, and some <u>expectations</u> of this workshop. What are some perceived <u>highlights</u> of your "Youth for Hope" club or program (*what can you offer to others?*).

III. SOME CHALLENGES IN THE HIV/AIDS ARENA:

A. **'Grey areas' in our education:**

1. Some unknowns in the spectrum of HIV disease:
   It is difficult to give absolute answers for the time frame of this disease *(e.g. - exact time for the development of antibodies; the specific signs and symptoms for every infected person; the exact time frame from infection to AIDS).*

2. Difficulties in the continuum of risk-taking behaviors:
   It is difficult to ever determine when behaviors are ever 100% risky or 100% safe *(except for casual contact with people living with HIV/AIDS).* **Many activities *can* be modified to be *less risky*** *(e.g. - How risky is sharing razors – this can be very risky or not at all. Is deep kissing a problem - this, too, can range from very risky to really quite safe. The fragility of HIV - the virus is fragile (very weak) and dies very quickly outside of the body but it can live for weeks in a syringe where there is no air.).*

What is particularly important is that we are giving consistent and accurate information to our populations!

3. The origin of HIV/AIDS:
   The truth is, **we cannot determine the exact origin of HIV/AIDS**. There are many theories none of which have well researched or have disputable documentation. It is more important to focus on *where is the virus going* than where did it come from. **We can stop it from spreading with prevention through education.** We cannot blame geographical locations or populations for the origin of HIV/AIDS!

What are some of the theories you have heard ?

_____

_____

*** In my opinion** *(an educated guess from Wendy)* the virus has probably been in the world for years and years. Who knows if someone actually died of AIDS 200 years ago? But now we are more aware of the symptoms of HIV/AIDS and can identify AIDS as the cause of death for so many. Look - It does not matter if the virus was first in the USA, England, China, Africa, or Asia!

We cannot accuse specific populations for HIV; we can only blame the virus.

It is here and we must eradicate it. *

B. **Stigmas**, **barriers:** These can block HIV/AIDS information - some examples:

1. **Homophobia** *(a dislike and fear of people who are gay).*
2. The quality of **sexuality education** *(it is vague and inadequate).*
3. **Denial** *(*Some people feel that *"There is no hope for people with HIV/AIDS."*

PEP/International believes that we can always provide some hope for our friends with HIV/AIDS!

B. **Gender** roles *(in many countries, women cannot talk about sex with their partners).*
C. **Religion** *(are we permitted to talk about condoms and 'barriers' in some religious gatherings and churches?).*
D. Racial and 'sexual' **minorities** *(we are <u>all</u> at risk for HIV, regardless of our race or sexual orientation).*
E. **Cultural values** *(conservative cultures prohibit discussions about sensitive subjects).*

F. What are some of YOUR ideas of the barriers in HIV/AIDS education in Africa?
a.
b.

IV. EXERCISE: The culture and values of Namibia through pictures.

A. This exercise will help make our training more culturally adaptable to the values and traditions of Namibia. ***An American program will <u>not</u> be effective in Africa; it must be YOUR program in YOUR unique culture.***

Now we will learn about some of *your* feelings and emotions.

B. We have some pictures of many aspects of life. Please tell a story about the picture. What happened before the scene? What does it mean to you? How will the situation be resolved? What emotions came up for you? **How do these emotions influence your work in HIV/AIDS prevention and care?**

This game shows that we all can have <u>different feelings</u> of the same situation. We cannot stereotype a person because of his/her race, or clothes, or age, or appearance. The big word here is

RESPECT!

<u>For example</u>: Just because a friend of yours is wearing dirty clothes does not necessarily mean that this is a poor and unloved person. Perhaps this friend just likes to play rough and get dirty! *(Kind of like Wendy!)*

V. WHY DO HIV INFECTIONS CONTINUE TO RISE GLOBALLY? *(Just a few thoughts...)*

What are some of your ideas? _____
_____

(Please see the next page for other reasons.)

1. **Poverty:** So many of the reasons listed below are related to the extreme situation of poverty throughout Namibia and the entire continent of Africa. This relates to the lack of information about HIV/AIDS; poor nutrition; prostitution; sex for school fees; expensive travel to medical clinics; the inavailability of testing sites and medical equipment; barriers to education and so much more….
2. **Denial**: *("We feel helpless and hopeless about AIDS; there is nothing we can do; AIDS will not happen to me or my family")*; the actual numbers of people living with HIV/AIDS are not known *(because of inaccessible testing centers and people are not getting tested)*; denial of alcohol/drug use; denial that some behaviors *are* risky; feelings that other populations *(sex workers, injecting drug users, sexual minorities)* are to blame; misconceptions about transmission; etc.
   - ♣ more?_____
   - ♣ _____
3. **Gender roles**: Subordination of women in many countries; sexual abuse; economic pressures that can lead to working for sex; having "sugar daddies"; biological factors of women, such as being the receptive partner.
4. **Lack of information and education**: Scarce resources; stigmas of HIV/AIDS; school restrictions and teachers who will not or can not talk about sexuality *(and other sensitive issues)*. **Sometimes the available information is *wrong, wrong, wrong:***

Some very wrong information about HIV/AIDS:

- A.I.D.S does ***NOT*** stand for the "**A**merican **I**nvention to **D**iscourage **S**ex" !!! It stands for **A**cquired **I**mmuno-**D**eficiency **S**yndrome.
- Having "sex with a virgin" does ***NOT*** cure HIV/AIDS. This is exactly how and why the virus is infecting our young girls.
- The "Americans are ***NOT*** hiding a cure" for HIV/AIDS. There is no cure - not in the USA or developed countries. The only 'cure' is ***prevention through education.***

5. **Media**: Glamorization of sex; sex is too casual; no mention of protection.
6. **Inaccessible medical services**: Geographical, financial, hourly barriers.
7. **Cultural values**: Inability to talk about sex or negotiate protection; wife inheritance.
8. **Socio-economic factors**: These affect nutrition, life-styles, medical care.
9. **Peer pressure and the use of alcohol/drugs**: These can both elevate risk-taking behaviors...
10. **Lack of treatments**: In many countries, anti-virals or vitamins are simply not available or are too dangerous to use.
11. **Environmental hazards**: Some PEP/International countries do not have access to a clean water supply and infected mothers cannot use formulas to feed their babies. These infected mothers could transmit HIV through their breast milk. Also, poor hygiene and diseased food materials damage the immune system.
12. **Lack of disposable needles, syringes, medical equipment**: If these materials are not sterilized (and one person is infected with HIV) - this is direct blood-to-blood contact.
13. **There are no condoms available**: And in some parts of the world, the condoms are totally ineffective.

14. **The role of religion**: Some of our friends in strongly Catholic countries feel strongly that semen is only for procreation; they feel 'the seed' must be planted in a woman'. This discourages condom use or the discussion of barriers. Some men feel that "one drop of wasted semen is like 1,000 drops of wasted blood" - disease will follow.
15. **High prevalence of STDs:** If people have STDs they are more susceptible to HIV because of the open infections and lesions.
16. **Age factors:** Many older women feel that they do not have to worry about HIV/AIDS *("It only happens to those who are promiscuous.")* The symptoms of HIV disease can be mistaken for age *(fatigue, weakened immune system).*

Also: A woman with HIV is less fertile and will not visit the clinic as often as one who is pregnant. An HIV infection may not get detected.

17. **Use of other birth control methods:** Taking the "tablet" or using "withdrawal" will not protect a woman from HIV. Proper use of the latex condom is the only contraceptive that will prevent HIV transmission.
18. **Polygamy and multiple partners:** This, of course, increases the risk of an exposure to HIV.
19. **Why do YOU think the prevalence of HIV/AIDS is so high in Namibia?**

_____
_____
_____

VI. (Optional..) *EXERCISE - It can be hard talking about sexuality!*

Important note for our training: If you feel uncomfortable with any of our exercises, you do not have to participate! We want you to have fun and we do not want you to feel uneasy!

A. Lists of male, female anatomical parts *(and we're not talking about hands, nose, etc...!!),* and sexual activities *(this is done in the local language with local slang.).*
B. Open discussion on feelings, embarrassment, comfort *(or discomfort!)* level when talking about sex.

☒ When we hear slang words or phrases, do we really know what is being described?
☒ We recommend using the correct anatomical words and medical activities for us to provide consistent information.
☒ If we are really uncomfortable talking about sexual conduct, then we can not be effective educators in HIV/AIDS....

C. Here is an example of why this exercise can be helpful:
What do the following sentences mean?: *(from the South Africa trainings 9/05)*

(next page, please)

"**Going to the village**?"
"I put a ***'garden tool'*** in the ***'garden'***, that's all!"
"Doctor - I hurt ***'down there'***."

(Did you understand what these PEP/South Africa "Trainers" were saying? Each of those phrases was describing unprotected sex!)

VII. WORKING WITH "SPECIAL POPULATIONS": Setting up a Peer Education Program *(PEP).*

*("Special populations" include **adolescents, women**, **sex workers**, the **homeless**, people **living with HIV/AIDS** and **other groups** mentioned in the introduction.)*

A**. Initial considerations**: financial support, multi-disciplinary committee of advisors *(teens, parents, program directors, professionals)*, concept of volunteerism, location for trainings and follow-up meetings, materials and resources, etc.

B. **Recruitment of peer educators**: *(This varies by group and by culture.)*
1. **Teens**: personal contacts, school recommendations, medical referrals, posters & flyers, articles in print media, radio announcements.
2. **Sex workers**: street outreach, posters, STD clinics, hotels, clubs, bars, etc.
3. **Women**: factories, medical clinics and hospitals, markets, retailers.

C. **Policies and procedures of your program**: *(These maintain professionalism and respect of your project.)*
1. **Confidentiality** and honesty *(within volunteers and with the target population).*
2. **PEP/LA** recommends: 6-month **commitment**, mandatory **attendance** at in-service meetings, **punctuality** at events, **respect** for the person speaking.

D. **What special populations do you work with?** What are some challenges with these groups?

teens: _____
other teachers: _____
parents: _____
drug addicts: _____
patients/clients: _____
other program directors: _____
staff members: _____

VIII. EXERCISE - Group identification and confidentiality.

➔**CONFIDENTIALITY: If someone tells you something personal, it should remain *YOUR* secret.** ←

(Please see the next page for our exercise)

Here is what we will do in this lesson about confidentiality:

A. Seated participants in the room stand if they **identify** with these situations. You then sit down after each phrase. *Warning:* The situations get increasingly more sensitive as the exercise continues *(and remember that if you feel uncomfortable, you can watch but you still have to maintain confidentiality!).*

B. The **discussion** that follows will emphasize the importance of **confidentiality**:

1. What is confidentiality and how does it relate to our educational outreach?
2. We should not discriminate on the basis of backgrounds and experiences.
3. We should keep what we observe and/or feel to ourselves.
4. We need to acknowledge our own individuality and relate this to our professional activities.

C. **Here are some "identifications": Please stand if you.....**

1. Have ever traveled outside of Namibia.
2. Attend a local school as a student.
3. Are married.
4. Have more than 5 brothers and sisters.
5. Have children.
6. Have more than 5 children.
7. Were the only child in your family.
8. Have ever hit or kicked your brother or sister when you were a child.
9. Were brought up by a single parent.
10. Have both parents alive.
11. Have witnessed physical abuse between parents.
12. Know someone with an alcohol or drug problem.
13. Know someone with HIV/AIDS.
14. Have a family member living with HIV/AIDS.
15. Prefer not to work with someone with HIV/AIDS.
16. Felt you had no choice in sexual activity.
17. Have friends who are having unprotected sex outside of marriage.
18. Want this exercise to end!!!!

IX. HIV/AIDS STATISTICS - Global, Africa, Namibia, USA:

As of July 2006 *(UNAIDS, World Health Organization* (WHO), UNICEF *and CDC):*

A. **In the world:**

1. Estimate that there are **43 million** people living with HIV.
   25 million have already died from AIDS.
   ➡ 90% live in developing countries.

☹ Worldwide, 50% of all new HIV infections occur in young people ages 15 – 24 years. Every minute, 5 young people are infected. This is over 7,000 per day. ☹

➡ 75% were infected through heterosexual sex.
➡Estimate that **16,000** people in the world get infected **every day** (2,000 of these are babies...); this is **667** people every hour; **11 people every minute**.

2. Estimate that **>26 million** *(out of the 43 million)* have an AIDS diagnosis.
   - ➧ **15** million children under 13 years of age are orphaned because of death of HIV- infected parents).

B. **<u>In Africa</u>:** *(Updated 7/06)* ***The most important are highlighted:***

"HIV/AIDS has become the number one overall cause of death in Africa." *(As reported by above international agencies.)*

➔Sero-prevalence ranges from **10%-40%**.

One in eleven Africans has HIV/AIDS.

➔ In 2004, there were 5 million <u>new cases of HIV infections</u> in the world; **3.5 million** were in Africa.

>9,000 HIV infections in Africans/day.

➔ **58% are women and young girls.**

>29.4 million Africans are living with HIV/AIDS.

➔ **<u>Youth</u>:** >10 million are age 15-25 years; **experts estimate that more than 500,000 African youth will die from AIDS by the year 2005!**

➔ **<u>Children</u>:** > 3 million are < 15 years.

- ➔ Africa has 95% of all **AIDS orphans** in the world.
- ➔ **>13 million**, most live on the streets.
- ➔ By the year 2010, there could be 20 million orphans to AIDS.
- ➔ Africa has 87% of all the children living with HIV/AIDS.

>17 million Africans have died from AIDS.
>7,000 Africans die from AIDS/day.

➔ Life expectancy in some Africans countries could drop below 30 years.

<u>➔➔➔ Impact on African society and political stability⬅⬅⬅</u>:

- ⇨ <u>Agriculture</u>: 7 million farmers have died from AIDS; HIV/AIDS could kill an additional 16 million by 2020 *(no farmers=no food=starvation, malnutrition and poverty.)*
- ⇨ <u>Education</u>: 85% of teacher deaths in Namibia over the last 20 years have been due to AIDS *(no teachers=no education for young.)*
- ⇨ <u>Medical system</u>: With 50 – 80% of hospital beds occupied by people with HIV/AIDS, there is "health system chaos".

"Sub-Saharan Africa is the most afflicted by the HIV/AIDS epidemic than any other region in the world." "Africa is where AIDS has entrenched itself in the last two to three decades, and is still spiraling out of control. The spread of HIV continues relentlessly across the continent. Today, the only visitor wielding any impact in Africa is the Angel of Death." *(See above resources.)*

C. **In Namibia:** *(These updated statistics will be provided by our Namibian officials. Here are some numbers from IRIN/PLUS News, April 2006:)*

1. Estimate **21.3% of the adult population** has HIV/AIDS. That's more than 420,000 Namibians… *(and this is a very low estimate).*
2. **President Hifikepunye Pohamba** has recently informed Parliament that a majority of Namibia's 82,000 orphans lost at least one of their parents to AIDS.
3. There are fears that **by 2021**, more than 10% of the youth under age 15 years will be orphans and vulnerable children (OVC).
4. _____

⇨ **Here is a quote that justifies the importance of our work with PEP/Namibia: "The UNDP suggests that low-cost, grassroots strategies are essential to provide clear, unambiguous and sustained messages about vital behavior changes that can save lives and build hope for Namibia's future."**

This is exactly the goal of PEP/"YOUTH FOR HOPE" – NAMIBIA:

with peer education, people talk directly to their peers using their* own *words and provide realistic behavioral changes!

D. **In the USA:**

* More than **1 million** AIDS cases are registered.
* ~850,000 total deaths *(case fatality rate of 58%).*
* ~1.5 – 2.0 million are HIV-infected *(one in every 250 people in USA is HIV+).*
* ~45,000 new infections each year *(110 people infected each day).*

In the USA, 1-2 teens are infected every hour

See? HIV/AIDS is not only a problem in developing countries! The whole world is fighting this disease...

VIDEO: Churchill Film - Let's review some of the medical information on HIV/AIDS with a movie!

This video is very sad for Wendy to watch: All of the people who share personal experiences and fears of living with HIV/AIDS were all my best friends in America. Within one year of the video, most of them died of AIDS-related complications. ☹

Discussion questions: (We will provide all the details in the next part of our training!)

1. Why is the category "Risk group" out dated? (It's the behavior, not the group!)
2. "The test" – is this a test for HIV (the virus); is it a test for AIIDS? (No! It is a test for the HIV antibodies.)
3. Is there a cure for HIV/AIDS? (No!)
4. Are the 'AIDS medicines' working for everyone? (No, for many there are severe side effects.)
5. Does the virus discriminate between people who are old or young or of different cultures? (No)
6. Why did the teens get infected with HIV? (Peer pressure, experimentation, denial, alcohol/drug use)

7. Why did my friend Christine, who is a woman with AIDS, have to hide her face? (Discrimination)

X. MEDICAL PERSPECTIVES OF HIV/AIDS:

A. **Medical definitions**:

1. **HIV** (***H*** *uman* ***I*** *mmuno-deficiency* ***V*** *irus)*: the virus that leads to AIDS).
2. **AIDS** (***A*** *cquired* ***I*** *mmuno-****D*** *eficiency* ***S*** *yndrome*): the complications that follow when a damaged immune system can not fight off infections.
3. **Immune System**: the body's defense system. HIV damages the Immune System.
4. **T-cells**: the cells in the immune system that help fight off infections. These are the cells that are destroyed by HIV *(normally a person has between 800 -1200 T-cells).*
5. **Opportunistic infections**: when the immune system cannot fight off infections *(like when HIV has damaged the immune system)* there are certain infections that take the "opportunity" to get into the body. These infections often develop into **opportunistic diseases** *(which can lead to death for a person with HIV).* Three of the most common are: **PCP** *(Pneumocystis Carinii Pneumonia damages the ungs)*, **KS** *(Kaposi's Sarcoma is like a skin cancer)* and **TB** *(Tuberculosis).*

Malaria and TB are major opportunistic diseases killing so many Africans with HIV/AIDS.

6. **"Window Period"**: the time it takes to develop antibodies to HIV. This can be between 2.5 weeks and 6 months *(every one is different...).*
7. **"Incubation Period"**: the time it takes between an HIV infection *(by unprotected sex, blood to blood, or mother to child)* and the development of signs and symptoms *(see below).*
8. **HIV antibody test**: this is a test for the antibodies to HIV. It is not a test for AIDS. *(The test should be* ***anonymous*** *and there should be* ***pre and post-test counseling****.)*

- ⌘ A negative test could mean:
  1. A person is not infected with HIV.
  2. A person could be infected but showed no antibodies because he/she was in the 'window period' *(the antibodies had not developed yet).*
  3. A **false-negative**: there was a mistake in the testing procedure.
- ⌘ A positive test could mean:
  1. A person is infected and has shown antibodies.
  2. A **false-positive**: there was a mistake in the testing procedure.

9. Some ***possible*** **symptoms** associated with an HIV infection:

* chronic cough, * swollen lymph glands, * unexplained weight loss *(wasting syndrome)*, * chronic diarrhea, * yeast infections, * night sweats, * low grade fever, * blue lesions, * severe nausea, * skin infections, * more...

Remember: These symptoms are associated with lots of other disorders. They ***may*** indicate an HIV infection *{if the person has had high-risk behaviors}* or may be due to the common cold! If *any* symptom for *any* problem persists for more than 2 weeks and has no explanation - ***go to a doctor or clinic!***

B. **Treatments, research**:

There is no cure for AIDS. In some countries there are some medicines that can *sometimes* help a person infected with HIV:

But there are many major problems with these medicines:

- They are prohibitively **expensive**. It can cost more than $2,000 each month to take some of these medicines and drugs.
- They are very difficult to take *(the **protocol**)*: for example - some must be taken with food; another one without food; another one with high fat; another one every 2 hours; another one every 6 hours; another one must be refrigerated; etc.
  If even one dose is missed, HIV will build a resistance and the drug is no longer effective.
- There are **severe side-effects**: the drugs interact with each other and make the HIV/AIDS person very sick. Often they suffer severe diarrhea, fatigue, weight loss, nausea, rashes, numbness, disorientation, dementia, disfigurement, depression, high fevers, etc.
- A **tolerance to the drugs** can develop: after a period of time, HIV can build a tolerance and/or resistance. Not only is the medicine no longer effective, but **HIV can become even stronger and more dangerous!**

Here are some examples of HIV medicines:

1. **anti-virals** slow down the replication of HIV *(AZT, DDI, 3TC, etc.)* as well as **protease inhibitors** *(indinavir, ritonavir, saquinavir, etc.)*.
2. **immune modulators** strengthen the immune system *(interleukin,etc.)*.
3. Treatments against **opportunistic diseases** *(bactrim, clarithromycin, interleukin)*.
4. A **vaccine** is difficult because the virus mutates so much *(it changes its form)*.
5. Some people prefer **homeopathic treatments** *(herbs, acupuncture, stress reduction, meditation, etc.)*.

XI. TRANSMISSION

1. HIV is **not** transmitted by casual contact *(hugs, sweat, mosquitoes, swimming pools, hand shakes, restaurants, eating utensils)*.
2. HIV **is** transmitted by **only 3 activities**:
   - ➔ **Unprotected** *(without a condom)* **sexual activity** *(anal, vaginal, oral)*.
   - ➔ **Blood-to-blood contact** *(sharing needles such as those used for injecting drugs, tattoos, ear and body piercing)*, contaminated **blood products** *(blood supply in USA and many other countries has been tested for HIV since 1985 so **transfusions** and **organ transplants** are much safer)*. **Surgical instruments** can transmit HIV if they are not sterilized.
   - ➔ **Infected mother to child** *(during pregnancy, at birth or through breast milk)*.

More info: ■ **~30% of infected mothers** transmit HIV to her baby.

■ Research indicates that most babies are infected **at birth** when the baby is in the mother's HIV-infected vaginal fluids and blood from the birth *(mucous membranes of the baby's mouth and nose).*

■ The chance of infecting the child can be reduced by **cesarean section** and/or the administration of **AZT or nevirapine** to the pregnant mother or to the child after birth *but this procedure can be very risky and is NOT available to our programs in developing countries and there are potential problems with the drugs...)*

That's it!!! If one avoids these 3 behaviors, one will not get infected with HIV!!!! It seems so easy, yet it is still *so* difficult…☹

C. **4 Body fluids** that have a high concentration of HIV:

- blood,
- semen *(includes pre-ejaculatory fluid)*,
- vaginal fluids,
- breast milk.

HIV CAN BE TRANSMITTED WHEN THESE FLUIDS ARE EXCHANGED WITH A PERSON WHO HAS HIV/AIDS!

Again!!!!! That's it!!!! If one avoids these 4 body fluids, one will not get infected with HHIV!!!!!!

XII. EXERCISE: Why HIV infects so many people so fast...

One person with HIV can infect an entire community if that person is engaging in unprotected sex or has blood-to-blood contact with others. **It is your partner's previous partner's partner's partner, etc.** This exercise clearly shows just how this can happen!

XIII. PREVENTION

1. **Abstinence** from sex and drugs (**the safest!!**).

PLEASE NOTE: It is very important to give choices to the people you are educating. There are some who follow strong family, cultural and religious values to wait to marriage to have sex. This is exactly the value system we want to promote. It is vital to emphasize the benefits of virginity until they find their partner for life!

Then, we can discuss what we refer to as *"SAFER SEX"* for those who have already made the choice and feel that they are ready for sex or who have already had sex:

2. **IF** you know of someone who is sexually active, then Safe**r** sex means the proper and consistent ***(it must be used every time)*** use of a **latex condom** with a **water-based lubricant** . (Please stay with only one partner: fidelity and monogamy!).

Condoms are not effective unless used correctly!

Proper condom use:

➔ Check the expiration date on the condom wrapper.

➔ Storage: they must be kept in a cool and safe place.

➔ They must be put on properly ***(we will do a demonstration if this is O.K. with you)***

➔ They must be used with a water-based lubricant *(not oil-based like Vaseline, or lotion).*

➔ A condom can only be used one time and then disposed of properly.

3. **Latex dams** *(a thin sheet of latex)* are recommended for oral sex.
4. **Female condoms** *(plastic, polyurethane)* are also effective.

E. Prevention: blood-to-blood contact

IF YOU KNOW ANYONE INJECTING or using any DRUGS - GET THEM HELP!!!

…..If they will not get help…. we can help them **sterilize the needles**:

5. **Bleaching**, (Clorox) injecting drug user's needles and syringes **3X** and then rinsing with water 3X, will *help* kill HIV.
6. Tattoo, ear, body **piercing needles** must be soaked in alcohol for 10 min or boiled in water for 10 minutes will *help* reduce the risk of HIV transmission.

F. Prevention: Positive life-style changes

1. **Health promotion** - we want to help the immune system *(good nutrition, exercise, sleep, bathing, washing hands, brushing teeth).*
2. There are **universal health precautions** *(do not re-cap needles, the use of gloves, gowns, masks, disposable needles* {if possible}*)* for medical care **personnel.**

XIV. ATTITUDES & BEHAVIORAL MODIFICATION: Making your education more effective.

⇨ Changing attitudes does not necessarily mean changing behaviors.⇦

A. Look at some predisposing factors: demographics, culture, economy, values, beliefs; all of these influence behavioral change.

B. When trying to modify risk-taking behaviors, think about:

* **Incentives**: What incentives could lead to a change *(financial, free medical care, a certificate of merit)*?
* **Motivations**: What is motivating a person to continue the risky behaviors and what would motivate him/her to change *(peer pressure, the excitement of danger, feeling immortal)?*
* **Perceived costs and benefits**: What are the costs of changing behaviors *(paying for condoms, monogamy isn't as exciting, losing a drug 'high')* and what are the benefits of changing behavior *(sex without fear, fidelity, healthy living, family cohesion, disease prevention)?*
* **Short term and long term changes**: Are you looking for immediate changes *(changes in knowledge, attitudes and behavior after a discussion)* or long term *changes (a reduction in prevalence of HIV/AIDS/STDs/unwanted pregnancies, abstinence until marriage)?*

C. **What do YOU think will help a person change a behavior?**

_____

_____

_____

XV. *EXERCISE: Are we a family yet? Music and movement!*

O.K. - Now we're going to have some fun! Are we friends with our fellow "Peer Trainer" participants? For this exercise, remind me that we have to start with an odd number of 'trainees' and, that *you* will help me with the music!

☺ *I wonder who will win?* ☺

XVI. SOCIOLOGICAL ISSUES: What is the social structure of your target population?

A. **Special populations all need special educational strategies**: consider the different concerns of homeless and runaways, drug addicts, sex workers, minorities, the incarcerated, young children, pregnant teens, people who are already living with HIV/AIDS....

1. How is the local culture influencing attitudes, knowledge and behavior toward HIV/AIDS prevention?
2. How accessible is medical care, the HIV antibody test sites, counseling?

What are some of your target populations?
What are some barriers of communication?
What are some successful strategies of reaching these populations:

_____

_____

B. Women and HIV/AIDS: Why are women particularly at high risk for HIV/AIDS:

1. Global statistics on women and HIV/AIDS *(UNAIDS fact sheet, 2005):*
   b. Approximately **26 million** women are HIV-infected worldwide.
   c. The number of AIDS cases in women **doubles every 1-2 years**.
   d. More than 50% of female cases were infected by **heterosexual** transmission.
   e. The increases in number of AIDS cases in women is directly related to the increase in number of pediatric cases *(peri-natal infection of mother to child)*.

This is repeat information but so very important!

➔More than 14 million children *(under 13 years)* are HIV-infected.

➔Each day, more than 2,000 babies are getting infected by HIV; 1,000 babies die from AIDS every day. By the year 2010, the World Health Organization estimates that more than **20** million children will have lost their mother or both parents to AIDS.

2. Women carry the burden of **caring for family members with HIV/AIDS.**
3. "In most **developing countries**, a woman becomes infected with HIV **every 20 seconds**" *(HIV Frontline report, August 2003).*
4. **Young women are particularly vulnerable:**
   a. **Biological vulnerability:** women are the receptive partners in heterosexual transmission; there is a larger mucosal surface exposed during intercourse.
   b. **Social and cultural vulnerability:** sexual subordination of women occurs in many societies; there can be a sexual coercion by men. Also, some women do not have 'permission' to talk about sex with men or to negotiate safer sex practices.
   c. **Economic vulnerability:** women are often forced into the "sex industry" and prostitution because they are not permitted into the work force. There is an economic dependency so to care for and feed their children.
   d. **Epidemiological vulnerability:** women tend to marry or have sex with older men *(many of whom have had multiple partners).* Also, in many developing countries, women frequently require a blood transfusion during child delivery *(hemorrhaging, birth complications)* and this blood may be infected with HIV.
5. **Older women are also vulnerable:**

   a. In the USA, **women over the age of 50 years** made up more than 17% of the AIDS cases reported in 2005.
   b. **Why?**
      1. HIV/AIDS information is not available in clinics for older women because of the stigmas.
      2. Doctors rarely ask about risk-factors because they know the older women

are embarrassed.

(We are still discussing why older women are at risk for HIV/AIDS.)

3. HIV symptoms can be misdiagnosed as 'normal aging' *(fatigue, weight loss, low energy, etc.).*
4. Because of denial *("This is a disease of younger, promiscuous people")* many older women are not getting tested.
5. With age, the lining of the uterus gets thinner which decreases vaginal lubrication; with friction during vaginal intercourse there can be bleeding.
6. Menopausal women feel there is no need for protection; only 1/6 report condom use.

THE FOLLOWING DISCUSSION IS OPTIONAL AND A BIT CONTROVERSIAL IN MOST PEP/INTERNATIONAL COUNTRIES. You let me know if we can share some thoughts on women's rights…

3. **Women's Health Care Rights:** *(Some of this information was provided by The International Women's Health Coalition, New York, USA)*

A. **Reproductive Rights**:

a. **Counseling and education** on sexuality, pregnancy, contraception, abortion, infection and disease prevention.
b. Fully **informed and voluntary choice** among a range of contraceptive practices, if they are available.
c. **Safe** abortion services *(if available or culturally acceptable).*
d. **Prenatal** care and post-partum **care.**
e. Health services for infants and children ***(accessible health care)***.
f. Healthy sexual life that is **free of violence**, coercion, fear, pain.
g. An **option to conceive** when they want to and to **terminate** unwanted pregnancies.

B. **Sexual Rights**:

a. Full **respect** for the physical integrity of the human body
b. The right to necessary **information and services** with full respect for confidentiality.
c. All persons are **equal** before the law and are entitled **without discrimination**.
d. A sexual life that is **free from**: disease, violence, fear, pain, guilt.

C. **What can we do to insure women's health care rights?**

1. International and inter-agency **collaboration** and sharing.
2. **Expand services** addressing women's **multiple** reproductive and sexual health needs.
3. Design **services to protect** women's rights; **empower women** with knowledge.

4. Educate women at an **early age** to foster their understanding of rights as they relate to sexual and reproductive health.
5. **Encourage and support men** to take their share of responsibility for sexual and reproductive behavior *(prenatal, maternal, child rearing and health, HIV/AIDS prevention, STDs and violence).*
6. **Peer Education**: Women reaching women and *men reaching men* are effective educational strategies for sharing vital information in disease prevention through health promotion.

D. Why are adolescents particularly at high risk for an HIV exposure:

Teens are at risk for many of the same reasons that put adults at risk!

1. Levels of maturity: physical, hormonal, emotional influences.
2. Curiosity: teens are curious about sex, drugs, alcohol.
3. Lack of role-models: are there parents and other friends showing good behaviors and life-styles?
4. Education: where and *how* are teens getting information about positive sexuality?
   Are we giving them consistent information?
5. Misconceptions:
   * "I really know my partner."
   * "I can trust my partner."
   * "I'm too young to get sick."
   * "I am *monogamous*!"
   * "My partner looks healthy."
   * "He didn't ejaculate."
   * "I'm *practically* a virgin."
   * "I'm using protection."
6. Drugs and alcohol: these negatively affect judgment and choices.
7. Peer pressure: teens are often pushed into dangerous activities by their friends.
8. Double standards: young men are 'studs' *(American word!)* if they have multiple partners; young women are 'sluts' *(another slang word!*).
9. Mixed messages: the media *(movies, magazines, TV)* promotes sex yet teens are told to say 'no'. *(Wendy will show you some advertisements that I think appear to promote sex...)*

XVII. SPIRITUAL AND ETHICAL ISSUES OF HIV/AIDS

A. **Stigmas and discrimination:** *(Please, can you help provide information here?)*
   1. What can we do about the discrimination of people with HIV/AIDS?
      _____
   2. How does this discrimination affect the delivery of medical care?
      _____
   3. Your discussion? _____

B. **Some spiritual issues from a Christian clergy man** *(Dr. Rev. Stephen Pieters is a very good friend of all of us in PEP/LA. He has lived with AIDS for more than 22 years and is doing relatively well. He feels that his positive spirituality is*

mostly responsible for his survival.)

Here are discussion topics offered by Dr. Pieters:

1. Let's think about questions frequently asked to clergy, ministers, pastors:
   a. Is AIDS God's punishment? What did I do to deserve this?
   b. Why do bad things happen to good people?
   c. Where do I find meaning in my life, my illness, my death?
   d. What happens to me when I die?
   e. What is God's role in illness, suffering and death?

2. What spirituality can offer a person with HIV/AIDS:
   a. Believing in something beyond yourself *("God is more powerful than AIDS.")*.
   b. Believing in God's love for you.
   c. The power of prayer.

XVIII. PSYCHOLOGICAL ISSUES: Concerns of a friend with HIV/AIDS

This part of the outline will be helpful for all of us who work directly with people living HIV/AIDS.

A. **Kubler-Ross stages of death and dying**: Many people who have just found out that they are living with HIV will often go through these interactive stages.

*** shock**: a numbness, confusion, absence of feeling.
*** denial**: "This is not true. There is a mistake."
*** anger**: anger at the world, a partner, the disease, etc.
*** bargaining**: "If I pray every day, I will be better."
*** depression**: feeling helpless, hopeless, isolated.
*** acceptance**: the diagnosis is real, an understanding.

These stages are fluid; one goes through them in a different order and back again.

Have any of the "Peer Trainers" participants experienced these stages?
Do you care to share your thoughts with us?

B. **Here is a list of some predominant themes when working with people living with HIV/AIDS:** Are some of these relevant to the culture of Namibia?

Social issues:	**Psychological issues:**	**Health issues:**
1. family concerns	1. dealing with uncertainty	1. holistic, alternatives
2. social support	2. loss and grief issues	2. priorities

(Continued on next page…)

Social issues:	**Psychological issues:**	**Health issues:**
3. discrimination	3. survivor guilt	3. substance abuse
4. resources/finances	4. abandonment issues	4. nutrition, rest
5. sexual issues	5. self-blame, guilt, low self-esteem	5. setting limits
6. relationship issues	6. fatalistic thinking, death fears	6. neurological probs
7. racial/religious prejudice	7. loss of identity	7. fatigue, symptoms
8. poor parenting skills	8. disclosure issues	
9. single parenting	9. distrust	
	10. loneliness, isolation	
	11. anger, retribution	

➔ **Your ideas, please?**←

C. **Management of HIV disease: self care and families:**

1. Discussion topics:
   a. Issues of casual contact.
   b. Behavioral modification.
   c. Personal hygiene.
   d. Dental care.
   e. Pets *(often carry diseases)*.
   f. Household precautions *(wash hands, laundry, disposal, disinfectants)*.

2. **Nutrition:**
   a. HIV makes intestinal tract less absorptive; one needs to increase caloric and protein intake.
   b. When there are signs and symptoms of HIV, one needs to take twice the protein intake compared to a person who is asymptomatic *(does not show symptoms)*. Infections in the body take more calories.
   c. HIV often causes **lactose intolerance** *(an inability to digest milk because there is a deficiency of the enzyme lactose)*. This can lead to diarrhea, cramps, gas.
   d. HIV deletes lymphocytes which are needed to boost resistance to infections.
   e. HIV often causes low tolerance to fat, meat and saturated fats *(solids at room temperature)*'; fats can further suppress the immune system.

3. **Treatment of HIV-related symptoms:**
   a. **Fever**: cool body with cool bath; hydrate body with water *(water is better than fruit juices or soft drinks because of the electrolytes).*
   b. **Night sweats**: hydration.
   c. **Headaches**: aspirin, hydration, rest.
   d. **Loss of appetite**: try small quantities on regular basis.
   e. **Nausea**: sugared juices at a cool temperature, some sweet soft drinks.
   f. **Diarrhea**: avoid milk and milk products; replace lost potassium with bananas, potatoes, broccoli; reduce fiber in diet *(grains, nuts, raw vegetables)*; eat meals at room temperature *(cold or hot meals aggravate diarrhea).*
   g. **Fatigue**: encourage consumption of carbohydrates because they give ongoing

energy *(cereal, pasta)*.

h. **Thrush**: *(yeast infection)* avoid spicy and acidic foods *(some vegetables and fruits)*; dip food in liquid before eating.

I. **Depression/anxiety**: care, compassion, respect, psychological support groups.

XIX. EXERCISE: RISK-MODIFICATION CARDS

This exercise shows the "risk continuum" of behaviors associated with HIV/AIDS/drugs. We will hold cards with the words **"high risk**", **"moderate risk"** or **"no risk**". How can we make certain behaviors less risky? When do we need more information?

Risk Modification Game:

Need more information	**High Risk**
* tattoos	* unprotected sex
* sharing razors	* sharing needles
Moderate Risk	**No Risk**
* deep kissing	* mosquitoes
* monogamy???	* warm hugs

Where do you think we should put the following behaviors?

1. "It's only my 5th glass of beer, so..."
2. "Of course I trust my partner..."
3. "He would tell me if he was HIV-+..."
4. "Penetration without ejaculation..."
5. " I feel that God supports my every action..."
6. "But he won't have sex if I insist on using a condom...
7. "May I use your hairbrush?"
8. "No problem! I got tested for HIV last week and I tested HIV antibody negative."
9. "That baby with AIDS just drooled on me."
10. "I took herbs before having sex so I'm protected."
11. "Let's pierce our ears!"
12. ...candles, wine, snuggles, a little vodka...
13. "Let's use hand lotion with the condom!"
14. "My partner said that I was his very first!"
15. "Let's go visit our good friend who has HIV/AIDS."
16. "If I get infected, I'll just go to the Doctor and get the treatment."
17. "I can't remember what happened last night; I had too much alcohol to drink."
18. "I think that it's fun to have sex when I'm high."
19. "What's the big deal if we shared needles only once?"
20. "As a sex worker, I get more money if I do not use condoms."
21. "I thought that it was your responsibility to bring protection."
22. "My partner looks perfectly healthy!"

23. "We used condoms for the first couple of times but now I know her better."
24. Reading pornographic books.
25. "Of course I know how to use a condom. I used one the last time."
26. _____
27. _____ *(Your ideas, please!)*
28. _____

How can we respond to these comments? And how can we make them safer or negotiate a change in behavior?

XX. COMMUNICATION SKILLS:

Effective comprehension of your message in disease prevention through health promotion is improved with some communication strategies:

A. **Needs assessment** of target population: Who are they? Why are they there? How much HIV/AIDS knowledge do they already have? What is the literacy rate? What are their **primary concerns** *(do not try to educate if their primary needs are hunger or getting warm or taking care of a medical problem)*?
B. **Conversation openers** will give you a lot of information about **who** you are educating:
   1. "Have you heard about HIV/AIDS?"
   2. "Are you worried about HIV/AIDS?STDs?"
   3. "What kind of people get infected with HIV?"
   4. "How would you feel if you met someone with AIDS?"
   5. "Would you feel comfortable negotiating 'safer sex' with your partner?"
   6. **What questions would be appropriate for the culture of Namibia?**
      - _____

"CARDINAL RULES" FOR PEER TRAINERS:

We should think about these rules when we educate….

1. Respect **confidentiality** *(A secret remains a secret!).*
2. Be **honest**, trustworthy, professional *(you are a role-model and 'expert').*
3. Be empathetic, **non-judgmental**, non-discriminatory *(regardless of your population's background, religion, ethnicity).*
4. Know your **limitations** as an educator and trainer *(we cannot be counselors, nurses, teachers, best friends all at the same time!).*
5. Have **realistic expectations** about who you are and how many you will reach with HIV/AIDS information *(none of us can reach all the people all the time!)..*
6. Know the **community resources** *(other HIV/AIDS agencies, National AIDS Program, referrals to substance abuse or STD clinics, medical care providers).*
7. Never **"fake" an answer** and there are **no "stupid" questions**.
8. Do not **tell them** what they should do; let them make up their **own minds** *(e.g. do not tell them that they must take the HIV antibody test or they should get out*

of a relationship). **(….More on next page…)**

(More 'Cardinal Rules' for our program)

8. Remember HIV/AIDS-related **language guidelines**: **Do not use:**
"AIDS victim", "AIDS carrier", "Normal" sexual behavior, "innocent" victim.

B. You are not the **disciplinarian** *(do not yell or get angry)* if the group gets rowdy.

C. **Share** the presentation with your fellow peer educator *(i.e. if there are two or more presenters, decide who will cover which HIV/AIDS topic.)*

C. Counseling skills: some strategies for one-to-one information exchanges

1. Arrangement of chairs: non-confrontational, should be 'conversational'.
2. Body language, tone of voice and behavioral observations: watch arms, slouching, eye contact, better to say "I notice that you are angry " instead of "You are angry".

D. Be open-minded and non-judgmental: e.g. - just because a person is requesting an HIV antibody test **do not assume** that this person is promiscuous.

E. Active listening ***(this is the most important!)***: let him/her/them explain the situation; ask questions; nod your head to demonstrate you are understanding feelings; "uh huh".

F. Ask open-ended questions: questions that can be answered with "yes" or "no" can stop the conversation.*(e.g. - "How did that make you feel" instead of "Did that make you angry?").*

G. Clarify responses and emotions: make sure you *really* understand the situation *(e.g. – "So, you are feeling alone and abandoned, is that right?").*

H. Avoid giving specific advice: you want him/her/them to decide the course of action. *(O.K. to say, "Well, in my opinion...").*

8.The **Mirror Game**: are we *really* hearing what they are saying?

A bad "mirror": She says "My husband gives me no choice in sex."
Counselor says "Your husband pushes you into sex all the time and you really hate that."
A good "mirror": She says, "I feel my husband gives me no choice in sex."
Counselor says, "It is your perception that your husband does not let you discuss sexual Activity. This makes you feel concerned."

D. **Role-playing difficult situations**:

A. Definition: Role-playing simply means you "play the role *(occupation, profession, activity)* of another person". For example:

- ♥ A friend talking with a friend.
- ♥ A counselor talking with a troubled community member.

B. Why does role-playing work?

1. A role-play is like a mental rehearsal for working out a problem.
2. A role-play helps to prepare one for providing advice.
3. A role-play is improvisational *(spontaneous, specific to a situation).*
4. Role-plays are fun and very effective in providing information to others.

You can pretend that you are actors in Hollywood!

Perhaps you would like to see a video of teens doing role-plays that are related to HIV/AIDS prevention and risk-reduction?

VIDEO: Disney film on youth doing role-plays.

XXI. EXERCISE: Let's apply these new skills to role-plays!

Here are some to get us going *(then YOU set up your own culturally adaptable situations).*

1. "Of course I trust my partner!"
2. "How do I tell my partner that I want to abstain from sex?"
3. "I just found out that my friend tested HIV - positive. What does this mean?"
4. "I have a friend who is having unprotected sex. What can I tell him?"
5. "I just found out that I have HIV. Does this mean I'm going to die soon?"
6. "How should I tell my husband that I am HIV-positive?"
7. "What is the point of living - there are no treatments and there is nothing I can do."

7. **Your ideas:**

_____ _____

_____ _____

XXII. PUBLIC SPEAKING

A. **Initial considerations:**

1. Who is your group? *(age, gender, background, education)*

SOME SUGGESTIONS FOR DISCUSSIONS WITH LITTLE KIDS:

(7 to 10 year olds)

- Start off with asking them bunches of questions: **What** do they know about AIDS? **Where** did they get this information? **Who** gets AIDS? **How** can HIV *(explain that this is the AIDS virus)* go from one person to another? Do they know **anyone** living with HIV or AIDS? **How** do they feel around this person?
- Allay their fears about "getting AIDS" *("AIDS is hard to get by casual contact!" "It is O.K. to hug and be around people with AIDS").*
- Talk about building the immune system *(nutrition, hygiene, exercise).*
- AIDS is associated with behaviors that they are not doing now *(ask them if they know how HIV is transmitted and they will probably mention sex!).*
- The good new? AIDS can be prevented by not experimenting with sex or ever sharing needles. It's important to **say "NO"** to drugs and alcohol.
- Let the young ones know that **a person with HIV/AIDS is still a friend** and shouldn't be treated any differently. We want to give this friend or family member lots of hope and love and help with the cleaning and cooking.
- Get the youth to do a **role-play**?: For example **resisting peer pressure** to get into risk-

taking behaviors *(having 'sugar daddies? Using alcohol? Missing school?)*

(More on how to prepare your presentation to different groups)

2. Size of group? *(under 10? over 40?)*
3. Where is the presentation? *(school? clinic?)*
4. Acoustics? *(will they hear you?)*
5. Why are they there? *(school? obligatory meeting? own choice?)*
6. How much time do you have?

B. There are many **types of speeches:** *(Reading, memorizing, outlining).*

C. **Visual and vocal dynamics:** *(Body language, attire, pitch and tone of voice, your physical movement, eye contact).*

D. Use of **visual aids, props, videos:** *(Let them visualize what you are describing).*

E. **Organization and clarification** of subject material: *(emphasize key points; make your message very clear).*

F. **'Stage fright'**: *(Dry mouth, using a podium or microphone, it's O.K. to say "I'm nervous and feel uncomfortable about discussing sex!")*

XXIII. FUTURE PLANS FOR PEP/Namibia: Where do we go from here? How can we effectively take this knowledge to the communities?

A. **Coordinating Council of Trainers**: In many countries with PEP/International, the participants elect a council of leaders who will help with program promotion, maintenance and progress. Would you like to do this as well?

B. **Regularly scheduled meetings**: It is important for the "Trainers" and youth peer educators to meet together as a group and family to practice your discussions and plan for your educational outreach into the community.

C. **Let's think about these target groups:** **We will now break into 'focus groups':**
   - ♥ Churches and religious organizations: _____
   - ♥ Schools and Universities: _____
   - ♥ Communities: _____
   - ♥ People living with HIV/AIDS and their families: _____

D. **Evaluation**: we should tabulate the number of presentations you do and the number of people you meet. This will show credibility for PEP/Namibia. **And this will help us with future funding, we hope.**

E. **What are your suggestions for our continued success? ☺**

_____

_____

_____

More space for your ideas to sustain the progress of PEP/Namibia!

XXIV. FINISHING UP !!!!! *(Whew !!!)*

Hopefully - all of the above information has provided information to you as a 'Peer Trainer' to train your peers, staff members, patients, clients, colleagues, etc. to be effective educators in HIV/AIDS prevention. Now, there are only a couple of final activities before you are a certified trainer:

A. **Practice presentations and more role-plays:**
(Now we give the participants of our workshop a chance to show fellow trainees what they have learned about communicating HIV/AIDS information.)

1. Participants choose a discussion topic that they will discuss for 2 - 5 minutes.
2. You can also do a role-play situation.

SOME SAMPLE TOPICS FOR YOUR PRESENTATION:
(If we cannot all do presentations, **here are some for you to practice in your meetings!)**

1. How does HIV affect the body's immune system?
2. What is the difference between HIV and AIDS?
3. How is HIV transmitted?
4. Discuss the ways that HIV is *not* transmitted.
5. What are some symptoms that are seen with HIV disease?
6. What are some of the statistics of HIV/AIDS in the world, Africa and Namibia?
7. What are some psychological issues of HIV/AIDS?
8. Why are women at particularly high risk for an HIV infection?
9. What is *"discrimination"*; how has this affected the AIDS epidemic?
10. What is the "window period"?
11. What does "incubation" mean"?
12. Why are teens at high risk for HIV/AIDS?
13. What cultural traditions of Africa influence HIV/AIDS prevention?
14. What is the HIV antibody test? What can a positive/negative test result mean?
15. **What is Wendy's favorite animal? ☺ (Hint: it has wings but does not fly!)**
16. Tell us something about the Government's role in AIDS prevention in Namibia.
17. How do drugs and alcohol relate to HIV/AIDS?
18. Are there any *positive* aspects of HIV/AIDS?
19. What are some important communication skills for a peer educator?
20. Where did HIV/AIDS come from?
21. What is peer pressure?
22. What are some ways to help the immune system?
23. How can a baby get HIV/AIDS?
24. With regards to sexual activity, what is the very best prevention against HIV/AIDS?
25. What do we mean by *"safer sex"*?
26. If one condom is good, are two condoms better?
27. Do married people who live with HIV/AIDS still have to use condoms?
30. What is discrimination? Why is this bad?
31. Why is confidentiality so important?
32. Is "French kissing" safe?

33. What are the body fluids that have a high concentration of HIV?
34. How has personally knowing someone with HIV/AIDS influenced your work as a peer educator?
35. What has been the most favorite part of this training?
36. What kinds of activities will you do as a peer educator in HIV/AIDS prevention?
37. How can we talk to younger children about HIV/AIDS?
38. How can we talk to much older people about HIV/AIDS?
39. Why are some of the treatments for HIV/AIDS not very effective?
40. Tell us a story about one of your most favorite friends with HIV/AIDS.

Or you can pick your own topic!

3. There will be a "Question & Answer" period for a couple of minutes.
4. Group feedback on: medical accuracy, organization of material, attitude, public speaking skills, command of questions, overall comprehension and communication of information.

B. **Post-test and evaluation:**

A final exam will document changes in participants' HIV/AIDS knowledge, attitudes and intentions to modify behaviors. This will help us validate the effectiveness of the workshop. We will also let you share your comments anonymously on a sheet of paper so we know where we can make improvements for the next training.

F. Certification:

CONGRATULATIONS!!!!!

You are now certified as a

"Specialized Peer Trainer in HIV/AIDS Prevention with PEP/Namibia and PEP/International"

We sincerely thank you for your time and help in HIV/AIDS prevention in the Namibia!

love,

ADDITIONAL THOUGHTS AND NOTES:

* * * * * * * * *