

CERTI

Crisis and Transition Tool Kit

HIV Prevention and Behavior Change in International Military Populations Training Module 7 HIV Prevention in Crisis Settings

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HIV Prevention in Conflict and Crisis Settings

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Introduction

There is a critical need to find effective ways to lower the risky behaviors that lead to infection with HIV and other sexually transmitted infections (STIs) in uniformed service populations (i.e., military, peacekeepers, police). Behavior change, based on acquiring knowledge and learning skills, along with individual risk assessment, is an effective method for reducing risky behaviors.

HIV poses a real threat to both uniformed service and civilian populations, especially during complex humanitarian emergencies including the descent into and emergence from crises involving armed confrontations. However, HIV prevention is not always the first thing on a service person's mind in a conflict or crisis situation because the "guns are going" and they are preparing to be deployed into difficult, dangerous and stressful situations. Nevertheless, learning about HIV/STIs and prevention strategies is critical for every uniformed service member before being sent into a conflict or crisis situation.

Throughout the world, uniformed service personnel, including military and civilian police, are especially at risk for infection with HIV and other STIs. Duty often puts individuals in stressful situations and can also take them away from home for extended periods of time. The need to relieve stress, loneliness, and boredom can lead to risky behavior. Using alcohol and drugs to cope with stress can increase the incidence of risky behavior even more. Many uniformed service personnel are young and think that "nothing will ever hurt me." To add to this type of thinking, uniformed service institutions encourage and value risk-taking and aggressiveness.

Men and women engaged in uniformed service work carry out admirable and important work, particularly in conflict and crisis settings. It is imperative that these individuals learn effective HIV/STI prevention strategies so they can protect their health and the health of civilian populations amidst whom they work and maintain the integrity of their missions.

This training-of-trainers module was developed for eventual integration within a larger training Curriculum that has been produced by the Civil-Military Alliance to Combat HIV and AIDS, in cooperation with the United Nations Department of Peacekeeping Operations (DPKO). This Curriculum presently consists of five training modules under the overall title ***HIV Prevention and Behavior Change in the Uniformed Services***. Another module, "***HIV Prevention for Women in Conflict and Crisis Settings***," is now under preparation and will be added to the Curriculum later in the year 2001.

Information for Instructors

Within Module 7 in bolded text, appear special notes to instructors. These notes explain what the different sections of each module cover and their purpose, and provide instructions for specific exercises.

Training Trainers and Educators

To accompany the curriculum for Module 7, an overhead/slide set is included in Appendix B. These overheads/slides are primarily intended to serve as teaching aides when training other trainers and educators on how to use this curriculum. However, some of the overheads/slides might be appropriate for use in teaching this course to the target audience. Instructors can modify these visual aides depending on the needs of their audience(s).

Detailed information about training is included in Appendix A, *Instructor's Notes*, which provides technical assistance to trainers and educators in implementing the curriculum and discusses the behavioral theories the curriculum is based upon. These notes serve as a guide for conducting the course and provide information that will help instructors to maximize the effectiveness of the curriculum.

Cultural Considerations

The information and activities included in Module 7 are based on the premise that HIV infection is preventable. However, effective prevention may require people to change their behavior, which is often deeply rooted in culture. Instructors for this course may have the opportunity to work with people from diverse cultural backgrounds and will be more effective in helping people to reduce their risk for HIV/STI infection if they are aware of the cultural dynamics that influence behavior. Instructors need to pay particular attention to sexual and drug-use behavior, including alcohol consumption, which can place individuals at risk for HIV/STI infection. It is also important to understand how participants choose to communicate about personal issues and their attitudes about seeking information and assistance.

The operating definition of “culture” used here is the shared values, norms, traditions, customs, arts, history, folklore and institutions of a group of people. These shared beliefs serve as guidelines for behavior within cultural groups. Culture is complex and dynamic – it helps people adjust to an always- changing environment. While cultural commonalties can be observed among groups of people, considerable variation can also be identified within groups based on factors such as age, education, gender and exposure to other cultures. It is therefore of little value to attempt to identify cultural characteristics for broad groups such as Asians, Africans or Europeans. The best approach for instructors is to be sensitive to and aware of the cultural issues that may be influencing the behavior of their participants. Instructors are also encouraged to explore these issues when conducting the training.

The following suggestions may be helpful to instructors when speaking about behavior change issues, particularly when participants are from cultures different from their own.

Listen =

- actively listen to participants;
- respond to what is being said, not how it is said;
- allow individuals to fully express themselves before responding to the situation;
- avoid an ethnocentric reaction (i.e., anger, shock, laughter) that may convey disapproval of participant's viewpoints, phraseology, facial expression and gestures;
- stay confident, relaxed and open to all information;

Evaluate =

- hold any reactions or judgments until you understand the message that the participant is conveying;
- ask open-ended questions (i.e., ones that cannot be answered with a simple "yes" or "no"), answers to these questions will give you valuable information.

Consult =

- agree with the participant's right to hold his or her opinion;
- explain your perspective of the situation;
- find out what the participant wants to accomplish;
- acknowledge similarities and differences in your perspective (the instructor) and the participant's perspective;
- offer options – suggest to the participant what he or she can do given the situation;
- allow participants to choose their own course of action;
- commit to being available to provide support;
- thank the participant for sharing his or her perspective with the group.

Keep in mind that some people and cultures focus more on individualism, while others focus more on being members of a group (which might influence interaction and participation in the course). Also, individuals and cultures vary in their comfort level with self-disclosure, especially around issues related to sexuality, personal relationships and health.

How Module 7 Was Developed

Parts of Module 7 were developed utilizing a number of training curriculums for HIV/STD prevention and other sources including the: U.S. National Institute of Mental Health's *Project Light*; U.S. Centers for Disease Control and Prevention's *Project Respect*; Civil-Military Alliance to Combat HIV and AIDS's *Winning the War Handbook*; U.S. Naval Health Research Center's *STD/HIV Intervention Program*; U.S. Marine Corps *HIV prevention training*; American Red Cross's *HIV/AIDS Education Basic Fundamentals*; U.S. Centers for Disease Control and Prevention's and Georgetown University's *Simulated Patient Intervention Train-the-Trainer Manual*; U.S. Department of Health and Human Service's, Health Care Financing Administration's *Instructor's Training Techniques*; and United Nations Department of Peacekeeping Operation's *Protect Yourself, and Those You Care About, Against HIV and AIDS, Ten Rules: Code of Personal Conduct for Blue Helmets and We are United Nations Peacekeepers*.

This module was field tested in Ghana with members of the Ghana Armed Forces, including male and female enlisted personnel, junior and senior non-commissioned officers and commissioned officers. Segments of Module 7 were developed in the field with members of the Ghana Armed Forces.

Course Summary and Rationale

This program will probably be like nothing you've done before. Throughout the program, we will be discussing sexual behavior that all people engage in. However, our special focus will be on how to engage in sexual activity safely, so you do not get infected or infect someone else with HIV or another sexually transmitted infection (STI).

- It is about reducing your risk of becoming infected with HIV, the virus that causes AIDS.
- It is about learning how to protect yourself from HIV infection and making choices that may save your life.
- It is about setting up a “buddy system” to look out for and take care of your friends, so everyone works together to reduce the risk for HIV/STIs.
- It is designed to provide you with the information and skills you need to always make choices that will prevent you from ever placing yourself, your spouse or future sexual partners at risk for contracting an STI, including HIV infection.
- Sexual behavior is a private matter. Only you know what your choices are and whether or not these choices place you or others at risk for contracting HIV/STIs. Only you know if you are being honest about what risks you are taking for yourself and others.
- In many ways this program is about **choices**. These kinds of choices are not always a simple or easy matter. For example, alcohol consumption can impair a person’s judgment and greatly increases the risk of making unsafe decisions about sex.
- Sexual desire is very powerful. It can easily cause one to deny or ignore the risks involved with sexual activity. Also, there are many other reasons why people take risks. Even though a person has knowledge about HIV and STIs, they don't always choose to protect themselves against HIV or STIs.
- This program will give you a chance to think about your choices and whether or not you choose to protect yourself and your sexual partners from getting infected HIV. HIV infection is life-long disease requiring life-long treatment. When HIV infection results in AIDS, AIDS has no known cure. In your jobs, you may be away from home for long periods of time and sent to areas where the HIV infection rate is high. You need to understand the risks and how to protect yourself, your present or future spouse, sexual partners, and children, your career, your peers and civilian communities where you are working.

- **Every time** you engage in sexual activity you have to protect yourself. **Every time.** If you choose to make even one exception to this rule and have unsafe sex, you risk getting infected with HIV. The choice is yours and only yours. No one else can **decide** or **choose** to protect you from HIV/STIs. Only you can. That's what this program is about.

Participant Guidelines

In order to meet the objectives of this course, we will discuss and explore some sensitive and personal issues. It is important to establish some basic guidelines to make sure that everyone has an opportunity to participate in the program and is treated with dignity and respect. Our expectation is that you will honor the following guidelines:

Confidentiality. Confidentiality means that any discussion that takes place in the context of this program should not be discussed with those who are not participating in the program. We will also abide by this rule. All that you say to us will be held in the strictest of confidence.

Honesty. Honesty means that you should speak from your own feelings and not just what you think people expect you to say. The honesty rule also applies to questions, because if we ask honest questions we won't waste time.

"I Statements." "I" statements are statements that you make when you speak for yourself. Be accountable for yourself and do not speak for anyone else. Even though you may be friends, it is important that each of you speak for yourself and not your friend.

One at a Time. We cannot all be heard at the same time. Allow others to speak without interrupting them. Listen while others are speaking and do not participate in side conversations.

Respect. Treat all participants with dignity, and respect their feelings and opinions. We will not always agree, but everyone has a right to his or her beliefs and ideas. Do not ridicule or make fun of others. Any question or comment that is honest is valuable.

Take Care of Yourself. Take care of yourself by being aware of your feelings. If any of the issues we discuss are disturbing to you or make you curious, let the instructor know. If answering any question or taking part in any discussion or activity makes you feel uncomfortable, don't do it. Throughout the course, you can choose not to participate in any activity that makes you feel uncomfortable.

Getting to Know Each Other

Instructor Note: When a group is assembled for the purpose of acquiring skills related to HIV/STI prevention, individuals can at first be reserved or shy about discussing personal issues. "Getting to know each other" type of exercises can be useful exercises to warm up a group and get them better acquainted with each other. This type of activity often helps participants feel more comfortable, which ultimately enables them to get more out of the training. Two examples of these types of exercises follow.

Example 1

When You Were in Training (Basic, Officer or Specialist Training) Exercise

<p>When you were in (basic, officer or specialist) training:</p> <ol style="list-style-type: none">1) How old were you?2) What were you like – were you shy, outgoing?3) What was your living situation like – were you living in the barracks?4) What did you do for fun?5) Did you ever do something you were not supposed to do like date or see someone?6) What was your instructor like?7) What did you like the most about your training?8) What did you like the least about your training?
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Directions for Exercise:

- 1) Distribute “When You Were in Training” exercise sheet (see next page) to each participant. Modify the exercise sheet accordingly depending on your audience i.e., new recruits, officers, specialists.
- 2) Give participants three to four minutes to write answers. Emphasize they should not spend a lot of time thinking about the questions; first impressions are best.
- 3) Have participants talk in pairs for two to three minutes and switch partners two or three times.
- 4) Bring participants back into a large group and process the exercise with the following discussion questions. What was it like to go back to basic training? What differences do you see in yourself today? What differences are there among people in the group?

When You Were in Training (Basic, Officer or Specialist) Exercise Sheet

When you were in (basic, officer or specialist) training:

- 1) How old were you?
- 2) What were you like – were you shy, outgoing?
- 3) What was your living situation like – were you living in the barracks?
- 4) What did you do for fun?
- 5) Did you ever do something you were not supposed to do like date or see someone?
- 6) What was your instructor like?
- 7) What did you like the most about your training?
- 8) What did you like the least about your training?

Example 2

When You Were 16 Years Old Exercise

When you were 16 years old:

- 9) **Where were you living?**
- 10) **What was your family like?**
- 11) **What was your community like?**
- 12) **What did you do for fun?**
- 13) **What was your favorite song?**
- 14) **Were you in love? With whom?**
- 15) **What did you look like?**
- 16) **What did you want to be when you grew up?**
- 17) **What were the social taboos (things that were not acceptable or appropriate) in your community?**
- 18) **What were the pressing social issues (sexuality, war, politics, etc.) for you or your community?**

Directions for Exercise:

- 1) Distribute “When You Were 16 Years Old” exercise sheet to each participant.
- 2) Give participants three to four minutes to write answers. Emphasize they should not spend a lot of time thinking about the questions; first impressions are best.
- 3) Have participants talk in pairs for two to three minutes and switch partners two or three times.
- 4) Bring participants back into a large group and process the exercise with the following discussion questions. What was it like to go back? What differences do you see in yourself today? What differences are there among people in the group?

When You Were 16 Years Old Exercise Sheet

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- 1) Where were you living?
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- 3) What was your community like?
- 4) What did you do for fun?
- 5) What was your favorite song?
- 6) Were you in love? With whom?
- 7) What did you look like?
- 8) What did you want to be when you grew up?
- 9) What were the social taboos (practices that are not allowed or acceptable) in your community?
- 10) What were the pressing social issues for you or your community?

Module 7: HIV Prevention in Conflict and Crisis Settings

Purpose: To help men and women engaged in uniformed service work to learn about HIV, AIDS and STIs and how to promote good health.

Goals: To educate participants about the kind of changes in behavior **everyone** needs to make in order to protect themselves and others from HIV/STI infection.

To educate participants about complex emergencies, or crisis and conflicts, and how the complex emergency can place uniformed service personnel and civilians at risk for HIV/STI infection.

- Objectives:**
- (1) To provide basic information on how HIV is transmitted, how it affects the immune system, AIDS and other STIs.
 - (2) To reinforce participant knowledge of risk factors for HIV/STI infection, awareness of personal risk factors and knowledge and skill in preventing the transmission of HIV and other STIs.
 - (3) To increase participant awareness of the efficacy of using condoms.
 - (4) To increase participant knowledge and skill regarding the use of condoms.
 - (5) To increase participant knowledge of the negative effects that alcohol and other drugs can have on decision-making, and how these substances can increase the likelihood of involvement in risky behaviors for HIV/STI transmission.
 - (6) To define the particular threat of HIV/STIs in pre- and post-crisis situations for uniformed service personnel (i.e., military, peacekeepers, police) as well as local civilian populations.
 - (7) To explore the relationship between sexual activity, STIs and HIV in crisis situations and their immediate aftermath.
 - (8) To increase participant awareness of the duty to protect themselves and civilian populations, not just from immediate harm, but also the threat of HIV/STIs

- (9) To encourage participants to serve as peer educators, both for fellow uniformed service personnel and to local civilian populations.
- (10) To review guidelines for professional conduct for uniformed service personnel and their implications for the prevention of HIV/STIs, particularly in crisis situations and their immediate aftermath.
- (11) To encourage participants to make a personal commitment to reduce their risk for HIV/STIs and to reduce the risk for civilian populations which is their duty to protect.
- (12) To teach participants how to serve as early-warning sentinels in pre-crisis situations, to identify deteriorating public health, socio-economic and political conditions and communicate that information to their chain of command and others.

Time: 4 hours; Part I is 2 hours and Part II is 2 hours

Format: Information and skills building exercises, group discussions, and interactive slide presentations.

Materials: Items needed:

- ✓ Flip chart or writing board
- ✓ Tape
- ✓ Slide or overhead projector and screen
- ✓ Slide set for Module 7
- ✓ “Strategies for HIV Prevention and Behavior Change Exercise Instruction Sheet” for Exercise IV.A.
- ✓ “Strategies for HIV Prevention and Behavior Change Scenarios” for Exercise IV.A.
- ✓ Male and female condoms
- ✓ Cling wrap (used for food preparation)
- ✓ Handout on Guidelines for Effective HIV Prevention Messages

Instructor Note: All information in Module 7 is summarized on slides to assist with the presentation. Information to enhance the written curriculum (i.e., graphics) appears on slides/overheads and is indicated by a box next to the part of the curriculum it refers to.

This module is divided into two parts. Part I is a review of basic HIV/AIDS, STI information and HIV/STI prevention strategies. Part II discusses HIV/STI prevention in crisis settings.

Part I: HIV Prevention and Behavior Change Issues

I. Introduction

Part I of this session will include

- 1) basic information about HIV and AIDS, the immune system and STIs;
- 2) information about risk factors for HIV/STI transmission;
- 3) information about correct condom usage;
- 4) a skills building exercise on negotiating safer sex practices.

II. Facts about HIV Infection and AIDS, Information about STIs, Global Impact of HIV and the Impact of HIV on Uniformed Service Personnel and Institutions

Instructor Note: This section has an exercise to discuss HIV/AIDS facts and myths, a summary presentation of HIV/AIDS facts along with information about STIs, statistics on the global picture of HIV infection, and a discussion of the impact HIV has on uniformed services. Encourage participants to ask questions throughout the exercise, presentations and discussions.

A. Facts Exercise: HIV and AIDS Myths and Facts

Instructor Note: This exercise provides an overview of HIV and AIDS facts; tailor your comments to the needs of the group, depending on the level of their knowledge about HIV and AIDS.

Directions for Exercise:

- 1) Before the session, write each of the statements below on its own sheet of paper in large, easy-to-read letters (do not write Fact or Myth next to the statement). You can add to or eliminate the statements depending on your audience.
- 2) Tape two sheets of flip chart paper (one entitled “Facts”; the other “Myths”) on a wall where everyone can see them. Tell participants that the group is going to do an exercise in which they will separate facts about HIV and AIDS from myths. Go over what myth and fact mean with the participants.
- 3) In turn, read each statement written on paper aloud, asking if it is a myth or a fact and calling for volunteers to give the answer.
- 4) If the volunteer answers correctly, ask him/her to tape the sheet on the correct flip chart paper.

- 5) Reinforce the correct answer with additional information. If the participant does not answer correctly, acknowledge his or her effort and then give the right answer.

Instructor Note: If individual participation is or would be threatening to participants, you can run this as a group activity, asking the group to determine the answers.

Statement	Myth or Fact
HIV is the virus that causes AIDS.	Fact
You can get HIV by drinking from a glass used by someone who has HIV.	Myth
HIV is spread by kissing.	Myth
You can get HIV from a blood transfusion.	Fact (if the blood has not been screened for HIV))
Someone who has HIV but looks and feels healthy can still infect other people.	Fact
Drinking alcohol can increase the risk of getting HIV.	Fact
Mosquitoes can spread HIV.	Myth
Using a latex condom during sex can reduce the risk of getting HIV.	Fact
Having an implant in the arm for birth control can protect a woman from getting HIV.	Myth
Most people who get infected with HIV become seriously ill within one year.	Myth
Vaccination can protect people from HIV infection.	Myth
AIDS is a syndrome that has no cure.	Fact
A woman who has HIV can give HIV to her baby by breastfeeding.	Fact
You can get infected with HIV by scarification (markings on face an body), tattoos and body piercing.	Fact

Exercise Wrap Up

Instructor Note: Close this exercise by summarizing the following facts. You can also use this information to explain incorrect or incomplete information offered by participants during the Myths and Facts exercise and to address participant's questions and concerns.

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 – when exposed to the air it dies in seconds. We will talk about how HIV gets into the body after we define AIDS.

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.

Body fluids that can spread HIV are:

- Semen
- Vaginal fluid
- Blood
- Breast milk

HIV is spread:

- By having unprotected vaginal, anal, or oral sex with an HIV positive person.

Vaginal sex means a man inserting his penis into a woman's vagina. Anal sex refers to a man putting his penis into the rectum, or anus, of a woman or a man. Oral sex 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.

Vaginal sex can let HIV in 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 can let HIV in your body through cuts or tears in the rectum, or anus. The rectum does not stretch readily (like 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.

Oral sex can let HIV in your body through any cuts or tears inside the mouth due to injury or gum disease. Often you cannot see or even be aware of cuts or tears inside your mouth. You can also have gum disease without your gums bleeding. Men can contract HIV through vaginal fluid when performing oral sex on a woman or through semen when performing oral sex on a man. Women can contract HIV through semen when performing oral sex on a man or through vaginal fluid when performing oral sex on a woman.

- By sharing needles or syringes with an HIV positive person, getting tattooed or body pierced with a needle contaminated with HIV or receiving body scars or markings with a needle or knife contaminated with HIV. With tattoos or body scarification, the same needle or knife can be used among several people and not sterilized for each new person. If one person is HIV positive, infection can be spread.
- During pregnancy, birth or breastfeeding from an infected mother 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. The decision to breast feed if a mother is HIV positive is a difficult one only the mother can make. Current statistics say there is a 30% change a 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. In Ghana, blood is now routinely being tested for HIV. If contaminated with HIV, the blood is not used and is thrown away.

The Natural History of HIV – 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 3 to 6 weeks (sometimes as long as 3 – 6 months) before the body reacts to the presence of this virus and produces antibodies (chemicals) that can be found in the blood by laboratory tests. If these substances (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 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 8 and 12 years. However, individuals can begin to become sick from a few to 5 years after infection.
- **The symptomatic period when the person is sick with AIDS.** 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” or OIs. OIs 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. OIs are infections such as diarrhea, 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 OIs and the availability of treatment and drugs. Individuals can live for 1-2 years or much longer (if receiving treatment with drugs).
- **HIV testing as a prevention strategy.** HIV testing is not a reliable prevention strategy because of the window period and asymptomatic infection (described above). However, 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 a 6-month period. They must agree to only have sex with each other and not sleep with anyone else. When the 6 months are over, the couple can get tested again 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 to not see anyone else.

HIV is not spread:

- Through casual (non-sexual) social contact like shaking hands, touching or hugging, toilet seats or eating food fixed by someone living with HIV.
- By kissing. Some people are concerned about 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. We all tend to blame something else when it comes to HIV, so we blame things like mosquitoes. But this is too easy. The fact is that we give ourselves HIV and we alone can take precautions to prevent it.

You cannot get HIV from a mosquito, like you can malaria. HIV affects people mostly in the 15-49 year age group, while malaria affects mostly children aged 6 months to 8 years. It is clear that different populations are affected by HIV and malaria, and if mosquitoes transmitted HIV (like they do malaria), the same age group would be affected by HIV (the 6 month to 8 year old children).

Mosquitoes bite people for blood, which is their food. With malaria, a mosquito bites a person then goes into a 2-week life cycle to incubate the parasite. After this 2-week period, they then go and bite someone else, infecting them with malaria. This same situation does not happen with HIV because HIV cannot live within the mosquito for 2 weeks – it dies and the mosquito cannot transmit HIV when it bites another person.

Other facts about HIV and AIDS:

- We are all at risk; 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 infections are caused by having unprotected intercourse with a woman or man who is already infected with HIV (70-80% of infections).
- There is no vaccine to protect people against getting infected with HIV. There is **no** cure for AIDS. This means that the only certain way to avoid AIDS is to prevent getting infected in the first place.
- Both men and women are vulnerable to infection from HIV and other sexually transmitted diseases, many of which have serious long-term consequences, especially for women e.g., pelvic inflammatory disease, tubal pregnancy, sterility.
- The presence of an untreated sexually transmitted infection (STI) like syphilis or gonorrhoea facilitates the transmission of infection with 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 risky behavior. Prevention and treatment of STIs is another way to protect yourself against HIV infection.

- Drinking alcohol or using illegal drugs will reduce your judgment and your ability to act within the bounds of safe behavior. When you are under the influence of alcohol and/or drugs, you are more likely to indulge in risky sexual contacts.
- Being tattooed or body pierced or body scarred/marked with unsterile needles and knives/blades can result in infection with HIV and other STIs e.g., Hepatitis B. Make sure needles and knives are sterilized or try to use your own needles/knives/blades.
- Sexual transmission of HIV can be prevented by practicing safer sex. Safer sex includes not having sex, fidelity between uninfected partners, using a latex condom **every** time engaging in vaginal, anal, or oral sex, non-penetrative sex and engaging in activities such as hugging, kissing, masturbation, mutual masturbation.

B. Information on Sexually Transmitted Infections (STIs)

Instructor Note: Present this information as a brief interactive discussion. Encourage questions from participants throughout the discussion.

There are many STIs. We will discuss Gonorrhea, Chlamydia, Syphilis and Genital Herpes.

Gonorrhea

- Gonorrhea is a disease caused by a bacteria called the gonococcus.
- Gonorrhea is caused by intimate contact with the sexual organs, rectum or mouth of an infected person.
- Approximately 10-20 percent of males have no symptoms at all. In those who do, the first symptom is usually a burning pain when urinating and/or a discharge of pus from the penis. Symptoms usually occur 2-8 days after sexual contact, but they may occur as early as 1 day or as late as 30 days after contact.
- Most women do not notice that they have been infected since the infection generally begins high up in the cervical area. The discharge of pus, if present, may be mistaken for the normal vaginal discharge. There is usually no pain associated with this discharge, although some women may experience a slight burning sensation when urinating.
- Gonorrhea can be completely cured; however, it can be caught again, particularly if sex partners aren't treated.
- If left untreated, gonorrhea can result in sterility, pelvic inflammatory disease (PID) in women which can lead to sterility and blindness in a baby if infected during birth.

Chlamydia

- Chlamydia trachomatis is a bacteria which causes significant genital infections in sexually active individuals, and eye and lung infections in infants born to infected mothers.
- The primary method of transmission is direct sexual contact with an infected person, usually sexual intercourse.
- Often Chlamydia shows no symptoms or can be mistaken for other STIs, such as gonorrhea. Men may have a discharge from the penis, a burning sensation when urinating, or pain in the testicles. Women may have an increased discharge from the vagina, a burning sensation when urinating, abnormal vaginal bleeding, abdominal pain, and a low-grade fever. Symptoms usually appear within 1-3 weeks after exposure to an infected person.
- Chlamydia can be completely cured; however, it can be caught again, particularly if sex partners aren't treated.
- In men, untreated Chlamydia can lead to complications, such as inflammation of the eyes and skin lesions may also be associated with genital Chlamydial infection. The most common infection in women who do not receive treatment is an inflammation of the cervix. Chlamydia is also a major cause of pelvic inflammatory disease (PID). The consequences of PID include recurring pain, tubal pregnancies, infertility, and pelvic abscesses. Chlamydia can also cause inflammation of the tissues on the surface of the liver in both men and women.
- Newborns of mothers infected with Chlamydia may also develop pneumonia, infections of the eye, ear and other infections.

Syphilis

- Syphilis is a disease caused by a spiral shaped bacteria, and can involve every part of the body.
- Syphilis is spread through direct contact with the sexual organs, rectum or mouth of an infected person.
- In the early stages, syphilis may go unnoticed by the infected person. The first sign of syphilis is usually a single, small, firm, painless sore (chancre) at the site where the infection entered the body (penis, vagina, mouth). The chancre generally appears 10-90 days after contact with an infected person, and will last from 1-5 weeks. The second stage of syphilis occurs approximately 0-10 weeks after disappearance of the primary lesion. During this stage, the infected person may break out in a rash anywhere on the body. (The rash is unusual, because it appears identical on both the right and left sides of the body.) Most commonly, it appears on the palms of the

hands and/or the soles of the feet. Rashes also go away but may reappear without treatment. This rash may be accompanied by fever, tiredness, sores in the mouth, or loss of hair. It is during these two stages (lasting up to one year) that the person is contagious.

- Syphilis can be completely cured; however, it can be caught again, particularly if sex partners aren't treated.
- If Syphilis goes untreated, after the second stage the organism may remain dormant (be present in the body but causing no harm) for a length of time. After a period of time, the bacteria may begin to damage the brain, spinal cord, heart or other organs. This late stage (possibly occurring 2-25 years after stage one) can result in mental illness, paralysis, heart disease, blindness or death.
- A pregnant woman may transmit the disease to her unborn child if she has not been completely cured. Premature birth, miscarriage, stillbirth and deformities of the unborn child are possible complications.

Genital Herpes

- Genital herpes is a disease caused by the herpes simplex virus.
- Genital herpes is transmitted through close physical contact, usually sexual intercourse with an infected partner.
- Approximately 2-12 days after contact with an infected person, a small sore (or several sores) similar to a fever blister will appear at the site where the infection entered the body (penis, vagina). The sore may be very painful, accompanied by swelling in the surrounding area. These symptoms may disappear in a few weeks with the disease remaining hidden for months or years. Some people experience recurrences of these symptoms, which usually involve the same area as the primary infection but are less severe and heal more quickly.
- At present, there is no cure for herpes. Treatment for herpes includes taking a medication (Acyclovir) which can reduce the severity of the symptoms during the initial infection and suppress future episodes. Keeping the sores clean and dry can also be helpful.
- The full effects of herpes are not known. Since a history of herpes infection may be linked with the occurrence of cervical cancer, women with herpes should have pap smears at least once a year.
- A pregnant woman may transmit the disease to her child at birth as it passes through the birth canal. In infants, serious infection or even death may result. To avoid this possibility, pregnant women with herpes need careful prenatal screening, and sometimes delivery by Caesarean section.

C. Global Impact of HIV

**Slide/Overhead
“Global View of
HIV Infection”**

This slide/overhead shows a map of different areas of the world with rates of HIV infection. As you can see, there is no area of the world without HIV, the virus that causes AIDS.

D. Impact of HIV on Uniformed Service Personnel and Institutions

Instructor Note: This discussion focuses on why uniformed service personnel are especially at risk for HIV infection and how HIV impacts both readiness and health of the communities where uniformed service personnel train and work. Conduct this session as a facilitated discussion.

Directions for Discussion:

- 1) Ask participants how they think uniformed service personnel are at risk for HIV; write their responses on a flip chart or writing board.
- 2) Review with participants the following points after the discussion:
 - Military, peacekeeping and police duty may take individuals away from home for long periods of time. The lack of the normal supports of family plus peer pressure from other soldiers leads to risky HIV behaviors, such as casual sex and commercial sex (paying prostitutes), not using condoms when having sex and injecting drugs like heroin.
 - The need to relieve stress, loneliness and boredom can lead to risky behavior. The use of alcohol and other drugs to combat stress, loneliness and boredom can contribute to excessive risk taking. “R and R” (rest and relaxation), or leave, post-training and post-deployment periods are especially dangerous for individuals getting infected with STIs, including HIV, because of the need to relieve stress.
 - The uniformed services employ large numbers of young men and women who are in the most sexually active age bracket. Also, young people typically feel that nothing will ever hurt them and do not think they are at risk for things like STIs and HIV. This way of thinking (i.e., “nothing will ever hurt me”) can be very dangerous because worldwide, the majority of new HIV infections are in young people between the ages of 15 and 24.
 - There may be “initiation rituals” in a uniformed service such as cutting or marking yourself, exchanging blood in a “blood brothers” ritual, raping a woman that can put a person at risk for HIV/STI infection.

- Character traits that are highly valued in uniformed services such as risk-taking and aggressiveness, can lead to greater dangers of getting infected with STIs or HIV when carried over into sexual situations.
- Soldiers have cash, or are perceived to have it; military installations attract commercial sex workers, or prostitutes.
- War and other social upheavals dislocate populations, increasing the number of persons who use sex as a means of survival. Since soldiers are deployed in periods of distress like this, there can be increased opportunities for sexual encounters.
- Uniformed service personnel need to take care of each other and work together to prevent infection with HIV/STIs. Units or organizations can set up “buddy” programs where individuals look out for each other, avoid risky situations and try to promote safer behaviors.
- HIV and STIs affects individual lives, as well as uniformed service organizations (i.e., careers, personal life, ability to have a family).

Instructor Note: Close this discussion by summarizing the following facts:

- HIV is the virus that causes AIDS.
- AIDS is the result of HIV infection.
- HIV infection **can** be prevented.
- HIV is **not** spread through casual social contact.

III. Demonstration to Review Correct Condom Use

Instructor Note: This demonstration teaches participants correct condom use. Emphasize that male condoms, if used consistently and correctly, can decrease the risk of transmission of pregnancy and all sexually transmitted diseases (including HIV infection) to less than two percent (2%). Ask for volunteers from the audience to demonstrate how to use a male and female condom, and how to use a condom to protect during oral sex, after you present the following information.

Directions for Demonstration of Male Condom

Demonstrate how to use male condoms correctly, according to the following 10 steps:

- 1. Choose a latex condom.** Latex condoms give protection against HIV. **Emphasize** that lambskin (also known as sheepskin or “natural”) condoms do not give protection against HIV/STIs or pregnancy.
- 2. Check the expiration or manufacture date on the condom package.** If the condom has expired, **don’t use it.** Condoms can become dry and subject to breakage with time. **Never** keep a condom anywhere it may become hot or under pressure because that may make it dry out. If there is only a manufacture date on the package, it should expire about two years from the manufacture date.
- 3. Open the package without tearing the condom.** With the package still intact, push the condom to one side and it will be out of the way when you tear open the package. Do not open the condom package with things like your teeth, scissors, knife.
- 4. Place the condom on the head of the penis prior to any contact with a partner’s mucous membranes. Make sure that the reservoir tip sticks out.** Putting a drop of lubricant inside the tip of the condom may give extra feeling.
- 5. Pinch the tip to let the air out.**
- 6. Slowly unroll the condom down to the base of the penis. Make sure that the condom covers the entire penis.**
- 7. If lubrication is desired, choose water-based (e.g., KY jelly or spermicidal jelly).** Oil based lubricants such as Vaseline can damage the latex and cause tearing.

Immediately after ejaculation:

- 8. Hold the condom at the base of the penis and carefully withdraw (pull out).** Do this while the penis is still erect to avoid having the contents of the condom spill out.
- 9. Roll the condom down and remove it from the penis, making sure that the contents of the reservoir tip do not spill.**
- 10. Dispose of the condom.** Condoms should **never** be used more than one time. It is **not** okay to wash them out and use them again.

Directions for Demonstration of Female Condom

Demonstrate how to use female condoms correctly, according to the following nine steps:

- 1. Check the expiration date on the condom package.** If the condom has expired, **don't use it.** Condoms can become dry and subject to breakage with time. **Never** keep a condom anywhere it may become hot or under pressure because that may make it dry out.
- 2. Open the package without tearing the condom.** With the package still intact, push the condom to one side and it will be out of the way when you tear open the package. Do not open the condom package with things like your teeth, scissors, knife.
- 3. Open the end of the condom (at the outer ring).** The outer ring will cover the area around the vagina. The inner ring will go inside the vagina and is used to guide insertion and hold the condom in place.
- 4. Hold the inner ring between the thumb and middle finger.** Place your index finger on the pouch between the other two fingers or just squeeze the inner ring.
- 5. Squeeze the inner ring to insert the condom into the vagina.** Insert the sheath into the vagina as far as it will go. It is in the right place when the woman can't feel it. It is **not** possible to insert the condom too far up into the vagina.
- 6. Make sure placement is correct by making sure the sheath is not twisted.** The outer ring should be **outside** the vagina.
- 7. If lubrication is needed, choose water-based (e.g., KY jelly or spermicidal jelly).**

Immediately after ejaculation:

- 8. Remove the condom before standing up.** Squeeze and twist the outer ring and pull out **gently.**
- 9. Dispose of the condom.** Condoms should **never** be used more than one time. It is **not** okay to wash them out and use them again.

Directions for Demonstration of Condoms for Oral Sex

Condoms help make oral sex safer. For fellatio, place a male condom (using the same instructions as already outlined) over the erect penis **before** beginning.

For cunnilingus, take a rolled male condom and cut it from any edge to the center. Carefully unroll into a rectangular piece of latex and place over the opening to the woman's vagina **before** beginning cunnilingus. You can also use a square of cling wrap (used in food preparation) to place over the opening to the woman's vagina.

Using Condoms When You Are Living with HIV

People who are living with HIV often ask what is the point of using condoms if I have HIV and so does my partner. It is very important to keep using condoms when you and your partner are HIV positive. The reason for doing so is that when you are HIV positive you can transmit the virus to you partner over and over again. When you keep passing the virus to another person, you can increase the amount of HIV they have in their body. People who have higher amounts of HIV in their body get sicker faster. To maintain optimal health for you and your partner, it is very important to keep using condoms with every act of vaginal, anal or oral sex.

IV. Review of Universal Precautions

Skills and simple measures against the transmission of HIV and other blood-borne diseases can be important when accidents or battlefield injuries result in active bleeding, and in the case where personnel are required to handle dead bodies. The following Standard Operating Procedures (SOP) should be learned by all uniformed service personnel – and consistently practiced – in the care of the wounded and the handling of the dead to minimize the risk of blood-borne disease transmission.

These procedures are referred to as Universal Precautions:

- Safe handling of sharps (needles, knives, and other cutting instruments) to avoid getting the skin cut or punctured.
- Hand-washing with soap and water after all exposure to blood or other body fluids or exposed bodily tissue.
- Wearing of gloves and protective clothing when blood and other body fluids are being contacted - this is especially important in the handling of dead bodies.
- Safe disposal of medical waste (drapes, sponges and wipes that contain blood or other fluids – and body tissues and fluids themselves).
- Decontamination of all instruments and equipment that have been in contact with blood and body tissues.

V. Strategies for HIV Prevention and Behavior Change

Instructor Note: This exercise gives participants an opportunity to put the knowledge and skills they've acquired in the course to potential real-life situations. Participants will be presented with scenarios where they will make choices and develop strategies with the ultimate goal of preventing getting infected with STIs, including HIV. Encourage participants to draw on their experiences as uniformed service personnel. This exercise may be challenging to participants because it may be very different from the type of training they are accustomed to. Let the group know before you do the exercise that this may be difficult for them, but emphasize they will learn important skills and ideas from this discussion. Be sure to tailor the discussion regarding "Guidelines for Negotiating Safer Sex" to best meet your audience's needs, taking into account cultural issues. Tailor the small group discussion scenarios to your audience as well.

A. Dyad or Small Group Practice

Instructor Note: Begin this exercise with a brief presentation on negotiating safer sex.

Guidelines for Negotiating Safer Sex

1) Practice TALK:

T = Tell your partner “I am listening to what you are saying.” Acknowledge them. Use “I” statements (speak for yourself).

A = Assert what you want in a positive way. State your goal or need. Be positive. Use “I” statements (speak for yourself).

L = List your reasons for wanting to be safe (use condoms). Be brief. Use a reason that is about you. Do not mention disease.

K = Know the alternatives (for safer sex) and your personal bottom line (exactly what you are comfortable doing).

TALK is a set of tools that a person can use to be assertive and persuasive. Use TALK to tell a partner you want to have safe sex, you won't have unsafe sex, or in any situation where you want to be assertive.

2) Be assertive, but not aggressive:

- make sure you say what you want;
- use “I” statements (speak for yourself);
- listen to what your partner is saying;
- respect and acknowledge your partners' feelings and options;
- be positive;
- use reasons for safe sex that are about you, not your partner.

3) If your partner is being negative (not wanting to practice safer sex):

- Find something positive in what they're saying and turn their negative objection into a positive thing. For example, if your partner is very controlling, you can say to them that you appreciate that and are glad they care so much about you (rather than accusing them of being too controlling).
- Never blame the other person for not wanting to be safe, blame the environment or something else, but never the other person.

4) Remember, HIV is not all you can contract from not practicing safer sex. You can contract another STI or cause an unwanted pregnancy.

Directions for Exercise

- 1) Have participants work in small groups or have them form pairs of two (dyads). If dyads are formed, one person will need to volunteer as a notetaker. If small groups are formed, the group will need both a facilitator and a notetaker. Give each dyad or small group flip chart paper and writing materials. Give each dyad or facilitator in the small group a “Strategies for HIV Prevention and Behavior Change Exercise Instruction Sheet.”
- 2) Give each dyad or small group a scenario (described below) from the “Strategies for HIV Prevention and Behavior Change Scenarios.” There are two scenarios; be sure to distribute them evenly. You can change the names on the scenarios to make them more real for the participants. Ask participants to review and discuss their scenario and develop responses/strategies to it. Each dyad or small group notetaker should write down the responses/strategies developed on paper or on flip chart paper (which they can use for their presentation to the larger group).

Small Group Discussion Scenarios

Scenario #1: Mahama and Naa

This is Mahama’s first mission outside of his country and it’s the first time he has ever been in another country. Mahama is surprised and overwhelmed with the amount of diversity in his new home environment (cultural, religious), not just in the local population, but within his mission. It has been very stressful for Mahama trying to adjust to so many different types of people and this new environment. He has formed a friendship with Frank, another soldier, and they have both been given their first two and a half days of “R and R” (rest and relaxation) and they are ready for it! They’re going to a nearby beach and are very much looking forward to it. Mahama and Frank are in a social club drinking, after spending a great day on the beach. Mahama meets Naa at the club. They dance and talk and Mahama can tell just by the way Naa smiles and touches him that she’s sexually interested in him. Naa invites Mahama back to her place. Mahama is worried about HIV and other STIs and wants to use a condom. After they get to Naa’s apartment, they begin to move towards intimacy.

Mahama: I should tell you now that it’s very important to me to use condoms. I have some with me.

Naa: Why do you want to use one of those things? I’ve never met a man who wanted to use a condom!

Mahama: Well, I think it might be a good idea...

Naa: But Mahama, it feels so much better without a condom.

What should Mahama do? What should Mahama say to Naa? Develop possible responses and strategies for Mahama to effectively negotiate safer sex with Naa.

Scenario #2: Christina and Olufemi

Christina suspects her boyfriend Olufemi has been sleeping with someone while she was away from home on a special six-month assignment. She's getting ready to go home and is worried about HIV and other STIs. She wants to use condoms when she and her boyfriend have sex, but does not know how to bring it up (they've never used them before). She's particularly worried because he has a bad temper and is jealous.

What should Christina do? What should Christina say to Olufemi? Develop possible responses and strategies for Christina to effectively negotiate safer sex with Olufemi.

B. Large Group Summary

Directions for Exercise

- 1) The instructor will request one volunteer from each small group or dyad to summarize the strategies that they identified in response to their scenario. Offer additional responses (if appropriate) to emphasize prevention of HIV/STIs.
- 2) Discuss any questions or concerns of participants.
- 3) To wrap up the exercise, review the guidelines for negotiating safer sex.
Practice TALK:

T = Tell your partner "I am listening to what you are saying." Acknowledge them. Use "I" statements (speak for yourself).

A = Assert what you want in a positive way. State your goal or need. Be positive. Use "I" statements (speak for yourself).

L = List your reasons for wanting to be safe (use condoms). Be brief. Use a reason that is about you. Do not mention disease.

K = Know the alternatives (for safer sex) and your personal bottom line (exactly what you are comfortable doing).

Be assertive, but not aggressive:

- make sure you say what you want to say ;
- use "I" statements (speak for yourself);
- listen to what your partner is saying;
- respect and acknowledge your partners' feelings and options;
- be positive;
- use reasons for safe sex that are about you, not your partner.

If your partner is being negative (not wanting to practice safer sex):

- Find something positive in what they're saying and turn their negative objection into a positive thing. For example, if your partner is very controlling, you can say to them that you appreciate that and are glad they care so much about you (rather than accusing them of being too controlling).
- Never blame the other person for not wanting to be safe, blame the environment or something else, but never the other person.

Remember, HIV is not all you can contract from not practicing safer sex. You can contract another STI or cause an unwanted pregnancy.

Instructor Note: If appropriate, use the following optional discussion to assist with the wrap-up of this exercise.

The process of negotiating safer sex is similar to the process of negotiation. The following analogy relates the steps of diplomacy, negotiation and action that uniformed service personnel are trained in to steps to take regarding talking about safer sex, negotiation and action.

Diplomacy = Talking together at the beginning of a relationship **before** having sex. This is an opportunity to express your point of view about safer sex and state your needs.

Negotiation = Trying to reach agreement on safer sex, so sexual activity will be comfortable for both individuals. You can use different words to talk about your preference for safer sex. For example, state that it is a matter of good health, it's not just for my, but for your safety as well.

Action = Take action to ensure your safety. You can insist on using a condom, you can decide not to have sex if your partner refuses to use a condom or you can decide to do other activities besides penetrative sexual intercourse.

VI. Part I Summary and Conclusions

The instructor should thank participants for their participation in this part of the training program. He or she should reinforce the importance of their mission and the need for them to protect their health and the health of their families.

Module 7, Part I: HIV Prevention and Behavior Change Issues Strategies for HIV Prevention and Behavior Change

Exercise Instruction Sheet

Directions for Small Group Discussion

- 1) The facilitator identifies the notetaker in their group and makes sure they write down responses and strategies to their scenario on flip chart paper.
- 2) Distribute the scenario to your group and have them read it.
- 3) Lead a discussion with your group and get them to talk about the scenario and develop responses and strategies to it.
- 4) Agree on a presenter, or have the entire group present, when you get back together in a large group with the instructor.

Module 7, Part I: HIV Prevention and Behavior Change Issues Strategies for HIV Prevention and Behavior Change Scenarios

Scenario #1: Mahama and Naa

This is Mahama's first mission outside of his country and it's also the first time he has ever been in another country. Mahama is surprised and overwhelmed with the amount of diversity in his new home environment (cultural, religious), not just in the local population, but within his mission. It has been very stressful for Mahama trying to adjust to so many different types of people and this new environment. He has formed a friendship with Frank, another soldier, and they have both been given their first two and a half days of "R and R" (rest and relaxation) and they are ready for it! They're going to a nearby beach and are very much looking forward to it.

Mahama and Frank are in a social club drinking, after spending a great day on the beach. Mahama meets Naa at the club. They dance and talk and Mahama can tell just by the way Naa smiles and touches him that she's sexually interested in him. Naa invites Mahama back to her place. Mahama is worried about HIV and other STIs and wants to use a condom. After they get to Naa's apartment, they begin to move towards intimacy.

Mahama: I should tell you now that it's very important to me to use condoms. I have some with me.

Naa: Why do you want to use one of those things? I've never met a man who wanted to use a condom!

Mahama: Well, I think it might be a good idea...

Naa: But Mahama, it feels so much better without a condom.

What should Mahama do? What should Mahama say to Naa? Develop possible responses and strategies for Mahama to effectively negotiate safer sex with Naa.

Module 7, Part I: HIV Prevention and Behavior Change Issues Strategies for HIV Prevention and Behavior Change Scenarios

Scenario #2: Christina and Olufemi

Christina suspects her boyfriend Olufemi has been sleeping with someone while she was away from home on a special six-month assignment. She's getting ready to go home and is worried about HIV and other STIs. She wants to use condoms when she and her boyfriend have sex, but does not know how to bring it up (they've never used them before). She's particularly worried because he has a bad temper and is jealous.

What should Christina do? What should Christina say to Olufemi? Develop possible responses and strategies for Christina to effectively negotiate safer sex with Olufemi.

Part II: HIV Prevention in Crisis Settings

I. Introduction

Part II of this session will include:

- 1) information about crisis settings and the role of the uniformed services in crisis;
- 2) information about what happens to civilians in crisis settings;
- 3) information on being an early warning sentinel for HIV/STIs in crisis settings;
- 4) review of professional conduct guidelines for uniformed service personnel;
- 5) information on the relationship between alcohol, drugs, sexual activity and HIV/STIs;
- 6) problem-solving exercises for uniformed service personnel involved in crisis situations.

II. Speaking the Same Language

Instructor Note: This is a brief exercise to make sure participants are all using the same terms to describe civilian populations in crisis. Present these terms briefly and ask participants if they use other terms to describe civilian populations. List their responses on writing board or flip chart paper.

For the rest of this module, we will be talking about crisis and using certain terms to describe people in crisis. To make sure we are talking about the same thing, we'll take a few minutes to define people in crisis settings.

Refugees. International law defines a refugee as a person who is outside his or her country and cannot return because of a well-founded fear of persecution, or who has fled because of war or civil conflict or the destruction of their homes and communities. Refugees fear persecution for many reasons including race, religion, nationality, membership in a particular social group or political opinion.

Economic Refugee. Sometimes refugees have left their country, not for fear of persecution or due to destruction of their home, but to make money. Employment opportunities may be rare in their own country and individuals leave to earn money in other countries in order to support themselves and their families.

Returnees. Refugees leave their homes under extreme duress and most of them want to return as soon as circumstances permit. They are called returnees when they return to their home country (repatriation), usually with the support of the United Nations or other international agency.

Internally displaced persons (IDPs). IDPs are individuals who have left their homes under extreme duress and are living in another location within their country. They are “displaced” within their own country.

Worldwide, there are an estimated 50 million people who have been forced to flee their homes, these individuals are refugees, returnees and persons displaced within their own countries. This represents about 1 out of every 280 people on earth.

Crisis Defined and the Role of the Uniformed Services in Crisis

Instructor Note: This is a presentation to define crisis and describe what happens during a crisis. It is recommended to deliver this information using a facilitated discussion format (rather than a didactic lecture format), where the instructor can ask questions and then have participants provide responses. For example, the instructor asks participants to define what crisis is. After doing so, the instructor can then summarize using the information below.

Crisis is defined as a breakdown of normal conditions (whatever conditions a country, region or community are used to), which results in an unstable environment. Crisis includes war and armed conflict as well as natural disasters, like floods and earthquakes. We will talk about crisis that includes war and armed conflict.

Crisis is:

- conflict - armed conflict and war (fighting between two or more countries)
- internal civil unrest or disorder (fighting among opposing or rebel factions, ethnic cleansing)

Stages of crisis:

- pre-crisis where normal systems begin to break down and affect daily life (health care, markets, employment)
- crisis stage itself where there is active conflict and civilian populations may flee their homes or be forced to leave their homes; sometimes civilians must go to another country
- post-crisis where the community or region works to return to normal; this may involve civilians returning to their homes if they fled or were forced to leave

Instructor Note: If appropriate (depending on the level of your audience), you can discuss this more in-depth description of the stages of crisis:

- Stage 1: The destabilizing event – results in a very chaotic situation
- Stage 2: Loss of essential services – breakdown of political and social infrastructure and cutting off access to basic needs
- Stage 3: Restoration of essential services – a return to meeting most basic needs and the capacity to expand services, this is where most of the work of humanitarian agencies and peacekeepers takes place; restoration of essential services and protection of the population are the goals of humanitarian interventions into complex emergencies
- Stage 4: Relative stability – services restored to the affected population that allows a greater development of interventions and care
- Stage 5: Resumption of normality – circumstances that allow the return of displaced populations to their communities and homes

What causes a crisis?

- Crises happen within, between and among nation-states over clashes of interests that the disagreeing sides believe are so basic to their identity and survival that little or no opportunity seems possible for peaceful resolution.
- Causes of crises include religious and cultural competition, territorial disputes and differences between groups that limit opportunity for social and financial advancement and political autonomy.
- Crises occur among peoples who often live close to each other in a common physical environment.
- At their worst, crises lead people and leaders to de-humanize their opponents. This can result in periods of violence and armed conflict that create injury, sickness and death, large numbers of refugees and IDPs and loss of basic human security and social/political order. More suffering and death may be caused by environmental problems such as flooding and earthquakes, famines, mental illness and waves of diseases. HIV thrives in crisis situations.

What happens during a crisis?

During a crisis, many things can happen that affect uniformed service and civilian populations:

- Combatants enter an area, people may move from their homes to get away from the conflict or live under difficult conditions (no electricity, running water, heat, not being able to leave their homes) because of fighting.
- Health care, educational and government institutions close down or limit their services. Stores close down or limit their hours. Civilians become vulnerable because they have limited or no access to needed medical care, food and safe drinking water. They may lose their jobs and have no money. Families can become separated. Adolescents and children have nowhere to go because schools are closed, may spend time on the streets and get involved with crime or the conflict itself by becoming child soldiers. Persons may be discriminated against because of their race, religion or gender and be denied access to medical care, employment, food and shelter.
- Uniformed service organizations spend most of their time dealing with the conflict and less of their time protecting civilians. Civilians become more at risk for discrimination and acts of violence (like rape). Human rights become hard to protect during a crisis.
- Civilians become more and more affected by the crisis as time goes by, and may choose to flee to another part of the country or a different country in order to be safe from violence or persecution and be able to get their basic needs met for safe drinking water, food and shelter. In some circumstances, civilians are forced to leave their homes and are

relocated to camps or institutions. When large numbers of civilians flee their homes, refugee camps are set up in other countries to help them and provide food and shelter. The crisis in Kosovo is one recent example of a mass fleeing of persons to safer countries.

- Humanitarian missions are set up to care for civilian populations and provide shelter, food, water and medical care. This often involves the creation of camps for refugees and IDPs.
- Peacekeeping missions are organized for when the crisis is over, often involving many different countries to contain disputes and maintain peace and stability.

What is the role of the uniformed services during a crisis?

The uniformed services play many different roles in a crisis, depending on the nature of the crisis:

- Combatant in an armed conflict. This is a tense, stressful situation. Lives are at risk and combatants are killed.
- Peacekeeper in a peacekeeping mission. Peacekeeping missions are established after a conflict or war, to separate fighting factions and keep them from potentially explosive incidents that could lead to renewed conflict. For example, the United Nations comes in after the fighting has stopped and keeps separate the formerly fighting factions. The situation is tense, but there is no fighting. In Lebanon, Ghana was part of a UN peacekeeping mission to keep the Muslims separated from the Christian population who were having a civil war at the time. Their job was to man the truce line and keep both sides separated.
- Peace enforcer. This is a complicated process that occurs when the fighting has stopped, but there has not been a firm truce yet – there is agreement by the fighting sides in principal not to fight, but anything can happen. The job here is to make sure that the fighting does not start up again, and if necessary to fire back if fired upon. NATO does peace enforcing, like they did in Bosnia when the UN peacekeepers were fired on and could not fire back and had to be assisted by NATO. Peace enforcers help factions after a conflict to adhere to truces and cease fires, deal with snipers and any violations of truces and cease fires. Ghana and Nigeria were both involved with ECOMOG in Liberia and Sierra Leone. They went in as peace enforcers and peace makers – they were able to shoot and their job was to separate the fighting groups.
- Peace makers. Peacemakers have the difficult task of fighting to separate the warring factions; soldiers are sent in as combatants. One example of this is the recent Gulf War.
- Protector of civilian populations.

- Peace builders. Uniformed services are often asked to help return the environment to normal after the fighting has stopped and warring sides have been disarmed. They are asked to build institutions like hospitals, assist in reestablishing trade, help and protect the new government, reconstruct roads, open schools and markets and resettle refugees or IDPs. This is a particularly hard role for uniformed services because individuals want to go home and do not consider these “civilian” tasks to be part of their mission.

III. Feelings and Opinions Exercise: Populations in Crisis Settings

Instructor Note: This exercise is designed to increase participant awareness of their feelings and attitudes about working in crisis settings and populations in crisis. All of the statements deal with aspects that can put uniformed service populations at risk for infection with HIV and other STIs.

Directions for Exercise

- 1) Before the session, write each of the statements or questions below on its own sheet of paper in large, easy-to-read letters. Prepare multiple copies of each statement
- 2) Divide participants into small groups. Ask them to spend 15 minutes discussing their feelings and attitudes, spending a few minutes on each statement. Let participants know that they can frame their answers in the third person, rather than discuss their own personal responses (this may facilitate more open discussion).
- 3) You can remind them every few minutes to move on to the next statement, if they haven't already done so. Wrap up the small group discussions after about 15 minutes.
- 4) Next, have one person from each group summarize their group's responses for the larger group. To save time, have subsequent groups relate only responses that haven't been mentioned.
- 5) Discuss each statement after all groups have given their responses (see discussion questions below). List responses to each statement on a writing board or flip chart paper.

Statements for Participants to Discuss:

Statement # 1: During a crisis, when civilians may be living in a war or occupied zone, relocated to camps, forced to flee their home and become refugees or IDPs, how much do uniformed service personnel need to worry about sexual violence or abuse toward civilians? How does this relate to getting infected with HIV or other STIs?

Key points to discuss in large group for Statement #1:

Sexual violence and abuse

- The potential for rape and violence is higher during a crisis.
- Women, children and men are at increased risk of violence, including rape. They may lose protection if their spouse leaves to join the conflict or is removed from their home. Women and girls are particularly at risk since coercive sex is likely to result in tears or other injuries to the genitals.

- In some conflicts, rape is used as a systematic campaign of terror and intimidation against certain population groups.
- AIDS can be used as a weapon of war where one military deliberately infects women with HIV (who will then infect their spouses or sexual partners).
- Children can be forced into joining the conflict as soldiers, abducted from their homes or right off the street. Children also become soldiers when they become separated from their parents, by becoming soldiers they are given another “family,” along with food and shelter.
- When refugees or IDPs live in camps, the potential for violence and abuse is great as people fight to get food, water and firewood. Sex is often traded for food, water and firewood. When Ghana was in Sierra Leone and Liberia, a soldier could easily get sex from a woman for only a cup of rice to eat.

Statement #2: During a crisis, what types of things happen to civilian populations when they have a limited ability to provide for their basic needs (food, money and shelter)? How does this relate to getting infected with HIV or other STIs?

Key points to discuss in large group for Statement #2:

Lack of income and basic needs (food, money and shelter)

- People cut off from their normal sources of income and basic needs may find that selling sex is one of few survival strategies open to them. In many refugee camps the sex industry has flourished, becoming part of the interaction between the refugee population and the local people in the host country.
- Food may be difficult to get and women, men and children alike can exchange sex for food.
- Sex can also be exchanged for money and shelter. Women turn to commercial sex work (CSW) as a way to support their families.
- Women and children may be sold into sexual slavery against their will by their families or spouses in exchange for basic needs.

Statement #3: When places of employment, schools, and hospitals and clinics shut down or are changed because of a crisis situation, in what ways do you think this affects civilian populations? What happens when families get separated or members get killed? What do people do to cope with their situation? How does this relate to getting infected with HIV and other STIs?

Key points to emphasize in large group discussion for Statement #3:

Breakdown in social and cultural structures

- The breaking up of community and family life causes stable relationships to break up, support to be lost and the cultural and family controls on individual behavior to loosen.
- Psychological damage can result from being a victim of sexual violence and abuse, losing a home or job, being forced into poverty, becoming a child soldier or losing parents or loved ones.

- Sex can be used as a coping mechanism, along with alcohol and drugs. Drugs and sex are very available near refugee camps. If a population with a large number of injection drug users is forced to flee an area, the traffickers and dealers flee as well to maintain their business. Likewise, the commercial sex industry moves near refugee camps.
- Young people may have no strong and positive role models or parental protection. Youth in refugee camps tend to become sexually active at an earlier age than they would under normal conditions.
- Boredom and stress from not having work or going to school can lead to alcohol and drug use to relieve boredom and stress.

Lack of education

- With no formal education system in place and in some cases the absence of parents, young people lack knowledge about HIV and other sexually transmitted diseases.
- Young people can engage in sex at earlier ages and the rate of unplanned pregnancy can rise.

Lack of health care

- Limited or no access to medical care, including sexual health services can lead to greater numbers of persons with infectious diseases which, if left untreated, can be spread to others such as tuberculosis and STIs.
- Condoms are seldom available in a crisis, as well as testing for HIV/STIs and other infectious diseases.
- In crisis settings, the risk of HIV transmission through the transfusion of infected blood may be high. More transfusions than usual may be needed because of war or civil unrest. It may be difficult to screen blood for HIV due to lack of equipment.

Statement #4: In what ways do you think working in crisis situations affects uniformed service personnel and relief workers? What do they do to cope with working in difficult settings (war zones, refugee or relocation camps)? How do they relieve stress? How does this relate to getting infected with HIV and other STIs?

Key points to discuss for Statement #4:

Impact on uniformed service personnel and relief workers

- Uniformed service personnel and relief (humanitarian) workers do not always receive training in what happens to civilians in crisis settings. They are often not prepared for the hardships and conditions civilians are forced to deal with.
- Uniformed service personnel do not always receive training in protection of human rights or issues that confront civilians, refugees and IDPs living in crisis settings. There are abuses that can occur when uniformed service and civilian personnel have “power” over the civilian population. They offer protection, food, medicine and shelter.
- Uniformed service personnel and relief workers alike are not always prepared for what they will have to deal with in a crisis. They can become stressed and lonely and turn to alcohol, drugs and sex (among themselves as well as with the civilian population) to relieve their stress and loneliness.

- The commercial sex industry and professional drug traffickers often set up near refugee camps and peacekeeping missions. They know uniformed service personnel have money. Uniformed service personnel and relief workers take advantage of these “services” as ways to relieve stress. Condoms and clean drug injection equipment are seldom available.
- Uniformed service personnel are under significant levels of stress during a crisis on conflict situation including normal stress (like anxiety of having to fight, being deployed); traumatic stress (from witnessing atrocities like the killing of women and children); and cumulative stress (stress not just from the current crisis, but from all the crises a soldier might have been deployed for). Stress management is difficult in crisis situations, long stretches of boredom are often interspersed with short episodes of sheer terror.

Exercise Wrap Up

Instructor Note: Conclude the discussion by asking for any final thoughts or comments. Suggest that participants think back on this discussion when they find themselves working in crisis situations.

In summary, emphasize the following key issues for populations in crisis:

- In crisis settings, both uniformed service personnel and civilians alike are at risk for infection with HIV and other STIs.
- The potential for rape and sexual violence is higher in a crisis.
- When sexual violence and abuse occurs, it can leave a life-long psychological impact on its victims.
- HIV can be used as a weapon of war, forever changing the lives of its victims.
- Children can be forced into becoming child soldiers, often they are orphaned or separated from their families.
- The lack of income and basic needs (food and shelter) creates serious problems for civilians; individuals can be forced to turn to exchanging sex for money, food and shelter.
- Alcohol and drugs are used to relieve stress, loneliness and trauma.
- Lack of access to medical care, condoms and education cause more people to practice unsafe sex, making them vulnerable to HIV/STI infection.
- Crisis affects not just civilian populations. Uniformed service personnel and relief workers sometimes cope with the stress by turning to alcohol and drugs. They can also engage in unsafe sex.

IV. Professional Conduct Guidelines for Uniformed Service Personnel

Instructor Note: This section emphasizes aspects of uniformed service professional conduct that reinforce avoidance of behaviors that place uniformed service personnel at risk for infection with STIs/HIV. The instructor should encourage discussion of these aspects and consider inviting their commander to present these guidelines or participate in this discussion. These professional guidelines are based on the United Nations Code of Conduct for Peacekeepers.

Professional Conduct Guidelines Highlights

Before we discuss general guidelines for professional conduct, we want to stress that your role and responsibility as uniformed service personnel is to protect civilian communities, your families and each other. You are protecting all these individuals, including yourself, when you prevent transmission of HIV/STIs. We also want to stress the impact individual behavior can have on an entire mission or organization. You are part of a group and your behavior reflects directly on the group as a whole and can impact the successful achievement of your objectives. What follows are general guidelines we all can agree on as uniformed service personnel:

We will:

- At all times conduct ourselves in a professional and disciplined manner.
- Support and encourage proper conduct among ourselves.
- Treat the inhabitants of the host country with respect, courtesy and consideration when stationed away from home.
- Respect local customs and practices wherever we work through awareness and respect for the culture, religion, traditions and gender issues. We recognize that social rules governing relations between men and women often have very different norms from one culture to the next, so that what may be interpreted as innocent behavior in one culture context may be taken as an offense in another culture.
- Always be aware of the human rights of women and children and **never** violate them.

We will never:

- Bring discredit upon our organizations through improper personal conduct, failure to perform our duties or abuse of our positions as uniformed service personnel.
- Take any action that might jeopardize our work or our organization's mission.
- Abuse alcohol, use or traffic in drugs.

- Commit any act that could result in physical, sexual or psychological harm or suffering to members of the civilian population, especially women and children.

We realize the consequences of failing to act within these guidelines may:

- Erode confidence and trust in the uniformed services.
- Jeopardize the achievement of our work or our organization's mission.
- Jeopardize our status and security as uniformed service personnel.

Instructor Note: To summarize, emphasize that adherence to these professional conduct guidelines will greatly reduce an individual's risk for contracting STIs/HIV or transmitting STIs/HIV to other persons.

V. The Uniformed Services as Early Warning Sentinels

Instructor Note: This discussion focuses on how uniformed service personnel can act as early warning sentinels in crisis settings, particularly for HIV/STIs but also for other emerging threats to health and security. First define what a sentinel is and then lead a facilitated discussion around how uniformed service personnel can act as sentinels for early warning especially regarding HIV/STIs, but also for other threats to health and security. Emphasize that this is a very important role to play in a pending health crisis.

Sentinel Defined

A sentinel is a guard, whose duties can range from watching or observing, preventing entry and informing. For uniformed services, sentinels can be:

- peacekeepers on an observation mission;
- guards posted to borders of countries to prevent smuggling or the entry of illegal immigrants;
- observers or "look outs" in armed conflict to warn of enemy movements or operations.

Directions for Facilitated Discussion Exercise

- 1) Ask participants to identify steps uniformed service personnel can take to identify situations that may place a community or area at increased risk for HIV/STIs; write their responses on flip chart paper or writing board.
- 2) Ask participants to discuss ways in which uniformed service personnel can warn about increased risk for HIV/STIs and who they should alert; write their responses on flip chart paper or writing board.

3) Review with participants the following points after the discussion:

Uniformed service personnel can take the steps of observing, listening and talking to identify developing problems that could lead to increased risk for a community/region for HIV/STIs:

- Observe people, both civilians and uniformed service personnel. Are more people going to sexual or reproductive health clinics and military medical clinics?
- Listen to what people are saying in the community, on the street, in the barracks – are they talking about themselves or their friends getting infected with STIs?
- Talk to health care providers, community social workers and police. Ask them if they see an increase in people experiencing STIs? Ask them about related issues - are there more rapes occurring? Are there more families experiencing violence and being broken apart? Are people losing their jobs? Is the crime rate rising for theft? Is the community experiencing any food shortages?

Once a potential or real problem is discovered, uniformed service personnel need to:

- Quickly inform through their immediate chain of command.
- Notify public health institutions – government offices, major hospitals and clinics.
- Notify humanitarian/relief offices in the area.

Exercise Wrap Up

Instructor Note: Conclude the discussion by asking participants for any final thoughts or comments.

VI. Alcohol and Drugs, Sexual Activity and HIV/STIs

A. Alcohol and Other Drugs Effects and Their Relationship To Behaviors That Put You At Risk For HIV/STIs

Instructor Note: This interactive presentation addresses the effects alcohol and other drugs can have on sexual decision-making and how this relates to HIV/STI prevention. Use “Alcohol, Drugs and HIV” slide during the presentation. Encourage questions and discussion throughout the presentation.

Slide/Overhead

“Alcohol, Drugs and HIV”

The Effects of Alcohol and Other Drugs

Instructor Note: Emphasize to participants:

- The use of alcohol and other drugs can impair thinking and judgment. When people are under the influence of drugs or alcohol, they sometimes take risks they would not otherwise take. These can include doing things that may place them at risk for STIs, including HIV infection, such as having sex without using a latex condom or sharing needles and syringes. **People may take HIV/STI-related risks when using alcohol or other drugs. Even just one incident of having sex without using a condom or sharing needles with a partner infected with an STI or HIV may lead to infection.**
- Alcohol and other drugs can impair thinking and judgment in other situations as well. When people decide to get a tattoo while they are under the influence of drugs or alcohol, they may take risks they otherwise would not take. For example, not checking to make sure the needles used for the tattoo are sterile or deciding to risk it if they are unsterile. Unsterile needles can transmit HIV and other STIs i.e., hepatitis B.
- Remember that when you drink or take drugs, **regardless of whether it is a lot or a little**, this will interfere with your judgment about many things, including sex. Chances are you will be more likely to engage in unsafe sex (i.e., sexual activity without a condom) because you were drinking or using drugs. This includes drugs like marijuana, and cocaine.
- Give some thought to what you do. You would never drive a vehicle or go into a risky professional situation if you were drunk. Why not? Because you would not be able to think as clearly as you should, and you could be killed or injured.
- Remember to take care of each other by using the “buddy system” (where friends agree to take care of and look out for each other), especially when you are in situations where your risk for getting infected with HIV may be high (for example, going out drinking, going on leave). If you do choose to put your self in a potentially risky situation (like going out drinking), make sure you bring a “buddy” with you who agrees not to drink so they can take care of you (drive you home safely, give you condoms so you can have protected sex).

B. How Can You Tell?

Instructor Note: This is a discussion that makes an analogy between safe weapons and safer sex. It addresses the misperception that one can “tell” if someone is likely to have an STI just by looking at them. In studies with United States military, many individuals felt they could tell if someone had an STI/HIV if they had dirty hair and blemished skin. Emphasize to participants that you can not tell someone’s HIV/STI status simply by looking at them! Ask participants to think about how they “size up” potential sexual partners at the end of the slide /overhead presentation. Emphasize that civilians are not the “enemy.” Uniformed service personnel and civilians alike are infected with HIV/STIs and it is not helpful to have an “us” versus “them” mentality; we (meaning both uniformed service personnel and civilians) are all in this together and together we can work on developing and maintaining safer behaviors.

**Slide/Overhead
“9mm Weapon”**

Is this weapon loaded or unloaded? Using the training you have received in weapon safety, what must you assume? Would you take this weapon and point it at your head and pull the trigger? The point is that you would **not** place yourself at risk with this weapon by not thoroughly checking it out, making sure it is safe.

**Slide/Overhead
“Female Model”**

The same safety issues hold true for people, especially strangers, when you are “sizing up” a potential sexual partner. You can't tell by looking at them if they are carriers of STIs or the AIDS virus. It's even possible that this beautiful woman is unknowingly infected with gonorrhea or worse. 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 that loaded 9mm weapon we saw before. Is risking your good health or life worth having “unprotected sex” with this stranger?

**Slide/Overhead
“Male Model”**

What about this gentleman? He looks like he could be a Peacekeeper or a soldier. Do you know his HIV status just by looking at him?

**Slide/Overhead
“Couples Models”**

Likewise, what about these couples? Can you tell who among them might have an STI or is HIV positive?

C. HIV/STI Butterfly

Instructor Note: The next few slides /overheads are the HIV/STI butterfly. The butterfly consists of a series of seven slides/overheads and shows how a person really doesn't have sex with just one person, but with every person that person ever had sex with before. Tailor the scenario to fit the group you are presenting to.

Slide/Overhead
"Butterfly I"

To demonstrate how STIs, including HIV, are transmitted from one person to another let's imagine the following situation:

Slide/Overhead
"Butterfly II"

Imagine that you're 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. In fact, you get a jump-start by having a few drinks in your living quarters prior to setting out on the town. You're sitting there when a group of beautiful young women come into the bar. 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 lovely 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 on the way out of your home. But you think to yourself "**just this one time**" nothing can happen. Besides, she's so fine she can't possibly have anything. So, you have sex without using condoms. As you lay 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.

Slide/Overhead
"Butterfly III"

What your new friend didn't know was that the guy she picked up from the bar two months ago had gotten 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 made an exception "**just this one time**" with at least two different sex partners.

Slide/Overhead
"Butterfly IV"

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

Slide/Overhead
"Butterfly V"

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 thirty people in bed with you and your beautiful new friend and any one of them could have an STI. The thing of it is, you don't know which one. It could be anyone ...

Now let's take a look at **you** and **your** other sexual partners.

Slide/Overhead
"Butterfly VI"

Before, you thought it was just you and your new friend having a romantic evening. Now, in fact, there are at least sixty people in bed with you.

Think about if this woman was a commercial sex worker (prostitute). How big would the bed have to be to hold all the people you were having unprotected sex with? Could be as much as a battalion! Think this is an exaggeration? **Any** time two people on the butterfly have unprotected sex, **you** are potentially at risk for getting an STI, including HIV. What if one of those red people on your side had herpes? Or if one of the purple people had HIV? It's that easy for you to get HIV or other STIs too.

Slide/Overhead
"Butterfly VI"

This slide shows how one person on the butterfly can end up infected with HIV or an STI.

D. What Would You Do If?

Instructor Note: This exercise is intended to help participants assimilate the information presented in this section, by participating in an exercise to learn about their potential HIV status and discussing how they would react to the news that they were either HIV positive or HIV negative.

Directions for Exercise:

- 1) Prepare small pieces of paper folded in half for the number of participants in your session. On half of the slips of paper, write “HIV positive.” On the other half of the slips of paper, write “HIV negative.”
- 2) Hand out the slips of paper to participants instructing them not to open them until you tell them to do so.
- 3) Take them through the following scenario: You are getting ready to come home from a remote posting on the border of your country or from a peacekeeping mission and you are really looking forward to getting back to normal life and seeing your family. It’s been a hard mission and you are ready to go home. Before leaving, each of you will be tested for HIV. What is in the folded slips of paper you have is the results of your HIV test.
- 4) Instruct participants to now open their slips of paper and lead a discussion about how they feel about: 1) learning their HIV status; 2) how they think it will affect their lives; 3) how they think it will affect the lives of their families and their community. Place a blank sheet of flip chart paper for each of these areas on the wall, or write on a writing board, participant’s responses.
- 5) Close the exercise by asking for any additional comments and emphasize the following points:
 - Alcohol and drugs can impair thinking and judgment and place a person at risk for getting infected with HIV and other STIs.
 - Unsterile drug injection equipment and tattoo needles can place a person at risk for HIV/STIs.
 - When you have sex with one person, you are also having sex with every other person you and your partner ever had sex with. It is critical to always use condoms correctly every time you have vaginal, oral or anal sex.
 - It is not possible to tell if someone is infected with HIV or another STI just by looking at them. Many HIV positive people look and feel healthy for years.
 - We are all at risk for HIV.

VII. Problem Solving Scenarios for HIV Prevention in Crisis Settings

Instructor Note: This exercise gives participants an opportunity to put the knowledge and skills they've acquired in the course to potential real-life situations. Participants will be presented with scenarios where they will make choices and develop strategies with the ultimate goal of preventing getting infected with STIs, including HIV. Encourage participants to draw on their experiences as uniformed service personnel. This exercise may be challenging to participants because it may be very different from the type of training they are accustomed to. Let the group know before you do the exercise that this may be difficult for them, but emphasize they will learn important skills and ideas from this discussion. Be sure to tailor the discussion to best meet your audience's needs, taking into account cultural issues. Tailor the small group discussion scenarios to your audience as well, including selecting appropriate names.

A. Dyad or Small Group Practice

Directions for Exercise

- 1) Have participants work in small groups or have them form pairs of two (dyads).
- 2) If dyads are formed, one person will need to volunteer as a notetaker. If small groups are formed, the group will need both a facilitator and a notetaker. Give each dyad or small group flip chart paper and writing materials. Give each dyad or facilitator in the small group a "Problem Solving Scenarios for HIV Prevention in Crisis Settings" exercise instruction sheet.
- 4) Give each dyad or small group a scenario. Be sure to distribute them evenly. Ask participants to review and discuss their scenario and develop responses/strategies to it. Each dyad or small group notetaker should write down the responses/strategies developed on paper or on flip chart paper (which they can use for their presentation to the larger group).

Small Group Discussion Scenarios

Scenario #1: Kwame

Kwame has been stationed on a peace enforcing mission to Liberia. He has been there for 14 months and still does not know when he will be sent home. He is a religious man who finds strength in reading his Bible, and misses his family and children a great deal. Kwame lives in a tent with four other soldiers. The other men routinely bring women back to the tent and have sex with them right in the open, no matter if anyone else is in the tent. Kwame leaves the tent during these times and tries to stay strong by reading his Bible. He is lonely and feels tempted to join in with the other men. It is hard for him to be strong when people are having sex right in front of him. One day Kwame is in great danger as his unit comes under fire while away from camp and one of his tent mates gets shot and seriously injured. Kwame

has never come so close to getting killed himself. He cannot handle the stress and decides to have sex with one of the women his tent mates brings in that night. Afterwards, he feels very depressed and is worried because he did not use a condom.

What could Kwame have done in this situation to protect himself from getting infected with HIV or an STI? How could he have managed his stress and handled the situation differently? Develop strategies for how Kwame: 1) could have handled the stressful situation differently; 2) protected himself from being exposed to HIV/STIs.

Scenario #2: Kweku and Margaret

Kweku is getting ready to return from a peace making mission in Sierra Leone. He has been away from his wife Margaret for six months. This mission has been hard for him because he and Margaret were married for just a few months before he was deployed. Kweku missed his new wife terribly while he was away and one night after he went out drinking with his buddies. He was very drunk and went home with a local woman and had sex without using a condom. Before being sent home, all soldiers in his unit were ordered to have an HIV test. Kweku tested positive for HIV. He does not know what to do. He knows Margaret will be waiting for him on the tarmac when his plane touches down, anxious to go home and be with him.

What should Kweku do? What should Kweku say to Margaret when he returns home? Develop possible responses and strategies for Kweku to talk with Margaret and protect her from getting infected with HIV.

B. Large Group Summary

Directions for Exercise

- 1) The instructor will request one volunteer from each small group or dyad to summarize the strategies that they identified in response to their scenario. Offer additional responses (if appropriate) to emphasize prevention of HIV/STIs.
- 2) Discuss any questions or concerns of participants.
- 3) To wrap up the exercise, highlight key points identified by participants.

VIII. Part II Summary and Conclusions

The instructor should thank participants for their participation in this part of the training program. Reinforce the importance of their mission and the need for them to protect their health and the health of their families.

Module 7, Part II: Problem Solving Scenarios for HIV Prevention in Crisis Settings

Exercise Instruction Sheet

Directions for Small Group Discussion

- 1) The facilitator identifies the notetaker in their group and makes sure they write down responses and strategies to their scenario on flip chart paper.
- 2) Distribute the scenario to your group and have them read it.
- 3) Lead a discussion with your group and get them to talk about the scenario and develop responses and strategies to it.
- 4) Agree on a presenter, or have the entire group present, when you get back together in a large group with the instructor.

Module 7, Part II: Problem Solving Scenarios for HIV Prevention in Crisis Settings

Scenario #1: Kwame

Kwame has been stationed on a peace-enforcing mission to Liberia. He has been there for 14 months and still does not know when he will be sent home. He is a religious man who finds strength in reading his Bible, and misses his family and children a great deal. Kwame lives in a tent with four other soldiers. The other men routinely bring women back to the tent and have sex with them right in the open, no matter if anyone else is in the tent. Kwame leaves the tent during these times and tries to stay strong by reading his Bible. He is lonely and feels tempted to join in with the other men. It is hard for him to be strong when people are having sex right in front of him. One day Kwame is in great danger as his unit comes under fire while away from camp and one of his tent mates gets shot and seriously injured. Kwame has never come so close to getting killed himself. He cannot handle the stress and decides to have sex with one of the women his tent mates brings in that night. Afterwards, he feels very depressed and is worried because he did not use a condom.

What could Kwame have done in this situation to protect himself from getting infected with HIV or an STI? How could he have managed his stress and handled the situation differently? Develop strategies for how Kwame: 1) could have handled the stressful situation differently; 2) protected himself from being exposed to HIV/STIs.

Module 7, Part II: Problem Solving Scenarios for HIV Prevention in Crisis Settings

Scenario #1: Kweku and Margaret

Kweku is getting ready to return from a peace making mission in Sierra Leone. He has been away from his wife Margaret for six months. This mission has been hard for him because he and Margaret were married for just a few months before he was deployed. Kweku missed his new wife terribly while he was away and one night after he went out drinking with his buddies. He was very drunk and went home with a local woman and had sex without using a condom. Before being sent home, all soldiers in his unit were ordered to have an HIV test. Kweku tested positive for HIV. He does not know what to do. He knows Margaret will be waiting for him on the tarmac when his plane touches down, anxious to go home and be with him.

What should Kweku do? What should Kweku say to Margaret when he returns home? Develop possible responses and strategies for Kweku to talk with Margaret and protect her from getting infected with HIV.

Appendix A
Instructor's Notes

I. Introduction

There is a critical need to find effective ways to lower the risky behaviors that lead to infection with HIV and other sexually transmitted diseases (STIs) in uniformed service populations (i.e., military, peacekeepers, police). Behavior change, based on acquiring knowledge and learning skills, along with individual risk assessment, is an effective method for reducing risky behaviors.

HIV poses a real threat to both uniformed service and civilian populations, especially during complex humanitarian emergencies including the descent into and emergence from crises involving armed confrontations. HIV and other STIs also affect the health of civilian communities where uniformed service personnel train and work. Uniformed service personnel can have a negative impact on civilian communities by spreading HIV/STIs. A cycle of HIV/STI infection between uniformed service personnel and civilians can result in serious and long lasting impact on the health of a community.

Throughout the world, military personnel, including peacekeepers and civilian police, are uniquely at risk for infection with HIV and other STIs. Duty often puts individuals in stressful situations and can also take them away from home for extended periods of time. The need to relieve stress, loneliness, and boredom can lead to risky behavior. Using alcohol and drugs to cope with stress can increase the incidence of risky behavior even more. Many uniformed service personnel are young and think that “nothing will ever hurt me.” To add to this type of thinking, uniformed service institutions encourage and value risk-taking and aggressiveness.

Men and women engaged in uniformed service work carry out admirable and important work. It is imperative that these individuals learn effective HIV prevention strategies so they can protect their health and the health of civilian populations amidst whom they work, and maintain the integrity of their missions.

A. About the Instructor’s Notes

These notes serve as a guide for conducting Module 7 and provide information that will help instructors to maximize the effectiveness of the curriculum. Following a thorough review of these notes, instructors should:

- Understand the curriculum and its application.
- Understand the basic principles of adult learning and group growth and development.
- Understand basic theories for promoting health-related behavior change.
- Be familiar with basic training presentation techniques.
- Be familiar with guidelines for using audiovisual materials and equipment.

B. Instructor to Participant Ratio and Instructor Qualifications

Optimal instructor to participant ratio is one instructor for each 10-12 participants. This ratio will enable the instructor to provide individualized attention and coaching during the training. When available, it is recommended to assign at least two instructors to deliver the program. This will allow participants to experience more than one training style; a team that includes both male and female instructors is optimal. Instructors need to be thoroughly familiar with the course content and experienced in presenting didactic information, facilitating group discussions and conducting interactive exercises i.e., role- playing and practice sessions.

The instructor can elect to identify facilitators from the participants to assist with conducting some of the exercises in the modules. Facilitators do not present content information, but help in leading small group discussions and other training exercises.

Optimum size for the small group discussions is from four to eight participants. This size is small enough for all members to be engaged in the discussion, and large enough for members to not feel pressured or singled out.

C. Seating Arrangements

Furniture in the training room should be arranged to encourage interaction between the instructor and participants. The instructor can also sit with the group itself from time to time. The more “equal” the seating, the better the discussion.

No matter what seating arrangement the instructor prefers, the instructor needs to make sure that participants can see him or her and that all visuals (i.e., slides, overheads, flip chart paper) display clearly and easily. A semi-circle arrangement of chairs is the best way to achieve this. Because it is open on one side, the instructor can move freely back and forth from the front of the room to the center of the semi-circle. U-shaped arrangements like the open rectangle and the horseshoe offer the same advantages with one exception – it is difficult for people to see others on their own side of the table. This also applies to the square table. Round tables are good for small group exercises.

D. Equipment

Visuals have been developed for the curriculum that instructors can utilize slides or overhead transparencies. If neither a slide nor overhead projector is available, visuals can be reproduced on flip charts. Before each session, gather all the necessary audiovisual equipment and make sure the participants can see clearly. Check that the equipment is in working order, know how to use it correctly, and be ready for small emergencies such as burnt-out bulbs. If you are going to use flip charts, have at least two available with plenty of writing markers. One chart can be used for prepared material, and the other for recording information from the training.

E. Materials

Photocopy in advance of each training all curriculum handouts, including exercise instruction sheets, informational handouts, and evaluation forms. Organize the handouts in a folder or three-ring binder and number the pages for easy access. This way, the instructor can avoid endless paper shuffling during the training sessions.

Provide participants with necessary stationary supplies such as paper and pens. If participants do not know one another well, consider using name tags. Name tags are particularly helpful when participants break out into small group activities.

Instructors need to check to make sure they have all the materials needed to conduct the training session: instructor notes, extra copies of handouts and visual materials, plenty of water-based markers and masking tape or push pins for displaying flip chart paper. Plan to arrive at least one hour before the start of the training session to make sure the room and equipment are set up properly, become accustomed to the room and relax before welcoming the participants.

F. Pre-Training Checklist

Before implementing a training course, it is important for the instructor to identify and highlight the behind-the-scenes aspects of training. Many instructors may not be aware of the preparation required to run a successful training course. The following checklist of tasks needs to be completed by the instructor prior to the day of the training to help ensure a successful training experience for the participants:

- If the training will be provided by co-instructors, identify specific areas for which each instructor will be responsible.
- Communicate with the organizers to confirm the training date, site and time as well as to review participant registration forms.
- Decide in advance if the training needs to be modified in any way based on the information provided in the participant registration forms.
- Be well prepared. Become familiar with all aspects of the training. Conduct a dry run of the session in order to be familiar with the slides/overheads and present a fluid presentation. Try to anticipate participant questions and concerns. This will reduce anxiety when questions and concerns come up in the actual training.
- If traveling to the training site, arrive the day before the training. Bring training materials for all modules of the training in the event of a co-instructor's absence. Use this time to meet with the co-trainer and discuss any issues or changes to the training.

G. Cultural Considerations

The information and activities included in Module 7 are based on the premise that HIV infection is preventable. However, effective prevention may require people to change their behavior, which is often deeply rooted in culture. Instructors for this course may have the opportunity to work with people from diverse cultural backgrounds and will be more effective in helping people to reduce their risk for HIV/STI infection if they are aware of the cultural dynamics that influence behavior. Instructors need to pay particular attention to sexual and drug-use behavior, including alcohol consumption, which can place individuals at risk for HIV/STI infection. It is also important to understand how participants choose to communicate about personal issues and their attitudes about seeking information and assistance.

The operating definition of “culture” used here is the shared values, norms, traditions, customs, arts, history, folklore and institutions of a group of people. These shared beliefs serve as guide lines for behavior within cultural groups. Culture is complex and dynamic – it helps people adjust to an always- changing environment. While cultural commonalities can be observed among groups of people, considerable variation can also be identified within groups based on factors such as age, education, gender and exposure to other cultures. It is therefore of little value to attempt to identify cultural characteristics for broad groups such as Asians, Africans or Europeans. The best approach for instructors is to be sensitive to and aware of the cultural issues that may be influencing the behavior of their participants. Instructors are also encouraged to explore these issues when conducting the training.

The following suggestions may be helpful to instructors when speaking about health-related behavior change issues, particularly when participants are from cultures different from their own.

Listen =

- actively listen to participants;
- respond to what is being said, not how it is said;
- allow individuals to fully express themselves before responding to the situation;
- avoid an ethnocentric reaction (i.e., anger, shock, laughter) that may convey disapproval of participant’s viewpoints, phraseology, facial expression and gestures;
- stay confident, relaxed and open to all information;

Evaluate =

- hold any reactions or judgments until you understand the message that the participant is conveying;
- ask open-ended questions (i.e., ones that cannot be answered with a simple “yes” or “no”), answers to these questions will give you valuable information.

Consult =

- agree with the participant's right to hold his or her opinion;
- explain your perspective of the situation;
- find out what the participant wants to accomplish;
- acknowledge similarities and differences in your perspective (the instructor) and the participant's perspective;
- offer options – suggest to the participant what he or she can do given the situation;
- allow participants to choose their own course of action;
- commit to being available to provide support;
- thank the participant for sharing his or her perspective with the group.

Keep in mind that some people and cultures focus more on individualism, while others focus more on being members of a group (which might influence interaction and participation in the course). Also, individuals and cultures vary in their comfort level with self-disclosure, especially around issues related to sexuality, personal relationships and health.

II. How the Curriculum Was Developed

A. Behavioral Theory

This curriculum is based on two cognitive-behavioral theory models: The Stages of Change Model and The Health Belief Model. It is also based on Social Learning Theory, or Social Cognitive Theory.

Cognitive-behavioral theory has two key concepts:

- Behavior is considered to be mediated through cognition; that is, what we know and think affects how we act.
- Knowledge is **necessary but not sufficient** to produce behavior change. Perceptions, motivation, skills and factors in the social environment also play important roles.

The Stages of Change Model. The Stages of Change Model looks at a person's **readiness** to change or attempt to change toward healthy behaviors. Five distinct stages are identified in this model: pre-contemplation, contemplation, decision/determination, action and maintenance (see Table 1). It is important to note that this is a **circular**, not linear model. People don't go through the stages and "graduate;" they can enter and exit at any point and often recycle.

Table 1. Stages of Change Model		
Concept	Definition	Application
Pre-contemplation	Unaware of problem, hasn't thought about change	Increase awareness of need for change, personalize information on risks and benefits
Contemplation	Thinking about change, in the near future	Motivate, encourage to make specific plans
Decision/Determination	Making a plan to change	Assist in developing concrete action plans, setting gradual goals
Action	Implementation of specific action plans	Assist with feedback, problem solving, social support, reinforcement
Maintenance	Continuation of desirable actions or repeating periodic recommended step(s)	Assist in coping, reminders, finding alternatives, avoiding slips/relapses (as applies)

The Health Belief Model. The Health Belief Model (HBM) addresses a person's perceptions of the threat of a health problem and the accompanying appraisal of a recommended behavior for preventing or managing the problem. It is one of the first models that adapted theory from the behavioral sciences to health problems, and it remains one of the most widely recognized and utilized conceptual frameworks of health behavior. The HBM assumes that people fear disease, and that health actions are motivated in relation to the degree of fear (perceived threat) and expected fear-reduction potential of actions, as long as that potential outweighs practical and psychological obstacles to taking action (net benefits). The HRM has four basic constructs representing the perceived threat and net benefits: perceived **susceptibility**; perceived **severity**; perceived **benefits**; and perceived **barriers**. Table 2 shows how these constructs interrelate and apply to individual behavior.

Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels Personalize risk based on a person's features or behavior Heighten perceived susceptibility if too low
Perceived Severity	One's opinion of how serious a condition and its sequelae are	Specify consequences of the risk and the condition
Perceived Benefits	One's opinion of the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take: how, where, when; clarify the positive effects to be expected
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance
Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders
Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action

Social Learning Theory or Social Cognitive Theory. People exist within environments where other people's thought, advice, examples, assistance and emotional support affect their own feelings, behaviors and health. The significant individuals and groups include family members, co-workers, peers, health professionals and other social entities that are similar to or influential for them. People are both influenced by, and influential in, their social environments. Social learning theory (SLT) assumes that people and their environments interact continuously. SLT addresses both the psychosocial factors that determine health behavior and strategies to promote behavior change.

SLT is complex and uses concepts from cognitive, behavioral and emotional models of behavior change. It has six key concepts that are based on the continuous interaction of personal factors, environmental influences and behavior. A basic premise of SLT is that people learn not only through their own experiences, but also by observing the actions of others and the results of those actions. Table 3 summarizes SLT's key concepts.

Table 3. Social Learning Theory or Social Cognitive Theory		
Concept	Definition	Application
Reciprocal Determinism	Behavior changes result from interaction between person and environment; change is bidirectional	Involve the individual and relevant others; work to change the environment, if warranted
Behavioral Capability	Knowledge and skills to influence behavior	Provide information and training about action
Expectations	Beliefs about likely results of action	Incorporate information about likely results of action in advice
Self-Efficacy	Confidence in ability to take action and persist in action	Point out strengths; use persuasion and encouragement; approach behavior change in small steps
Observational Learning	Beliefs based on observing others like self and/or visible physical results	Point out others' experience, physical changes; identify role models to emulate
Reinforcement	Responses to a person's behavior that increase or decrease the chances of recurrence	Provide incentives, rewards, praise; encourage self-reward; decrease possibility of negative responses that deter positive changes

III. Principles of Adult Learning, Group Growth and Development

An important part of conducting a successful training is understanding how people learn and how groups grow and develop.

A. Adult Learning

The “Adult – Child” teaching style is a very standard teaching style and is one most people are familiar with. With this teaching style:

- The teacher decides what the student should learn.
- Education is one way: from teacher to student.
- The value of the student's own experiences are negated.
- The learner is considered an empty vessel and the teacher is considered a full vessel.

The “Adult – Adult” teaching style is one that can be summarized as: “I have information to share with you, you have information to share with me; we will learn together.” With this style:

- The teacher and the student negotiate what is to be learned.
- Education is based on give and take between the teacher and the student, as well as between students.
- There exists an assumed educational background that will influence the learning of the subject matter.
- The student’s experiences are valued.

Learning can occur passively or actively. With passive learning, the participant does not have to take an active role in the learning process. Participants are given information through reading, watching or listening to the trainer, or through interaction between the trainer and another participant. Passive learning can be valuable in that it leads to reflection, evaluation, assessment and analysis. Unfortunately, it is most often linked with memorization and simple fact recall. It is very important to link passive learning with active learning.

With active learning, new information is analyzed, discussed, debated, processed, linked to relevant activities, or incorporated into current decision-making processes. Participants may be challenged with a problem or activity that involves debate and resolution. Small groups may be used in order to negotiate a solution or identify how the issue being discussed is relevant to their current situation.

It often is best to combine passive and active teaching styles. Keep in mind that instructors have limited time to convey information and provide practical tools for skill improvement. Remember, too, that you want participants to understand as much of the information as possible, and be able to utilize that information effectively in practice once they have completed the course.

Effective training:

- Involves the learner in the learning process.
- Identifies what the learning goals and objectives are.
- Demonstrates the relevance of the subject matter to the learner; otherwise, the participants may not feel this training has anything to offer to them personally.
- Structures activities so that learners identify solutions to problems identified; in this way, participants get to practice new skills before they ever leave the training.
- Engages learners in high levels of thinking such as analyzing, critiquing, assessing.

- Utilizes various teaching/training modalities such as small group process, lecture, experiential activities because not everyone learns in the same way. Instructors are more likely to get more across to more people by utilizing multiple teaching methods.
- Is flexible and meets the learner's needs within the confines of the training.
- Provides information that will overlap familiar or known information, it is therefore important for instructors to know their audience.
- Repeats and reinforces information throughout the training; people learn more when they hear the same information more than once. It helps to convey the same information in different ways.

Keep in mind that a participant might interfere with her/his own learning experience for many reasons. Participants may:

- feel they are at least as competent in the subject matter as the trainer;
- resent authority figures (i.e., instructors);
- fear being seen as inferior or being embarrassed in the training; anxiety can interfere with learning;
- generalize a previous bad training they've experienced to all training experiences;
- have other problems on their mind and be unable to focus;
- have been forced to come to the training and resents this;
- be interested in the material, but be constrained by time or focused on other things;
- "pick on" an irritating or annoying mannerism of the trainer.

Although an instructor strives to meet as many needs of the participants as possible, it is unrealistic to be everything for everyone. The instructor can assess the participant's needs and issues. However, some issues can be beyond the scope of an instructor's responsibilities. On the other hand, some issues may be dealt with by establishing the value and relevance of the training to all participants. Instructors strive to:

- **Create a Need.** Participants need to know why they need the information, how they will benefit from this information and how it can be made practical in their lives.
- **Develop a Sense of Personal Responsibility.** By establishing a need and having participants identify their expectations of the training, participants will begin to develop their own sense of responsibility to learn.

- **Create and Maintain Interest.** Encourage questions; change teaching styles and techniques regularly. Remind participants often of how the information will benefit them in their personal lives.
- **Structure Experiences to Apply Content to Life.** Link training content to experiences or issues participants' face in their daily lives, including work settings.
- **Give Recognition, Encouragement, and Approval.** Acknowledge positive input provided by participants. Thank participants for their involvement.
- **Foster Wholesome Competition.** Establish personal competition by encouraging active involvement in the training course.
- **Become Excited Yourself.** Instructors need to believe in what they are training and be excited about the ramifications of successfully using the material. Monotone, uninterested presentations are deadly.
- **Establish Long Range Objectives.** Assist participants in establishing long range goals for the use of the material covered in the training.
- **See the Value of Internal Motives.** Help participants identify their own motivation for acquiring the skills and information covered in the training.
- **Intensify Interpersonal Relationships.** Instructors need to become involved with participants. Be available before the training and never leave the training before participants do. Be available during breaks and meal times. This will foster increased familiarity and comfort with discussing issues that come up in the training.

The following chart illustrates rates for which individuals retain information, depending on the training or learning method. Lectures and reading are the least effective learning techniques, even though they may be the easiest methods of teaching. Being forced to teach others, using material in immediate, applied, practical ways and to practice by doing are the most effective techniques for learning.

Learning Chart	
Learning Method	Average Retention Rate
Lecture	5%
Reading	10%
Audio-visual	20%
Demonstration	30%
Discussion Groups	50%
Practice by Doing	75%
Teach Others/Immediate Use of Learning	90%

B. Group Growth and Development

When delivering training programs, it is helpful for instructors to understand the stages of growth and developments groups experience. In every on-going group there are three types of needs to address:

- **Individual needs.** These are “I” or personal needs and involve getting each individual into the group, despite his or her hidden agenda.
- **Group needs.** These are “we” or group needs and involve developing useful membership roles, ground rules, procedures and group structures, as needs emerge.
- **Group Tasks.** These are “group” tasks that focus on the agreed upon group objectives.

Groups typically progress through three stages of group growth. The length of time for each stage depends on many variables, a major one being the age of the group. The three stages of group growth are:

Infancy. During this stage, participants may be reluctant to take on leadership roles and usually delegate this responsibility to the instructor(s). They may also feel insecure about their status in the group. The focus during the infancy stage is on establishing personal status in the group and achieving personal agendas. As the term infancy implies, individuals may exhibit immature behaviors. It is common for individuals in this stage to conduct side conversations and act out their personal frustrations. There is little commitment to the task during this stage.

Adolescence. Group members have moved beyond most of their personal insecurities during the adolescence stage, and begin to function as a group. Participants start to take on useful roles within the group to assist with information sharing and to ensure inclusion and participation. However, the focus at this stage is more on a commitment to the group than on a commitment to the task. Peer support and involvement is very important. Participants may band together to challenge the instructor(s).

Maturity. During this stage, group members (within given limits) assume responsibility for identifying and resolving problems and group tasks. There is an appropriate balance between personal needs, group needs, and group tasks. It is when the group achieves maturity that they are able to most effectively complete meaningful work. The instructor(s) should encourage participants to assume as much responsibility as they are able to manage during this stage.

The following graphic illustrates the stages of group growth and evolution of the three different types of group needs.

Stages of Group Growth								
Infancy			Adolescence			Maturity		
I	We	It	I	We	It	I	We	It

I = Personal Needs We = Group Needs It = Group Tasks

The progression of groups from infancy, through adolescence to maturity is not a linear process. Groups often move back and forth between these stages. When groups have completed their task(s), they often disband or revert back to immaturity. This model is helpful for understanding the dynamics that affect behavior in groups.

IV. Conducting an Effective Training

No matter how well prepared, well versed, or skilled an instructor may be, there will always be training courses that have problems. At the end of each training, instructors need to evaluate themselves. Co-instructors need to agree before each training that they will provide honest critiques to one another at the end of the training. Remember that future presentations can only get better if instructors make the time to evaluate themselves. What follows are some general guidelines for conducting an effective training, including sample evaluation questions.

A. Know Your Subject and Audience

It is vital that instructors gather as much information about the participants in the training as possible. Find out about their background (i.e., age, gender, types of employment, education, training) and current job. It is best to get this information as early in advance of the training as possible. This way, the instructor can prepare the training material to better meet the needs of participants. Knowing who the audience is, what they already know, and what they need allows the instructor to be better prepared.

Content – the skills, attitudes, values, and information the training course is intended to transmit to participants – is the essence of any training course. If an instructor is not knowledgeable about the topic they are teaching, the course will not be successful. No amount of fancy training techniques will help an instructor if they are not able to answer unexpected questions from participants. The number one rule in training is to **know the subject**. Ways instructors can familiarize themselves with the topic areas of their training course are to:

- Read books, recent journal articles, and reports.
- Write down relevant experiences in their own careers that will enrich the training course materials.
- Speak to members of the participants' peer group, or better yet to the participants themselves **before** the training to find out what their questions, concerns, interests or problems are, as they relate to the topics to be covered in the training.
- Talk with experts in the field to learn more about the training course topic. Invite any local experts to come to the training course and speak to participants.

B. Personal Style and Training Skills

Every instructor develops his or her own personal training style. It is important for instructors to express their individual style and not to mimic another training style. This generally develops over time, as an instructor becomes comfortable with the material and presentation. A few points to keep in mind when preparing for presentation are:

- Find a balance between pacing and standing in front of the audience.
- Speak to the participants and not to the slides or walls. Eye contact is important.
- Fluctuate your voice. A monotone style will cause disinterest among participants.
- Project your voice.
- Enunciate clearly and pronounce words correctly.

- Dress professionally - err on the side of being too formal.
- Always remember that you have something to offer and participants have something to gain. Be confident.

Appearance. Before an instructor ever speaks one word, the participants will already have begun to form some judgments (conscious and unconscious) about them. What an instructor wears and their general appearance says a lot about them. If instructors are not required to wear their dress uniform (or if they are civilians), follow the guidelines of appropriate business attire. Choose an outfit that is subtle and one that will not draw attention away from what you are saying. Details like these can seem unimportant, but they reflect an instructor's authority and can contribute to the success of the training.

Training skills. No matter how well designed a training course is, it can fail or “just not work.” The curriculum could be at fault, or the skills of the instructor may not be strong. What follows is a list of suggestions to assist instructors with their training.

- **Know the materials.** This is critical. Participants will know if an instructor does not know what they are talking about. It is not enough to be familiar with the subject matter and the curriculum. This does not mean that instructors need to have all the answers, but not knowing the majority of the answers will invalidate expertise.
- **Rehearse.** An instructor may know the information in the curriculum, but if they have not practiced the presentation all of their knowledge may be lost in fumbling lines. Although no two training sessions will be exactly the same, it is important to rehearse and practice timing. The instructor has a message and information that the participants need. Therefore, an instructor needs to present the material in the best fashion they can.

By knowing the material and rehearsing, you can avoid one of the worst training errors there is, reading to the audience. Participants do not want to be read to. They can read for themselves. Preparation will help instructors to avoid this common mistake.

C. Verbal and Non-Verbal Communication

Much of the success of any training is directly attributable to how an instructor presents themselves. Do they enunciate when speaking or mumble? Is their voice appropriate? Do they pace the room or have any distracting body movements? Instructors may have tremendous knowledge and experience, but the success of their training will also depend on their ability to effectively **communicate** that knowledge to participants.

Non-Verbal Communication. When teaching, instructors want to “sell” the audience on the value and the relevance of the information. By concentrating on non-verbal communication, instructors can become animated and engaging teachers, which will heighten participants' interest in the topic.

Non-verbal communication includes:

- **Appearance.** This topic was addressed in the previous section. The bottom line is to use common sense. Instructors want participants to pay attention to what they are saying, not what they are wearing.
- **Eye contact.** Engaging the audience with eye contact is important in determining audience reaction. It requires significant preparation and self-confidence. Without it, the audience may spend the day watching the top of the instructor's head while they read from a script. Some questions instructors can ask themselves when training include: What kind of response am I getting? Does everyone look interested? Tired? Confused? Making eye contact with as many participants as possible can help engage the audience. However, looking at only a few participants may make them uncomfortable as they may feel singled out. The audience may interpret a lack of eye contact as an indication of lack of knowledge and/or confidence.
- **Facial expression.** A smile or frown can convey more information in one second than a ten-minute speech. Understanding and confusion are equally well reflected in facial expressions. Instructors need be aware of both the ir own facial expressions and those of the participants. Facial gestures can provide a cue as to whether or not the participants understand the material an instructor is presenting. Similarly, participants may misinterpret nervousness as lack of knowledge. Facial expressions can either reinforce or diminish credibility as an instructor.
- **Gestures and movements.** Gestures can be used to express or emphasize ideas or emotions. While gestures are often powerful tools in convey meaning and in animating content, try not to be excessive. Try to maximize the use of gestures that help emphasize the content or purpose of the discussion. It often helps instructors to practice various forms of this non-verbal technique before the training. While some may feel foolish or may not want to appear over-scripted, it is often helpful to identify both appropriate and inappropriate gestures. It is often the case that instructors may not even be aware that they are using inappropriate gestures. One example is the act of pointing a finger at the audience. This gesture is usually not a good idea because many people find it patronizing. Practicing in front of other people and eliciting their comments and suggestions will help instructors become more comfortable with the material, as well as their own gestures.

Movement is defined as changing location. Some instructors feel more comfortable staying at the front of the room, while others like to move around the room and be closer to participants. Keep in mind that some people may feel uncomfortable if the instructor is in close proximity to them. Pacing back and forth across the front of the room is often distracting for participants, while the instructor may not even be aware their movement. In addition, one often-overlooked problem is the instructor turning their back to the audience. If an instructor has his or her back to the participants, the participants will be unable to hear, see, and ultimately understand the instructor.

- **Use of silence.** Silence is a powerful communication technique. A common phenomenon is the quieting of a group of people when someone stands at the front of a room and waits without saying a word. It creates an air of expectation. Pausing during a question and answer session also allows a participant sufficient time to internalize the question and respond. However, it is also important to highlight that extended periods of silence may make the audience uncomfortable.

Verbal Communication. There are some things about individual voices that are beyond our control (e.g., accent, nasal quality). However, an instructor can control the tone of voice, rate, and volume of delivery:

- **Tone.** This refers to the inflections in a person's voice. Friendliness, interest, and enthusiasm are more conveyed with tone rather than actual words.
- **Rate.** It is often advantageous to pay attention to the rate of speech. When the material is complicated, instructors will need to slow down and give the listeners time to assimilate the information
- **Volume.** If an instructor speaks so softly that the participants have to strain to hear what is being said, they will often lose interest and not put forth the effort to pay attention. If an instructor speaks too loudly they are likely to find participants shell-shocked.

D. Audience Participation

Most people would agree that being lectured to for an extended period of time is not their favorite way of being taught. Active learning involves participation. Instructors will find they have a better sense of how participants feel about their presentation if participants take part in the learning process. Tips for encouraging participation include:

- **Open-ended questioning.** Close-ended questions actually discourage discussion. For example, "Do you understand?" begs a "yes" response. Open-ended questions spark dialogue. For example, "Why is it that this type of question is more engaging?" creates an interactive environment. A simple rule to gauge whether or not questions are open-ended is that open-ended questions cannot be answered with a one-word answer ("yes" or "no"). Open-ended questions do not imply that there is a "right" or desired response.
- **Enthusiasm.** If an instructor conveys a sense that the material they are presenting is both interesting and important, participants will be more engaged.
- **Small groups.** Using small group exercises or discussions allows participants to learn information and skills in a hands-on fashion. Although this takes more time than a simple lecture or slide presentation, it is a great way to encourage audience participation.
- **Answering questions.** Any interested audience will have questions for the presenter. It sometimes can be difficult to determine the intent of a participant's question. Instructors may need to ask for clarification or reframe the question entirely.

When answering questions from the audience:

Repeat the question to ensure you heard the question correctly and participants also understand what is being asked.

Keep your answers short and avoid getting off the training course schedule. A tangential discussion may be counterproductive, it is important to stay focused. The key is to find the balance in an answer that addresses the question directly and briefly, but at the same time fully provides all the information asked for in the question. The only way to master this skill is by knowing the material and by practicing with sample questions.

Do not get defensive if you do not know the answer or if feel attacked by the questioner. Simply say you do not know the answer and offer to obtain the information for the participant after the training. If a questioner is hostile, try to deflect the hostility by rephrasing the question in non-hostile terms. The important point is not to take the hostility personally. Doing so could distract the instructor and affect the rest of the program. Taking this type of an approach helps an instructor maintain control.

- **Humor.** When used appropriately, humor is a tool that can enhance any training experience. However, for it to be effective, the humor needs to be related to the training. When used appropriately, humor can make a point or stress a concept in a way that creates a bond between the instructor and participants. It is a tool that keeps participants alert, increases retention of the information, and facilitates the interaction with the instructor. Some concepts to keep in mind when using humor include:

Use common sense. If an instructor's sense of humor does not fit the situation, do not use it. Know the personal tastes and beliefs of participants, and never offend anyone. If participants do not respond, or respond negatively, to humor, move on and do not continue to try and make it work.

Back up your humor with seriousness. Do not make important points with humor alone; participants will not always be able to discern what is important. Follow critical information with a more serious tone to ensure that participants understand the importance of the message.

Keep it short. Avoid telling long stories. Brevity is more important than comedy.

E. Trouble Shooting

In an ideal setting, all participants would come to a training motivated and invested in the learning process. Unfortunately, this is rarely the case. In any training course there are going to be a few "difficult" participants. These people can be distracting to both the instructor and audience. Unless the instructor takes control of the situation, the learning process can be impaired. The best way to prepare for difficult participants is to be aware of the potential danger and to become familiarize with typical profiles in order to be able to identify problems early and diffuse them.

The following scenarios offer advice on how to handle different types of “difficult” participant:

- **“Know it all.”** This person is an “expert” in everything and wants everyone to know it. Never debate with this type of participant, an instructor will never “win.” Instead, acknowledge the person’s expertise and ask if you can call on him/her as the training proceeds for support on various issues.
- **“Nay-sayer.”** This person refuses to see how what an instructor has to offer can or will work. They are determined to prove an instructor wrong. As with the “know-it-all,” if an instructor gets caught up with this participant in debate, the other participants may feel left out. And, it is easy for an instructor to become defensive with this type of person. If an instructor identifies a nay-sayer, a comment like, “I see you have some problems with what I am saying. I appreciate what you are saying, but there are people here who want to see how what I am saying will work” may cut him/her off. If he or she continues, an instructor can talk to the person during the break and try to address their concerns.
- **“Monopolizer.”** A monopolizer may attempt to spend a great deal of time reinforcing what an instructor is saying or in contradicting them. Also, the monopolizer may simply have a lot of questions or stories to tell. These participants can become very annoying for other participants. A gentle way to work with these types of participants is to simply avoid eye contact with this person or, if possible, walk to another area of the room while speaking. An instructor can also indicate that they appreciate their interest and excellent questions, but want to permit others to talk. An instructor can also suggest they talk afterwards.
- **“Chatterbox.”** This participant seems to have forgotten that the instructor is providing the training. This person carries on conversations with other participants while the instructor is speaking, seemingly oblivious to how distracting and rude the behavior is. Although it may be uncomfortable to limit a participant’s behavior, instructors need to remember that this chatter is most likely disruptive for other participants. To intervene, simply point out to this person that their conversation is distracting. A more subtle approach is to continue the training while walking over and standing by the participant. Few participants will continue a sideline conversation under this situation. If they do, it is appropriate to acknowledge it.
- **“Reluctant Learner.”** This person may be reading a magazine or newspaper during the training. Although seemingly less disruptive than the other types, this participant is conveying a negative message to the other participants. The message is that “although I may have to be here, this training is not important enough for my attention.” Instructors need to not take this behavior personally. Ask this participant to put their newspaper or magazine away. This may be done in a joking manner such as, “Wow, it’s hard to believe there is any news half as interesting as what I am saying. Do you suppose it could wait until a break or until after the training?”

- **“Preacher.”** This participant has values. It is not that other participants do not have values, but these participants expect to infuse their values into the training frequently. These values are most often expressed when the subject matter is not supporting their values. Never debate or attempt to modify this person’s values. That is not the goal or objective of training. Values take years to develop and will not change in a five-minute, two-hour, or six-hour debate. Acknowledge the participant’s values (without editorialization) and move on. If they persist, acknowledge and point out that not everyone shares their values. An instructor can diffuse this person by stating to the group that it is important to recognize that not everyone shares everyone else’s values but that everyone’s values should be considered valid.
- **“Unresponsive Participant.”** This type of participant can be difficult only because it is hard for an instructor to figure out why they are unresponsive. They give no clues for their behavior and tend not to take an active role in brainstorming, questioning, or other exercises. They may be totally interested with the training or they could be day dreaming. They may also maintain this composure to avoid being called on or challenged by exercises. The only way to know is to check in with these participants during the training. For instance, during a brainstorming exercise, rather than starting with a request for people to volunteer input, ask these participants what they think. Their reaction should give the instructor sufficient information as to what is leading to their behavior. Some unresponsive participants simply need a little encouragement to become active participants.

F. Structured Closure

Ending a training course appropriately is just as important as starting it off right. Planning meaningful activities for the end of the training ensures that participants will reflect upon what they have learned and determine how they will put their goals and information learned into action. Participants appreciate the opportunity to bring closure to their learning experience.

Instructors can review information and exercise sources for an appropriate structured activity that fits the training course objectives, and adapt the activity as needed. Examples of closing activities are written evaluation/feedback and asking participants to offer what they liked and did not like about the training and writing responses on flip chart paper (i.e., “pluses” and “wishes”).

G. Evaluation

Evaluation of a training course is often overlooked by instructors. Yet, this type of feedback is critical for instructors and will help improve future course content and an instructor's training technique. Evaluation can be conducted using written forms and/or verbal discussion. Sample evaluation questions to ask are:

- Were the training course objectives met?
- What was your objective in taking this course? Did the course meet this objective?
- Identify at least two topics covered in the course that you believe will be valuable to you. Explain why.
- Identify the topics you regard as being of least value to you and explain why.
- What topics, if any, need to be added?
- What topics, if any, need to be covered in greater depth
- What topics, if any, need to be dropped?
- What three things were most helpful to you?
- What was least helpful to you?
- What improvements would you suggest for the course?
- How would you rate the training environment?
- How would you rate the instructor's knowledge of the material and ability to maintain interest?
- How would you rate the presentation of the course (excellent, good, fair, or poor)?
- How would you rate the content of the course (excellent, good, fair, or poor)?

Appendix B

Slides/Overheads to Accompany the Module 7 Curriculum