Section C: How to deliver effective staff training and resident education: Implementing Inside Out

Introduction

Section A contains a range of educational and training activities under each of the four modules of the programme. Section B contains supplementary activities for use by group leaders when dividing or energizing the group. This Section C outlines how these activities might be used in the delivery of effective HIV harm reduction programmes for residents and staff. This is a flexible package of materials that can be used in a variety of situations so careful reading of this section is essential before programmes are delivered.

Specifically Section C assists programme developers in centres, or in-country to:

- Deal with the sensitive issues that the delivery of Inside Out raises.
- Design and deliver resident education including the development and delivery of specific pre-release programmes for residents.
- Design and deliver staff training.
- Use print material effectively.
- Develop and deliver peer education programmes for residents.
- Evaluate resident and staff HIV harm reduction programmes.

Delivery of effective staff training and resident education requires a significant level of planning and a strategic approach. The programme developer needs to consider all of the relevant issues raised about behaviour change programmes in the Introduction Section and integrate them within the local programme. In each centre, a local and strategically sensitive approach to the training needs of staff and the educational needs of residents is required. It is likely that even in countries where it is supported as a national programme, Inside Out will take on different forms within individual centres.

A strategic approach is not just a matter of selecting an activity or two for implementation. It requires in-depth planning of the programme that is to be offered to residents and to staff.
Dealing with sensitive issues in harm reduction

Delivering effective programmes for staff and residents is a challenging process. In part, this is because harm reduction education requires an appreciation of the sensitive issues that are involved in working effectively with those who use drugs and practise unsafe sexual behaviours. Also, it is because harm reduction education requires acceptance of pragmatic values and approaches that acknowledge that the highest order need is to effectively reduce the incidence of HIV transmission.

It is essential that senior staff in each Drug Rehabilitation and Treatment Centre be committed to the delivery of education programmes that promote harm reduction. Regardless of the extent to which the programme might differ from personal views and values, its success depends on complete acceptance of the value of harm reduction and a capacity to deal with the sensitive issues outlined below.

Sensitivity is required to deal effectively with a range of issues:

1. Actual behaviour: not the person with whom the behaviour occurs

The activities in Module 3 of Section A relating to ‘How do you avoid HIV’ make it clear that it is the behaviour that places people at risk of HIV. Anyone may have HIV; residents and staff need to be aware that unsafe behaviour must be avoided in all circumstances. It is essential that the delivery of Inside Out is sensitive to the fact that residents and staff frequently see some people that they relate to closely as ‘HIV safe.’ If they hold this view, they forget about safe behaviour and place themselves at significant risk.

Staff may hold the view that knowing the HIV status of all residents will protect them from HIV. As it is not possible to know the status of all residents at all times, this is a false point of view. In fact, over time, studies have shown that there are higher levels of disease transmission in hospitals where the infection status of patients is known. This is because people assume they know where the risk is and do not follow basic safe procedures in all situations.

Residents may think that if they have sex or share a needle with someone that they know well, this will protect them from HIV. This is a false point of view.

Sensitive delivery of Inside Out will ensure that safe behaviour is the focus of the programme.

2. Sexual behaviour and risk

Activities within Section A of Inside Out are designed to help staff and residents to understand safe sex and to appreciate that some sexual behaviours are safe and others are not. All of the activities in Module 2 ‘How do you get it?’ provide opportunities for this area of content to be discussed.

To ensure that these issues are well understood, those delivering Inside Out must be able to discuss sexual behaviour with the participants in the programme. Challenging issues like masturbation, oral sex, sex with
sex workers and men having sex with other men must be discussed openly and without embarrassment. Sexual behaviour and trust within a marriage or relationship must also be discussed. Full delivery of the programme involves a consideration of some contextual issues including consensual sex, sexual assault, condom use within primary relationships and sexual involvement with someone who is HIV positive.

It is essential that challenging issues are discussed and it is not appropriate to avoid them. In order to deal with them effectively, people delivering the programme need to be trained so that they understand how to sensitively discuss issues related to sexual behaviour. Not all those delivering programmes will be able to do this without support.

3. Zero tolerance of drug use and HIV Harm Reduction

A Harm Reduction approach can be complementary to zero tolerance of drug use. Most often, the sensitive delivery of Inside Out will exist within a zero tolerance climate within centres. Staff and residents are able to deal with education that discourages the continued use of drugs, but acknowledge that when people return to the community and are “hungry for the drug,” former residents may use and even inject drugs. Therefore, a realistic approach to the programme delivery will acknowledge that a hierarchy of messages is appropriate. In descending order of importance, the key messages from the whole programme about reducing harm related to the use of drugs are:

1. Try not to use drugs in the future.
2. If you do continue to use drugs, then don’t inject them.
3. If you do inject drugs never share (reuse) injecting equipment.

4. Cleaning of injecting equipment

While it is important that residents understand how to clean injecting equipment effectively this should be an option of "last resort". It would be preferable that people who inject drugs in the community did not need to know how to clean their equipment because they never shared equipment. However a realistic approach must include this information.

With regard to cleaning injecting equipment, the key messages, in order of importance, from the whole programme about reducing harm related to the use of drugs are extended as follows:

1. Try not to use drugs in the future.
2. If you do continue to use drugs, then don’t inject them.
3. If you do inject drugs never share (reuse) injecting equipment.
4. If you do share (reuse) injecting equipment then clean it as well as possible.

When delivering the programme, staff in centres need to provide continual reinforcement to residents about this hierarchy of messages.
Designing and delivering resident education
This section:
- Provides a rationale for the need to undertake resident HIV harm reduction health promotion;
- Outlines the in-centre benefits and community benefits of an effective programme;
- Describes how to design a programme;
- Provides advice on how to integrate specific aspects of a programme, for example peer education and pre-release; and
- Discusses some major issues about education for residents.

Rationale
Compulsory drug treatment and rehabilitation centres provide a significant point of access to people at high HIV risk, especially through their injecting behaviour. Effective harm reduction education efforts with residents in these centres will have a significant impact on the future spread of HIV in the community. Every resident who does not reuse injecting equipment on release results in a reduced potential incident of transmission of HIV. Additionally, there are benefits that accrue with regard to reducing the transmission of hepatitis C.

Essentially, the major reasons for educating residents include:
- All those who inject drugs have the right to education about the HIV risks that they are facing if they continue to inject and to use other people’s injecting equipment.
- Reducing the spread of HIV will mean that fewer people in a specific community will be HIV positive and thus the potential spread of infection will be minimized.
- There are significant benefits in reducing human suffering.
- The public health/health system benefits are substantial in that limited resources can be directed towards providing health care in other areas.
- The economic benefits of an effective programme are significant: less hospital beds, drugs etc are required to deal with HIV/AIDS.
- The social benefits are also substantial in that there will be reduced dislocation in communities, less family breakdown, less bereavement etc.

Which residents should be educated and by whom?
All residents must be educated throughout their time in the centre (post-detoxification). The education programme developed must be ongoing and cannot merely be delivered on a one-off basis. All residents should be provided with education across all four modules outlined in Section A. It is important that education programmes assume that all residents will be in close proximity to someone who has HIV and so all modules, including ‘How do you live with it?’ are relevant.

Resident education programmes can be delivered by:
- Staff from the centre
- Visiting experts
- Residents themselves (see peer education)
- A combination of all of these approaches.

In order to be comprehensive and to provide the best chance of success, all delivery approaches should be used (see table 1). The value of this is that residents will receive messages from various sources and they
can assess the appropriateness of each source. The modelling provided by staff, peers and experts is important in that it reinforces safe behaviour and a harm reduction approach. It is strongly advised, therefore, that centres approach the planning and delivery of resident education from the perspective of delivery by staff, peers and experts.

**Important issues in educating residents**

Using resident education for harm reduction in closed settings will be most effective if the following key issues are considered:

1. All residents need to be included in educational activities that occur throughout their time in the centre, once detoxification is completed. One-off education is ineffective as reinforcement is essential.

2. Residents need information on how to reduce the risk of transmission while they are in the centre as well as when they leave it. It is important that this focuses on:
   - avoiding fights etc, where blood spills can occur;
   - avoiding body piercing;
   - safe sex;
   - not sharing injecting equipment (or cleaning equipment effectively); and
   - first aid procedures.

3. The focus of resident education programmes should be on avoiding risky behaviour. There is a tendency for people to focus on “who the behaviour is with” rather than “what the behaviour is.” Many residents believe that they are safe if they share injecting equipment with a friend but not safe with a stranger.

4. In most circumstances, it is anticipated that residents will be educated in single sex groups. Due to the number of men in Drug Rehabilitation and Treatment Centres, most programmes will be conducted with men. Advice is provided in Section A on how to adapt the programme for use with female residents. Where mixed groups are to be educated, the programmes may need to be adapted accordingly.

5. It is important that residents are educated as part of a pre-release programme immediately prior to leaving the centre. Information on pre-release programmes is given later.

6. Resident education must focus on promoting safe behaviour. It must provide useful and practical information that helps residents to avoid infection if they do not have HIV and to avoid transmission if they are HIV positive. Primarily, education should be focused on reducing risky behaviour when residents leave the centre.

7. Education should help residents to consider how they are going to be safe even when they are “hungry for the drug.”

8. It is best for residents if the entire centre has adopted a policy of HIV harm reduction and therefore the culture of the centre is oriented towards limiting the spread of HIV and caring for those who have HIV. If this occurs then all staff "speak with the same voice".

9. Effective HIV harm reduction resident education will not occur if programmes are conducted only in large groups. While there is a place for major events, competitions, broadcasts etc within an integrated programme, the use of these mechanisms alone will be unsuccessful. Groups of no more than thirty are recommended for ongoing programmes using *Inside Out*. This group size allows for the discussion and interaction necessary to promote ongoing safe behaviour choices.
Models of resident education

A comprehensive resident education programme is required in order to have the best chance of reducing the incidence of transmission. In many centres, education about HIV occurs only on a monthly basis and is often conducted by visiting experts within large groups. This is clearly insufficient if real knowledge and attitude growth and behaviour change are the intended outcomes. The use of Inside Out is intended to promote a more comprehensive programme in all centres across the Western Pacific Region - a programme that affects “what people do” as well as what they know.

In order to be as comprehensive as possible the education approach in any centre should cover all of the components outlined in the Table 1.

Table 1: Essential components of a resident education programme

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of written information.</td>
<td>All residents must be provided with locally relevant print information about HIV/AIDS. Posts and signage about HIV prevention around the centre.</td>
<td>Print information alone has limited value beyond, at best, describing safe behaviour. Some residents cannot read, and even where they can the published word alone is highly unlikely to impact on behaviour.</td>
</tr>
<tr>
<td>Delivery of resident education by centre staff or by an outside agency.</td>
<td>All residents provided with ongoing education about HIV, delivered by staff or visiting members of an outside agency.</td>
<td>It is important that someone who has an understanding of HIV and has become familiar with the activities in Inside Out provides residents with the education. This should complement any peer education efforts.</td>
</tr>
<tr>
<td>Delivery of a peer education programme.</td>
<td>A comprehensive peer education programme is conducted for all residents while they are in the centre.</td>
<td>See Section C and Appendix 1 for how to develop a peer education approach in a centre.</td>
</tr>
<tr>
<td>Specific education is delivered pre-release.</td>
<td>Specific education programme designed for all residents immediately prior to release. Staff, external experts or peer educators, as appropriate, could conduct the programme</td>
<td>The most appropriate opportunity and timing of education occurs immediately prior to the resident’s release from the centre. Key messages about safe behaviour in the community are highlighted in this part of the programme. In addition, information should be provided about local services available.</td>
</tr>
<tr>
<td>Where possible and appropriate, education occurs with residents who are HIV positive.</td>
<td>Medical or other appropriate staff provide education. Activities in Module 4 will be of particular value</td>
<td>In many centres, staff will not know who is HIV positive. This is entirely appropriate and must be respected. Where residents and staff know the identity of people who are infected, specific education can be provided.</td>
</tr>
</tbody>
</table>
Sample resident programme

It is recommended that the entire programme be used with residents (except for those activities marked for staff only). This recommendation applies whether a peer, visiting speaker and/or a staff delivery model is to be used.

The programme should be conducted in the order that it is written in Table 2. For the purpose of planning, two hour two-hour blocks are most appropriate. These can be conducted over a period of time, for example 3 weeks, or over a shorter amount of time.

Table 2: Sample resident programme

<table>
<thead>
<tr>
<th>Module</th>
<th>Activities</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is HIV?</td>
<td>Module 1: All three activities</td>
<td>Almost 2 hours</td>
</tr>
<tr>
<td>2. How do you get it?</td>
<td>Module 2: Activities 1 to 3</td>
<td>2 hours</td>
</tr>
<tr>
<td>2. How do you get it? (continued)</td>
<td>Module 2: Activity 4</td>
<td>1 hour</td>
</tr>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Module 3: Activities 1 and 2</td>
<td>Almost 2 hours</td>
</tr>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Module 3: Activity 4</td>
<td>1 hour</td>
</tr>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Module 3: Activity 5</td>
<td>30 minutes</td>
</tr>
<tr>
<td>3. How do you avoid getting it (continued)?</td>
<td>Module 3: Activities 6, 7, 8, 9, 10, 13, 14 and 15</td>
<td>3 hours</td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Module 4: Activities 1 and 3</td>
<td>2 hours</td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Module 4: Activities 4, 5 and 6</td>
<td>2 hours</td>
</tr>
</tbody>
</table>

Designing and delivering a pre-release resident education programme

Residents need to receive HIV education during their time in the centre, as it is important for them to be aware of possible risky behaviour in any situation. It is also crucial that they receive pre-release education before they return to their communities. Education immediately prior to the resident’s release from the centre takes advantage of an opportunity that should not be ignored. Staff, peer educators and the resident him/herself will be highly motivated at this time to learn as much as possible about how to prevent the spread of HIV. In a manner that complements what has been done previously, it is essential that harm reduction education is provided at this time.

In order to be most effective, pre-release HIV harm reduction education can be integrated within other approaches that prepare people for release. It might be conducted one-on-one or preferably with small groups.
Integrated programme delivery:

The pre-release programme should be developed and delivered in an integrated way with the remainder of the residents’ HIV education programme. Key messages about safe behaviour in the community should be emphasized during this part of the programme. From a harm reduction perspective, all residents must be well prepared for their re-entry into the community and education that focuses on how to avoid reuse of injecting equipment is vital at this time.

"The practice of sharing can be strongly influenced by the context in which it occurs, group norms and rituals, inaccessibility of injecting equipment, and an inability to carry injecting equipment because of familial, social or legal environments. Such factors explain why needles and syringes are shared with others even when sterile equipment is available. There are various additional avenues for HIV transmission, generally in social situations where IDUs prepare and use drugs together. For example, IDUs often share other items while preparing drugs for consumption, e.g. cookers, water cups, filters, spoons, swabs, ampoules and other containers used for drug preparation, storage and transport." 

In addition, information should be provided about local services. It is the responsibility of the staff of a drug treatment and rehabilitation centre to maintain up-to-date information about relevant community services so that outgoing residents can be well prepared for their entry into the community. This may mean that staff in the centre need to maintain close contact with local community organizations and health services, so that advice can be provided to outgoing residents.

Brochures and booklets produced locally will form a part of this material in some locations. Where these are not available, centre staff may need to develop written information sheets about HIV services available locally.

Nature of the pre-release Programme:

In many centres, the HIV status of residents will not be known, either to the residents or the staff. This can be a desirable situation because it protects the confidentiality of all residents. In this case, a general pre-release programme for all residents should be delivered. It is essential that this programme be provided to residents as close as possible to their release date. This programme should focus on reinforcing objectives about safe behaviour and about “how to live with HIV.” It will also include education about how to behave safely in the community and information about support/ local medical services.

The sample programme in Table 3 is proposed. Note that while these activities might be used elsewhere in the HIV harm reduction programme, they can be repeated at this time.

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<table>
<thead>
<tr>
<th>Module</th>
<th>Activity</th>
<th>Intent of activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Activity 1: Drug use: Harm reduction</td>
<td>To increase participants’ understanding of ‘harm reduction’ in relation to drug use.</td>
</tr>
<tr>
<td></td>
<td>Activity 2: Safe sex: Harm reduction</td>
<td>To increase participants’ understanding of ‘harm reduction’ in relation to safe sex.</td>
</tr>
<tr>
<td></td>
<td>Activity 3: Drug use: Harm reduction</td>
<td>Understanding of drug use and HIV.</td>
</tr>
<tr>
<td></td>
<td>Activity 4: Using a condom</td>
<td>Understanding of safe sex.</td>
</tr>
<tr>
<td></td>
<td>Activity 5: Cleaning injecting equipment</td>
<td>Understanding of condom use.</td>
</tr>
<tr>
<td></td>
<td>Activity 9: Drug use and sexual risk</td>
<td>Understanding how to clean equipment.</td>
</tr>
<tr>
<td></td>
<td>Activity 10: Storyboard Happy and unhappy endings</td>
<td>To explore some factors that influence drug use and sexual risk.</td>
</tr>
<tr>
<td></td>
<td>Activity 15: Women and HIV risk (women residents only)</td>
<td>Safe behaviour in the community.</td>
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<tr>
<td></td>
<td></td>
<td>Safe behaviour for women.</td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Activity 3: Who can</td>
<td>To encourage participants to consider possible sources of help for those with HIV.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Activity 4: Peng has HIV</td>
<td>To encourage participants to consider some of the issues for those living with HIV, their contacts and friends.</td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Activity 5: Discrimination</td>
<td>To reduce discrimination against people with HIV.</td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Activity 6: Values line-up</td>
<td>To explore the groups’ values and attitudes about HIV and related issues.</td>
</tr>
</tbody>
</table>
In some centres, staff and other residents will be aware of the HIV status of residents. In this situation, it may be possible to deliver specific HIV positive pre-release education in a small group setting or, if necessary/desirable, with individuals alone. Such education would emphasize the ‘How do you live with it’ module. In many centres, medical staff may be those best placed to be involved in the delivery of this individual/small pre-release education for those who are HIV positive. Depending on the nature of the broader HIV education programme conducted in the centre, it may be that police staff and/or the appropriate peer educator are also involved in this education process.

It is important that this approach maintains confidentiality for residents and provides the necessary education at an appropriate level. This education should reinforce safe behaviour, both drug use and sexual, and also cover issues such as keeping family, friends and partners safe, and where to go for medical services, help and support. Table 4 provides a sample programme for those who know they have HIV.

<table>
<thead>
<tr>
<th>Module</th>
<th>Activity 1</th>
<th>Activity 3</th>
<th>Activity 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How do you avoid getting it?</td>
<td>Activity 3: Ali and Jela</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Activity 8: Drug use and sexual risk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Sample Programme: For people who know that they have HIV.

- To consider the implications and consequences of sexual and drug use behaviour.
- To explore some factors that influence drug use and sexual risk.
- To increase participants’ understanding of what it means to be HIV positive.
- To encourage participants to consider possible sources of help for those with HIV.
- To encourage participants to consider some of the issues for those living with HIV, their contacts and friends.
In some jurisdictions, while staff may be aware of the HIV status of residents, the individual resident does not know his/her status. From an HIV harm reduction perspective, this policy is of some concern. It means that no specific pre-release education programme can be provided to those residents who are HIV positive. Residents are aware that, as a result of the sentinel testing policy, the staff will know the HIV status of a resident but no counselling or other support will be provided.

The nature of the more general resident education programme is also affected by this policy position. In this situation, residents understandably want to know their HIV status and this affects their engagement with the content of education. Whenever the “How do you avoid getting it” activities are being delivered, residents will be concerned about whether their previous risk behaviour means that they are already infected.

It is important to note that all residents should be provided with education prior to release. Where the HIV status of residents is known, some centres might be tempted to only provide education to these people. This is not recommended as all residents need to be informed about HIV ‘safe behaviour’ when they rejoin the community.

**Designing and delivering staff training**

This section:

- Provides a rationale for the necessity of staff training in all centres.
- Identifies key issues for training of staff, including which staff should be trained.
- Identifies models of staff training including one-off and update training.

**Rationale:**

It is essential that all staff in closed settings are trained in HIV harm reduction. Training is vital to: reduce the risk of occupational infection; engage staff in the design and ongoing delivery of HIV harm reduction for residents; reduce discrimination; and inform staff about how to minimize HIV risk in their private lives.

Generally, staff understand the need for HIV training to reduce occupational health risk or to reduce harm in their personal lives, but may not necessarily understand why it is important to support resident education. At a purely practical in-centre level:

- If harm reduction approaches are effective, fewer residents within centres will be HIV positive and therefore there will be less risk to staff from occupational exposure.

- Fewer people with HIV also mean that there are fewer management issues in the centre. Issues such as universal infection control and sentinel testing are still important as residents who are HIV positive can be more easily integrated within the centre.

- Confidentiality and non-discrimination can be assured within the centre.

- There is less stress on medical and other facilities within the centre.

There are also considerable community benefits, including:

- There is less chance of HIV spreading from former residents of the centre into the community. The fewer people in a specific community who are HIV positive, the lower the rate of infection. Therefore, there are significant benefits for the community in which most staff reside.

- There are significant benefits in reducing human suffering and health system benefits are substantial in that limited resources can be directed towards providing services in other areas.
Models of training:

Staff training can occur in a number of ways, dependent on the expertise available and the usual method of training in place. Three optional models exist:

1. In-house training. Under this model, training is designed and delivered within the centre. Staff responsible review *Inside Out* and design training appropriately.

2. Planned in-house but delivered by external expert. Under this model, staff of the centre are responsible for identifying their training needs. They review *Inside Out* and determine which activities are appropriate. They then brief the external expert about the nature and content of the training required.

3. Planned and delivered out-of-house by an external expert. For HIV issues, this model is often the status quo. If this is the case, the external agency needs to review *Inside Out* and negotiate what activities are required with the staff of the centre.

Whichever model is used, it is essential that staff training ranges across all of the objectives and activities detailed in *Inside Out*. Failure to do so will mean that a complete, integrated education/harm reduction programme will not occur.

Which staff should be trained?

All staff of drug treatment and rehabilitation centres should be trained but some staff have more significant training needs than others. Training is proposed on three levels:

- **Level 1:** Significant training for those staff responsible for designing and delivering the HIV harm reduction programme (peer education supervisors etc.)

- **Level 2:** Training for all police and medical staff.

- **Level 3:** Some low level training for other centre staff, kitchen, administration etc.

Updating staff training.

One-off training will be less effective than training that is regularly updated. Ongoing training should reinforce issues around occupational risk and promote continued engagement in the resident education processes.

Also, as new staff is employed in the centre, they should be trained in HIV prevention as soon as possible after commencing employment. Where induction training is in place, HIV harm reduction education should be incorporated into this training so that key messages can be transferred as soon as possible.

Some Sample Programmes

The following programmes take the activities outlined in Section A and allocate them to various sample delivery models. They are provided as a guide only to centre staff.
### Table 5: One-day staff training model

<table>
<thead>
<tr>
<th>Module</th>
<th>Activity 1: Introductions and overview of programme</th>
<th>Length of activity</th>
<th>Intent of activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is HIV?</td>
<td>30 mins</td>
<td>• To introduce participants and group leaders. To provide an overview of the education session(s). To begin discussion about current levels of HIV knowledge. To agree basic ground rules for the sessions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activity 2: Introduction: Part 2 – What is HIV?</td>
<td>30 mins</td>
<td>• To provide basic information about HIV and its impact. To allow participants to identify their information needs and gaps.</td>
</tr>
<tr>
<td></td>
<td>Activity 3: What does it mean for me?</td>
<td>30 mins</td>
<td>• To recognise and begin to discuss concerns and fears about HIV. To begin to consider the implications of HIV in individuals’ lives and in their world.</td>
</tr>
<tr>
<td>2. How do you get it?</td>
<td>Activity 1: Principles of transmission</td>
<td>30 mins</td>
<td>• To provide basic information about HIV transmission. To allow participants to clarify their understanding of HIV transmission.</td>
</tr>
<tr>
<td></td>
<td>Activity 4: Transmission game</td>
<td>30 mins</td>
<td>• To allow participants to clarify their understanding of HIV transmission.</td>
</tr>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Activity 3.3 Drug use and safe sex: Harm reduction</td>
<td>30 mins</td>
<td>• Staff activity to promote safe personal behaviour.</td>
</tr>
<tr>
<td></td>
<td>Activity 7: Storyboard: Happy and unhappy endings</td>
<td>30 mins</td>
<td>• To consolidate information about harm education by applying it to a real life scenario.</td>
</tr>
<tr>
<td></td>
<td>Activity 11: HIV in the workplace. Transmission and infection control</td>
<td>30 mins</td>
<td>• To increase participants’ understanding of safe work practises in relation to HIV.</td>
</tr>
</tbody>
</table>

### Table 6: Sample two-day staff training programme model

<table>
<thead>
<tr>
<th>Module</th>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is HIV?</td>
<td>Module 1: All three activities</td>
<td>2 hours</td>
</tr>
<tr>
<td>2. How do you get it?</td>
<td>Module 2: Activities 1 to 4</td>
<td>3 hours</td>
</tr>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Module 3: Activities 3 to 12</td>
<td>7 hours</td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Module 4: Activities 1 to 6</td>
<td>4 hours</td>
</tr>
</tbody>
</table>
Sample: Half-day occupational health and safety focused model
It is likely that in some locations there will be a desire to deliver a programme that is focused only on OH&S issues for staff. While it is appreciated that there is a need for this focus, it is important to note that this should not be the only training that is offered to staff. The range of content included in all four components of the programme is essential for a full understanding of HIV.

It is not appropriate for a programme only to inform staff about workplace self-protection issues. Table 7 outlines the minimum that is recommended. Table 8 provides an example of a staff follow-up training programme.

Table 7: Minimum staff training programme

<table>
<thead>
<tr>
<th>Module</th>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is HIV?</td>
<td>Module 1: Activities 1 and 2</td>
<td>1 hour</td>
</tr>
<tr>
<td>How do you get it?</td>
<td>Module 2: Activity 1</td>
<td>30 minutes</td>
</tr>
<tr>
<td>How do you avoid getting it?</td>
<td>Module 3: Activities 11 and 12</td>
<td>1.5 hours</td>
</tr>
<tr>
<td>How do you live with it?</td>
<td>Module 4: Activity 1 and Activity 5</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

Table 8: Sample staff follow-up training programme

<table>
<thead>
<tr>
<th>Module</th>
<th>Activity</th>
<th>Intent of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. How do you get it?</td>
<td>Activity 4: Transmission game</td>
<td>• To allow participants to clarify their understandings of HIV transmission.</td>
</tr>
<tr>
<td>4. How do you live with it?</td>
<td>Activity 2: Van’s story</td>
<td>• To encourage participants to consider the needs of those diagnosed with HIV and the needs of the staff dealing with this.</td>
</tr>
<tr>
<td>3. How do you avoid getting it?</td>
<td>Activity 12: HIV in the workplace: Workplace situations</td>
<td>• To increase participants’ understanding of safe work practises in relation to HIV.</td>
</tr>
<tr>
<td>4. Van’s story</td>
<td>Activity 2</td>
<td>• To help staff to understand the issues for residents once they leave the centre.</td>
</tr>
</tbody>
</table>
Staff training issues

For effective HIV harm reduction to occur in drug treatment centres, all staff need to be engaged in training. The staff involved in developing the training regime should consider the following issues:

1. All staff have a right to comprehensive training so that the risk of occupational exposure to HIV is reduced and universal infection control principles are understood and implemented all of the time.

2. The content of staff training must be congruent with the policy of the centre. For example, if there is a universal infection control policy, then training should assist staff to understand this and to fully engage with it (See Section A “How do you avoid getting it?”).

3. As indicated above, staff training will be more effective if it is ongoing rather than a one-off workshop about HIV.

4. When planning staff training, staff turn-over rate is an important issue to consider. In centres where there is a high turnover rate, training will need to be conducted more regularly and significant update component should also be delivered.

5. In some centres, it might be advantageous to train staff in homogenous groups; all medical staff together, all police staff together etc. Mixed groups can sometimes be difficult due to the diversity of knowledge within the group and the range of responsibilities that different people have within the centre.

6. The staff training programme should be highly interactive and focus on personal behaviour as well as professional responsibilities. As indicated throughout the material, staff need to engage with the issues raised by HIV and AIDS harm reductions. Providing information alone is not sufficient to ensure that attitude and behaviour shifts occurs.

7. In some jurisdictions, there will be a temptation to train staff in large groups of more than the recommended 30 participants. This is not recommended because of the nature of the content and objectives of the programme. Where it occurs however, it is essential that:

   • The group comprises staff from a single work focus only (for example police staff only). It is extremely difficult to conduct effective training in large mixed groups.

   • All training activities within the Inside Out programme are undertaken so that the interactivity of the programme is not compromised. The trainer will need a significant level of people-management/facilitation skills to undertake effective training in this way.

   • In these circumstances, it is advisable to use a number of small group facilitators to assist small groups to work effectively. These assistants need to be well briefed prior to the training and to possess high-quality facilitation skills.

   • If training is to be conducted in large groups, the set-up of the room is vital. It is suggested that groups work at tables so that they can come together, undertake an activity and then reform as another group at other tables.

   • Conducting whole group discussions in this format is difficult. It is likely that the number of these will need to be reduced. A ‘roving’ microphone arrangement is also recommended.

   • Training in large groups always takes longer, is more challenging and less effective than working with a smaller group. It is important to note though that having a group that is too small [six or less] is also difficult.

8. Staff responsible for organizing and/or delivering the resident education programme have special training needs beyond those associated with the issues raised above. This training must focus on enhancing their skills in programme delivery as well as increasing knowledge about how resident education programmes can be structured. While these staff will have access to the Inside Out material, the complexity of the challenge of providing high-quality resident programmes with behavioural outcomes, demands additional training in how to deliver the programme.
Providing residents and staff with print material

As indicated throughout this document, print material forms an important but not exclusive part of any harm reduction programme. Print material is included in the activities in Section A of Inside Out. The use of local print material is also referred to in some depth in Section D, where adapting Inside Out is discussed in detail. It is likely that in many jurisdictions, the use of Inside Out will require the development of more local print material about the issues of safe sex, not sharing injecting equipment and appropriate referral options. Often this material is not available or does not exist at a sufficient quality or in sufficient quantity. Programme managers have a responsibility to ensure or work towards its availability.

However, it is essential to restate that the focus of any effective programme seeking behaviour change must go far beyond provision of print material alone. It is unlikely that merely reading a brochure will prompt the behaviour that is sought in the objectives of this programme. The literacy levels of residents are also an issue to be considered when determining the extent to which print material will form a part of the education approach. As indicated above, print material supports and reinforces other face-to-face strategies rather than replacing them.

Inside Out does contain two simple brochures that can be adapted and translated for local use. These are provided for use in circumstances where local material is not available. These brochures are found in Appendices 3 and 4. It might be that similar material is available locally and that these brochures are not necessary. The brochures are:

- Appendix 3: Understanding Hepatitis C
- Appendix 4: Understanding HIV

It is important to note that while Inside Out is not directed towards harm reduction of Hepatitis C, similar modes of transmission to those of HIV, exist. Hepatitis C is a chronic condition that has impacts on people’s health later in their lives. With increased availability of and access to ART, Hepatitis C is becoming more of a health issue internationally.

In some settings, it might be considered appropriate to provide some information about Hepatitis C at the same time as educating staff and residents about HIV and AIDS, hence the inclusion of the “Understanding Hepatitis C” brochure. While this only provides rudimentary information, it will assist in those circumstances and communities where Hepatitis C is an issue. Please note that many of the activities in Inside Out could be adapted to relate to Hepatitis C and how this might occur is discussed in Section D of this document.
Designing and delivering a peer education programme

The use of peer education as a harm reduction approach in closed settings is entirely appropriate and recommended. This section contains a brief introduction to peer education and must be read in conjunction with the information in Appendix 1.

Peer education is a harm reduction approach that has been used extensively around the world with marginalized groups. This approach involves identifying, training and supporting members of a given group to pass on accurate information, appropriate skills and health-responsible attitudes to others with similar characteristics. The desired outcome is that peer influence within the culture of the group is utilized to effect and sustain the desired change of behaviour.

Peer education is currently used in a number of compulsory drug treatment and rehabilitation centres in countries in the Western Pacific Region. If it is designed, delivered and supported well, then peer education is a highly appropriate strategy for harm reduction in closed settings. It links approaches and messages inside the centre to those outside in the community. Those people who are peer educators on the inside become substantial influencers within the injecting community on the outside.

As peer is a cost- and outcome-effective strategy it forms a key part of the Inside Out programme. If behavioural outcomes are desired from HIV harm reduction efforts, then a peer education approach should be considered within every compulsory drug treatment and rehabilitation centre in all WHO member countries in the Western Pacific Region. The only exception to this is where the length of stay in a centre involving compulsory detoxification is less than three months, as it is likely that delivering the programme via peer education will not be viable under these circumstances.

Appendix 1 outlines in some detail how effective peer education programmes might be structured. Guidance is provided about the principles of peer education for residents in closed settings; how peer educators are recruited, trained and supported; and how the achievements of the program might be maintained over time. It is important to note that peer education can be delivered at a number of levels. The information in Appendix 1 is designed to assist programme developers to deliver comprehensive programmes. These are most suitable for use where residents remain in centres for a long period of time (at least six months). In some centres, residents are held only for a short period of time. This does not mean that peer education is an inappropriate approach in these circumstances, but rather that its implementation should be more limited, with more modest outcomes. For example, the use of existing peer leaders and delivery of a less structured programme might be more sensible where residents are in centres for less than six months. The information in Appendix 1 will assist programme developers to determine the appropriate level of the programme.

With regard to the training of peer educators, it is advisable that they have a detailed understanding of HIV harm reduction and prevention. Hence their training should include engagement in all activities outlined in Section A. The training should focus on how they might use these activities to enhance the knowledge and attitudes of their peers in the centre and later in the community.
Evaluating the HIV harm reduction programme

As *Inside Out* is being implemented, it is important to make judgments about its effectiveness and efficiency to identify whether or not it is working to achieve its objectives, and what relevant Ministries want it to achieve. These judgments form the basis for evaluation of the programme.

Evaluating *Inside Out* involves two separate components:

- Evaluating the resident education programme.
- Evaluating the staff training aspect of the programme.

**Evaluating the resident component of *Inside Out***

The highest priority is to determine the extent to which the resident education activity is achieving the desired harm reduction impact. To what extent are the programme’s objectives - of increasing knowledge of HIV and reducing risky behaviour once residents are released into the community - being met? As actual behaviour in the community cannot be measured by an evaluation of the programme, behavioural intent information is collected.

The following are the programme objectives that should be measured for residents:

- Increased knowledge and skills among residents in closed settings about HIV, transmission and safe behaviour.
- Reduced incidence of risky practices by residents in closed settings.
- Increased safe behaviour among residents on release in the community.
- Reduced reuse of injecting equipment, to the extent that this becomes normative behaviour among IDUs.
- Increased understanding among people who are living with HIV/AIDS of how to live with HIV and how to avoid transmitting it.

Resident programmes are best evaluated by the administration of pre-release data collection forms that can identify the extent to which the harm reduction programme inside the setting has impacted on HIV knowledge, attitudes and skills and to what extent it has prepared residents to choose safe behaviour once they rejoin the community.

The following questionnaire has been developed to assist in this process. It is recommended that this questionnaire be administered to all residents on release from the centre. Responses should be collected anonymously. Once collected the data should be collated on a monthly basis; less regularly in smaller
Information should be analysed three-monthly to determine whether changes need to be made to the resident education programme.

Note 1: This survey has been called a Quiz so that the concept of evaluation does not have to be explained to residents. The Quiz is outlined in Box 1.

Note 2: In some centres, the quiz may be administered to residents individually (verbally where residents cannot write). In others, it may be administered to groups of residents and their verbal responses collected. If group administration is selected, it is important to obtain responses from all residents. However it is administered, it has been developed so that it can be read to a resident/residents and their responses recorded.

Note 3: The Quiz could be adapted to use before and after the implementation of Inside Out. Pre-programme data is only warranted in centres where residents stay for an extended period of time (six months or more). Data should only be collected after the detoxification phase of the programme. The advantage of collecting information prior to the delivery of the programme and after its delivery is that comparisons can be made about changes in knowledge and behavioural intent as a result of the programme.
Box 1: Inside Out quiz for residents on release from the Centre

What is HIV?

Does everyone with HIV have AIDS?

What is the difference between HIV and AIDS?

How do people get HIV?

Which of the following people are not at risk of getting HIV?
- A person who does not inject drugs and uses a condom every time he/she has sex.
- A person who does not inject drugs and is married or has a regular sexual partner.
- A person who injects drugs but does not reuse equipment and has sex with a number of partners without using a condom.
- Someone who only reuses needles with their friends.
- A person who uses the same injecting equipment as others.

When you leave the centre, what are you going to do if...
- Someone offers you drugs?
- Someone offers you drugs but does not have clean equipment?
- Someone encourages you to use the same needle as him or her, because “you are hungry for the drug?” They tell you they don’t have HIV.
- Someone wants to have sex with you but neither of you have a condom?

When you are back in the community, what are you going to do if....
- A friend of yours who has AIDS asks you to move in with them and be their career?
- You have put yourself at risk of HIV by using someone else’s needle or having sex without a condom?

How much did the information you received in the Drug Treatment and Rehabilitation Centre help you to understand HIV and AIDS better and protect yourself against infection?
- A lot. I did not know anything before I got here
- A lot. I knew something about AIDS before I got here but I have learnt more
- A little bit. I know more than I did before I got here
- Not too much
- It did not help.
For a guide to responses see Appendix 5

**Evaluating the Inside Out staff training programme**

It is important that the staff training component of the programme is also evaluated fully. Evaluation should occur against the following objectives.

- Increased knowledge and skills among staff in closed settings of HIV, transmission and safe behaviour.
- Reduced OH&S risk of HIV transmission for staff in closed settings.
- Increased understanding of the need for HIV harm reduction and how this relates to a compulsory drug treatment and rehabilitation programme.
- Increased capacity and willingness of staff in closed settings to educate residents in preventing the spread of HIV.
- Reduced discrimination towards people in closed settings who are HIV positive.

As the delivery of staff training may vary from facility to facility, there may be variations in the evaluation processes and data collection tools used. For example:

**Scenario 1.** In some centres, staff will be provided with a one-off training programme about HIV. This should be evaluated and the results analysed in order to determine whether the programme is meeting its objectives. Sample evaluation forms to assist in this process is included in Box 2 and Box 3.

**Scenario 2.** As well as the one-off training programme above, some centres will deliver update training for staff. This is recommended and should be evaluated accordingly. Additional questions for this component of the programme are included below.

An important question is “What is done with all of this data?” Initially, the key issue is that the data will inform those responsible for organizing and delivering training whether it is working or not and to make changes to the training content as required. The information is also important to the management staff in the centre, as they need to be sure that the programme is meeting its OH&S objectives, and staff are adequately prepared to reduce occupational risk. Evaluation must be undertaken with some purpose and have some effect on the programme.
Box 2: Inside Out staff evaluation form

What is HIV?

Does everyone with HIV have AIDS?

What is the difference between HIV and AIDS?

How do people get HIV?

Which of the following people are not at risk of getting HIV?

- A person who does not inject drugs and uses a condom every time he/she has sex.
- A person who does not inject drugs and is married or has a regular sexual partner.
- A person who injects drugs but does not reuse equipment and has sex with a number of partners without using a condom.
- Someone who only reuses needles with their friends.
- A person who uses the same injecting equipment as others.

As a staff member of a Drug Treatment and Rehabilitation Centre, to what extent are you at risk of HIV?

- At very high risk
- At high risk
- At risk but neither high or low
- At low risk provided proper infection control procedures are followed
- Not at risk at all

If you think you are at risk why might this be the case?

How can you minimize your risk in the future?

The correct way to clean up a blood spill is to...

The correct way to handle needles is...

Describe universal infection control procedures

Why is it important not to discriminate against people with HIV

How important is it for you to support the resident education programme?

- Very important
- Important
- Neither important or unimportant
- Not important
- I don’t/won’t support it

How can you support the resident education programme?
Box 3: *Inside Out: Evaluating follow-up staff training*

Additional evaluation questions to be used in update training:

To what extent did this additional training programme help you to understand HIV better?
- A lot
- A little bit
- Not at all

Why was this the case?

Did you need update training about HIV?

As a staff member, how do you support the resident education programme now?

Did this extra training help you to support the resident education programme? How?

For answers see Appendix 5.
**Section D: Adapting Inside Out**

The Introduction Section of this document makes it clear that *Inside Out* has been produced for a wide range of possible uses. Given the variations of policy and services between countries and settings, adaptation will be necessary, even if it is only at the simple level of ensuring that information provided for some of the activities is locally relevant. This includes locally specific advice about where to go for help when leaving the centre or locally developed and relevant print material.

Of more significance is the fact that the programme will need to sit within a harm reduction context supported by public health policies within the jurisdiction. *Inside Out* will not be effective if it is operating outside of a supportive environment (See Appendix 2, Ottawa Charter on Health Promotion).

Some significant adaptations (or inclusions) may need to occur with the materials that comprise *Inside Out*. Many countries have very different approaches to HIV harm reduction and different services, policies and resources related to it. For example, in some countries, needle and syringe programmes and methadone maintenance treatment, as well as ART are available. In other countries, none of these complementary harm reduction programmes are in place. Legal and policy approaches also vary significantly from country to country and these need to be considered locally. This section of the package provides some guidance for undertaking the adaptation process at a national level and also within a specific centre.

**Adapting Inside Out for national use**

The optimal use of this training manual occurs when the relevant Ministry or Ministries responsible for the administration of closed setting facilities (or other facilities e.g. prisons, if appropriate) determines that *Inside Out* is to be adapted for local use across all centres on a national basis. This approach will mean that all residents in all centres across the country are provided with a comprehensive harm reduction education programme. This is by far the optimal situation. It is important that during this process, liaison occurs with other Ministries who are important stakeholders. Diagram 1 outlines the steps in this process.
Diagram 1. Steps in the adaptation of the *Inside Out* programme on a national basis.

**Step 1:** Determine relevant country legislation and policy that establishes the framework for HIV harm reduction in closed settings (or other facility). Identify broad HIV harm reduction programme needs within the jurisdiction.

**Step 2:** Review the objectives of *Inside Out* to determine consistency with the broad programme needs identified in Step 1. Identify any additional objectives and/or those that are not locally relevant.

**Step 3:** Review sample programmes and other material in Section B of *Inside Out* and determine which activities/programmes might be implemented locally. Develop a Local Programme Outline to guide adaptation.

**Step 4:** Identify existing local material and resources that can be made available to all centres to support the programme. Develop new material if needed. This includes existing print material, advice re relevant health and support organizations etc. Be aware of relevant testing, counselling and treatment issues.

**Step 5:** Use the Local Programme Outline (Step 3) and materials etc (Step 4) to develop a local HIV Harm Reduction Programme for use in all centres. This should make clear how implementation is to occur, whether peer education and pre-release programmes are included, etc.

**Step 6:** Distribute the HIV Harm Reduction Programme and accompanying policy advice that makes its implementation mandatory in all centres. Provide appropriate training for staff of centres through a train-the-trainer programme.
Adapting *Inside Out* for in-Centre use

In some countries, *Inside Out* might be adapted for use in an individual centre only. Given that other centres may not be implementing HIV harm reduction programmes, this is not the most desirable situation. It is acknowledged, however, that this scenario may occur. The steps outlined in Diagram 2 will assist staff to adapt the material for use in their centre. It assumes that some HIV harm reduction training and education is already occurring in the centre (Diagram 2.)

**Diagram 2: Adapting the training manual for use in a Centre**

**Step 1:** Centre staff review *Inside Out* and identify the relevant activities and sample programmes for use within their centre. This review should take account of existing HIV harm education activities that the centre already conducts to train staff and/or educate residents.

**Step 2:** Centre staff identify existing local (and national) material and resources that can be made available within the centre to support the programme. This includes existing print material, advice re relevant health and support organizations etc. Availability of testing, counselling and treatment must also be considered.

**Step 4:** Draft revised HIV Harm Reduction Programme for the Centre. Obtain all relevant information for use with staff and residents. Draft new material if needed.

**Step 3:** Determine how the centre's current programme needs to be amended to broaden its impact. This may mean staff training needs to be changed or resident education programmes need to be enhanced, peer education activity developed etc.

**Step 5:** Gain approval for the revised programme. Implement revised programme including staff training and resident education components. Evaluate the effectiveness of revised programme.
Adapting Inside Out to include Hepatitis C

In some centres and countries, it may be appropriate to adapt Inside Out to include a focus on Hepatitis C. This can be done in one of two ways:

1. Adapting all activities so that they relate to Hepatitis C
2. Adapting some activities so that they are Hepatitis C specific.

**Adapt all activities:** It is possible to change the entire training manual so that it is directed at Hepatitis C and not at HIV. Almost all of the activities in Section A can be reworked so that they focus on Hepatitis C. This is quite a substantial task: although transmission is similar, it is not the same. Transmission occurs via blood-to-blood contact and therefore all behaviour through which blood-to-blood contact can occur needs to be discussed. Sexual transmission is not currently believed to be an issue; therefore, all safe sex information is irrelevant. This means, for example, that Activity 2 in Module 3 would not be included. Adapting Inside Out to this extent means all O/Hs and handouts need to be changed and the content of each activity needs to reflect Hepatitis C.

**Adapt specific activities:** Perhaps the preferred option is to adapt specific activities in Inside Out for Hepatitis C. Table 8 lists recommended activities for adaptation and a brief indication of what would be required to use each activity with a Hepatitis C focus.

It is recommended that if Hepatitis C is to be included in the content of the programme, some or all of the following activities only be adapted.
Table 9: Adaptation of activities to a Hepatitis C focus

<table>
<thead>
<tr>
<th>Module</th>
<th>Activity</th>
<th>Hepatitis C adaptation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Introduction and What is HIV?</td>
<td>1. Introductions and overview of programme</td>
<td>Change to include Hepatitis C focus. Minimal change required.</td>
</tr>
<tr>
<td></td>
<td>2. Introduction Part 2 – What is HIV?</td>
<td>What is Hepatitis C? Significant change to all materials.</td>
</tr>
<tr>
<td></td>
<td>3. What does it mean for me?</td>
<td>What does Hepatitis C mean to me? Significant change</td>
</tr>
<tr>
<td>2: How do you get it?</td>
<td>1. Principles of transmission</td>
<td>Principles of transmission of Hepatitis C Needs to be written</td>
</tr>
<tr>
<td></td>
<td>4. Transmission game</td>
<td>Needs to be reworked</td>
</tr>
<tr>
<td>3: How do you avoid getting it?</td>
<td>1. Drug use Harm reduction</td>
<td>Some change required</td>
</tr>
<tr>
<td></td>
<td>8. Safe behaviour brochure</td>
<td>Minimal change required</td>
</tr>
<tr>
<td></td>
<td>11. HIV in the workplace: Transmission and infection control</td>
<td>Hepatitis C in the workplace. Substantial reworking</td>
</tr>
<tr>
<td></td>
<td>12. HIV in the workplace: Workplace situations</td>
<td>Substantial reworking required</td>
</tr>
<tr>
<td>4: How do you live with it?</td>
<td>1. HIV in the body</td>
<td>Hepatitis C in the body Needs to be written</td>
</tr>
<tr>
<td></td>
<td>3. Who can help?</td>
<td>Needs adaptation</td>
</tr>
<tr>
<td></td>
<td>4. Peng has HIV</td>
<td>Needs adaptation</td>
</tr>
<tr>
<td></td>
<td>6. Values line-up</td>
<td>Needs adaptation</td>
</tr>
</tbody>
</table>

Other adaptations of Inside Out

It may be that the Inside Out programme is to be adapted for use within other institutions or circumstances. As the programme has an emphasis on reducing transmission, particularly among those who inject drugs, the most appropriate adaptation will be for use within institutions where a significant percentage of the clients of the service are IDU. Some examples of possible adaptations include:

- Use in community drug services.
- Use in justice settings/prisons.
- Use in other places of incarceration.
- Use with people with a higher level of literacy. Note that the introduction to the activities in Section A indicates that all hand-outs and overhead transparencies have been kept at a lower level of literacy in order to make them more broadly accessible. It may be that in some circumstances the content needs to be provided in more depth.
Essentially, adaptation may happen in one of two ways, either by changing *Inside Out* entirely for use in another institution or circumstance or by taking specific activities from *Inside Out* and adapting them for use within another programme.

The following flow diagram indicates the generic steps that must be undergone so that the material can be adapted to meet different needs.

**Diagram 3: Other adaptations**

**Step 1:** Review *Inside Out* and identify its appropriateness to the needs of the specific institution or circumstance. This review should take account of the existing HIV harm reduction programme that is conducted to train staff and/or to educate clients*.

**Step 2:** Identify existing local (and national) material and resources that can be made available within the institution to support an adapted *Inside Out*. This includes existing print material, advice re relevant health and support organizations etc. It also includes consideration of local testing, counselling and treatment services.

**Step 4:** Draft revised HIV Harm Reduction Programme for the institution or circumstance. Either fold in relevant *Inside Out* content and activities or amend *Inside Out* so that it can be used effectively as the training/education programme.

**Step 3:** Determine how the current programme needs to be amended to broaden its impact. This may mean staff training needs to be changed or client education programmes need to be enhanced, peer education activity developed, hand-outs and O/Hs need to be written in more detail etc.

**Step 5:** Field test (trial) the revised programme. Rework it on the basis of the results of the field test. Implement revised programme including staff training and client education components. Evaluate the effectiveness of revised programme.
* Note that the word “clients” is used as a generic description of those at whom the programme is targeted, for example prisoners in prisons as well as those undergoing treatment in community settings, etc.

With particular regard to adapting the *Inside Out* programme for use in prisons the following comments are offered:

- It is unlikely that *Inside Out* can be used in prisons without substantial adaptation. The culture of prisons is entirely different to that found in Drug Rehabilitation and Treatment Centres. Many justice administrators may not see the content as entirely relevant or perhaps they will not see the need for a programme given that not all prisoners are IDUs. From a harm reduction perspective this would be unfortunate. However, it is an understandable position. Partial use of the material is possible in these circumstances. To do this, adaptation is required.

- It may be that the activities included within *Inside Out* are not all appropriate and so while some may be used, others will not.

- The most appropriate adaptation for use in prisons may be incorporating the most specific activities into other education programmes, rather than attempting to adapt the entire programme.

- Justice administrators need to be involved in harm reduction activity. They have a responsibility to reduce the risk of transmission among inmates and to provide education that assists former prisoners to protect themselves from HIV infection upon release.
Appendix 1: Designing and delivering a peer education programme

The following provides guidance on the design and delivery of peer education in a compulsory Drug Treatment and Rehabilitation Centre.

What is peer education?

Peer education involves identifying, training and supporting members of a given group to pass on accurate information, appropriate skills and health-responsible attitudes to others with similar characteristics, where the desired outcome is that peer support and the culture of the target group is used to create and sustain a change in behaviour.

In closed settings such as Drug Treatment and Rehabilitation Centres, peer education involves residents in the delivery of HIV prevention messages to their peers. It means identifying residents with special roles, either specifically as HIV peer educators or through using existing peer leaders (e.g. room supervisors, etc.) and supporting them to take on an HIV harm reduction role.

The following information is provided to assist staff within Drug Treatment and Rehabilitation Centres to develop and manage effective peer education programmes. Peer education requires a high level of staff support. Programmes need to be set up and managed so that all residents have contact with peer educators. The management of even simple programmes is resource intensive but the benefits outweigh the costs.

A real advantage of peer education is that those who are selected and supported in the educator role often take this approach with them into the community. Thus, they have an ongoing impact on the behaviour of IDUs.

When is peer education appropriate/relevant?

In general terms, peer education works best when access to the intended recipient of the education process is an issue. Hence, it is used in areas of health promotion where it has been difficult to reach the target population by more traditional educational means. In the community, peer education is often used to reach people in marginalized groups, such as sex workers, IDUs, homeless people and/or men who have sex with men.

Peer education for harm reduction has also been used effectively in prisons around the world. Peer education is currently used effectively in Drug Treatment and Rehabilitation Centres. While access (in the sense that is implied by the list of target populations above) is not the issue in centres; peer education works because people in compulsory detention are often more open to messages carried by their peers than by those in authority.

In closed settings such as Drug Treatment and Rehabilitation Centres, peer education works effectively for similar reasons. When it is properly structured and planned, when peer educators are selected well, trained to carry out their role and supported by the staff of the centre, there is significant evidence that this method achieves very positive outcomes. Peer education is already used substantially in some countries in the Western Pacific Region, namely China and Viet Nam. Accessing all residents in a centre is possible through a peer-led approach.
When not to use peer education

In closed settings such as Drug Treatment and Rehabilitation Centres, peer education should not be used as an approach in the following circumstances:

- Where it is not strongly supported by staff and residents. In order to be effective the programme must be well supported. Senior police and medical staff must value its existence and support its establishment and ongoing maintenance.

- Where insufficient time is available to ensure that harm reduction messages are getting through. There is some doubt about the value of peer education as an approach if the length of stay in a centre is less than three months, and all residents spend part of that time in the detoxification process. Peer education needs time so that peers can establish themselves as a credible source of harm reduction messages. Also, if the length of stay is too short a great deal of time will be spent just identifying, training and supporting peer leaders, and little time will remain for the real work of the programme.

- Where each educator cannot be allocated a consistent group to work with in an ongoing manner. Peer education works because of the relationships built up between the educator and their peers. If the opportunity for this cannot be structured into the programme, then peer education is of limited value.

While there are some circumstances where peer education is not appropriate, it can be a highly useful strategy in most circumstances. It is important to note that even though a programme may be highly structured, it can be organized in line with these guidelines.

On the other hand, a fairly simple approach can also be taken to the implementation of peer education. As long as peer educators are selected and provided with some additional information, the process will have some impact. Often a room supervisor can provide peer education about HIV to others in their room. This system requires very little support from staff and can be used effectively by centres where a room supervisor model is in place.

How to design and deliver peer education effectively

The principles of peer education

The key principles of peer education identified below have been generated and collated from a range of sources. Peer education programmes in closed settings must be structured in line with all of these principles. Of particular importance are those highlighted in bold type and marked with an * below. If these are not essential aspects of the programme, then it will be of little value in a compulsory drug treatment and rehabilitation centre.

At its heart and expressed as principles, peer education involves:

- Collaborative learning between the peer educator and the peer group members- shared or two-way learning commonality – a bond of some kind.

- Social engagement and a supportive social atmosphere assist and/or influence people in a social group or context. Peer education always has a community aspect to it.

- Sharing experiences both positive and negative, to enhance learning about the issue at hand. Sharing should be based on respect - a partnership of equality. *

- Access to accurate, credible expertise/information. *

- Approaches that are seen as less threatening than other forms of education because of the credibility and commonality of experience of the peer educator.
• Face-to-face activity, communication - human interaction - supported by print or other material.*

• Working one-on-one or in small groups in a semi-structured or structured way.

• Support, continuity and recognition: providing ongoing support and recognition of people’s contributions and of the peer educator.

• The educator is not seen as an expert but is someone peers believe in i.e. – a role or behaviour model. The process relies on credibility, trust and the development of rapport. *

• Peer group ownership of the issues and acceptance of responsibility to be part of the solution. The peer identifies in some way with what is discussed or proposed.

• Action–it’s about ‘how’ to do something. Peer education leads to positive change in knowledge, skills, attitudes, beliefs and/or behaviour. *

Designing the project

The peer education programme in a closed setting could be designed as follows:

Option 1: Semi-structured programme. Peer educators are recruited and trained and deliver a discussion-based programme. They take every opportunity to discuss HIV prevention with other residents in an ad-hoc, informal manner. No structured information sessions are conducted.

Option 2: Structured programme. Peer educators deliver a structured education programme to a group of residents over time. Time is allocated, in each resident’s day, to peer education activity. Regular peer education sessions are delivered as part of an ongoing programme.

Option 3: A combination of structured and semi-structured activity occurs. Each peer educator is allocated a group of residents as their peer group. A peer educator delivers regular education sessions to this group of residents. Time with this group is also allocated for the delivery of more informal discussion-based interactions. Therefore, time is set aside in the work and/or treatment programme for regular formal instruction and for informal interactions.

Option 3 is recommended as it provides the maximum opportunity for learning. It accounts for different learning styles and maximizes the opportunities for relationships to be built up. Most education researchers¹⁴ would agree that, although data are not available to enable absolute certainty, it is likely that behaviour change is influenced more by a multi-pronged approach than any single strategy e.g. where formal education complemented by face- to- face informal discussion between the peer educator and other residents.

Recruiting peer educators

To ensure effectiveness regardless of which model is used, a peer educator must be trained to facilitate discussions about an issue and to promote appropriate behaviour/ attitudes etc. The peer educators are placed between the programme developers and the target population.

A peer educator is, in general, a person considered to be a peer by both the group and themselves. A peer is someone who matches the peer group on a number of key characteristics, such as age, gender, educational background, ethnicity and interest.

In closed settings, peers are residents of the centre. They might be drawn from compulsory residents, voluntary residents or both. To be an effective peer educator, the resident selected must be credible and therefore influential and be acceptable to his/her peers. In some centres, therefore, voluntary residents might not be acceptable. It is of little value putting lots of work into identifying and training peer educators if they are not going to be acceptable to other residents.

¹⁴ Prochaska J. Op cit. Ref 12: 14
Peer educators may have many roles including: facilitator, information source, role model, support worker and advocate.

Centre staff must choose peer educators based on some selection criteria. They may be based on the following important attributes:

- A person who is seen as a leader among their peers.
- A resident with a higher-than-average level of education.
- A good communicator.
- A person who is willing to undertake the role.
- A resident who is HIV positive. This should not be an absolute criterion; preference could be given to those who have HIV.

**Training peer educators**

The training of peer educators is vital to the success of the programme. Training must occur at the outset and throughout the programme. It should establish clearly the following context for the programme:

- the need for a peer education programme;
- the purpose of the peer education programme;
- the roles and responsibilities of the peer educators; and
- the motivating factors for peer educators and an understanding of the incentives that will keep them interested in the programme.

The training programme should include:

- **Content issues**: All peer educators should be trained in the use of a complete *Inside Out* programme. This will enable them to understand the content and to become familiar with the ways in which activities can be used with residents. Peer educator training may be delivered either by:
  - a staff member from the centre (police or medical staff);
  - staff from a local community agency who are familiar with *Inside Out*; and/or
  - in some circumstances, especially where residents are in the centre for a long period of time, a senior peer educator may be sufficiently equipped to deliver training (with assistance from staff).

- **Communication skills**: Training must also assist a peer educator to communicate effectively with his/her peers. This will involve helping them with discussion and facilitation skills and to present more formally within an education session. As part of the training, peer educators should be expected to present at least one of the activities in Section 1 to their peers.

- **Key messages**: All peer educators must keep sight of the key messages that the programme is promoting (see Box 4). They should regularly assess each member of their group against these messages.

The training programme should be ongoing in order to provide updates for peer educators. Refreshing the skills, knowledge and motivation of the educator, is an important part of the peer education process. This training can assist in supporting and supervising peer educators.

**Box 4: Key messages for HIV harm reduction peer education in closed settings**

There are a number of key messages that must be delivered by the peer education programme in closed settings. These include:

- Don’t inject.
- Don’t reuse (share) injecting equipment or use other people’s equipment.
- If you need to reuse, then clean the equipment appropriately, but only as a last resort.
- Use a condom every time you have sex.
- Without being discriminatory, use universal infection control procedures to protect staff and residents.
- Don’t discriminate against people with HIV and AIDS.
Supporting peer educators

Peer education will only work over time if the educators continue to be motivated and refreshed. Each centre should determine appropriate ways to do this. Well-supported peer educators are vital if the programme is going to continue over time. The suggestions below provide some options for this important part of the programme:

- Peer educators need to talk with each other to share strategies, techniques, successes and failures. It is important to structure in some time for communication among those who are delivering the programme.
- Regular meetings of peer educators are vital to the success of the programme.
- Encourage peer educators to review how each member of their group is progressing in the programme. Discuss strategies about how to reach difficult residents who are not reacting well to the harm reduction approach.
- Allow peer educators to conduct their sessions as part of their work day (where possible).
- Provide high-quality support materials that encourage participation and make their tasks easier. Train peer educators in their use.
- Offer badges or certificates of merit for peer educators who complete a period of service, such as a year.
- It should be made known that doing volunteer work as a peer educator is greatly appreciated.
- Provide peer educators with caps, t-shirts, polo shirts, armbands, badges or other clothing items, which identify them as peer educators and potentially increases their status and pride in doing the job.
- Provide financial incentives such as a small allowance for being a peer educator.
- Sometimes an incentives is the increased status in the group or credibility in the community.

Supervision of peer educators

In order to provide a quality programme, it is necessary to supervise peer educators effectively. Peer education has specific outcomes to achieve and the programme should be managed in such a way as to monitor whether these outcomes are being met or not. The following steps outline the process of establishing a supervision programme:

- Identify the number of supervisors needed. Each supervisor should be responsible for up to five peer educators.
- Identify the actual supervisors. Are they police and/or medical staff? Are they from within the centre or outside?
- Determine the method of supervision i.e., individually or as a group and determine the frequency of supervision.
- Prepare a checklist of tools for supervisors.
- Train the supervisors.
- Undertake regular and ongoing supervision.
- Determine how supervision is to be documented and who ensures that quality supervision happens.
- Continue to review supervision practices and the model of supervision, in order to keep the programme fresh and to maintain quality control.

Supervisors should be knowledgeable about HIV harm reduction and the peer education programme and be in close contact with peer educators. Two-way communication is needed between peer educators and supervisors. Peer educators should understand that they are not being judged individually; the supervisors are there to support them, and their experience is contributing to the success of the programme. Supervisors have a key role in ensuring and documenting the success of the programme. Table 9 provides a description of peer education models.
<table>
<thead>
<tr>
<th>Factor</th>
<th>Peer influence model</th>
<th>Peer teaching model</th>
</tr>
</thead>
</table>
| **Description**    | ‘Diffusion of innovation’ approach based on the idea that everyday informal interactions are the most effective form of education. Uses existing networks to circulate information and skills. | Peer educator prepares and conducts education sessions, much like a teacher in a classroom. There is usually a “hierarchy of power” Content is generally from outside the peer group and developed as part of a programme developed by staff in the centre. Peer educators:  
  · disseminate basic facts;  
  · facilitate informal/formal discussions;  
  · run training activities for peers;  
  · participate in broader project activities; and  
  · collect data and evaluate activity |
<p>| <strong>Appropriate for...</strong> | More appropriate for influencing cultural change and peer group norms. Also appropriate for developing a sense of ownership and empowerment within a group. | More appropriate if the aim is to increase individuals’ knowledge, understanding and skills. |
| <strong>Structured</strong>     | Little structure: informal discussion between residents, facilitated by the peer. Interactive. | Structured and formal |
| <strong>Approach</strong>       | Interactive in approach | Tends to be more didactic in approach, but works best if there is interaction. |
| <strong>Planning</strong>       | Tends to be casual, unplanned | Planned |
| <strong>Measuring impact</strong> | Can be difficult to measure. Sometimes it is difficult to assess what messages the peers are taking from each discussion. | Measurable by using pre/post surveys and through in-group discussions. |
| <strong>Method of education</strong> | Characterized by casual conversations between people with one or a number of common characteristics or interests. Limited or no curriculum/content. | Characterized by an organized programme, where there are peer educators trained to conduct education sessions with peer groups or individuals. |</p>
<table>
<thead>
<tr>
<th>Factor</th>
<th>Peer influence model</th>
<th>Peer teaching model</th>
</tr>
</thead>
<tbody>
<tr>
<td>The peer educator</td>
<td>Peer educator not necessarily a perceived expert but someone worthy of being listened to and/or believed due to trustworthy connection with residents. Still needs to be trained and supported in this role.</td>
<td>Identified peer educator who has been selected and trained. An identified expert because of training and experience – has information and skills worthy of note.</td>
</tr>
<tr>
<td>Credibility issues</td>
<td>Messenger-based credibility and message-based credibility: The resident who is the peer educator is trustworthy and socially credible. Due to an existing connection, there is a strong power of influence including willingness or desire to copy behaviour or attributes.</td>
<td>Messenger-based credibility and message-based credibility; Educator’s credibility is knowledge or expert-based. Information/skills are up-to-date, accurate and based on fact or available research.</td>
</tr>
<tr>
<td>Training of peer educators</td>
<td>Training is important but other residents value a person’s life experiences</td>
<td>Formally trained in facilitation/communication and knowledgeable in the content of the curriculum or modules of learning.</td>
</tr>
</tbody>
</table>
Appendix 2: The Ottawa Charter on Health Promotion

Inside Out has been established within the framework outlined by the Ottawa Charter on Health Promotion, developed at the International Conference on Health Promotion, 1986, by the World Health Organization. The Charter, summarized below, has five key elements. In particular Inside Out is located within elements 3 and 4.

Building healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services and cleaner more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - take care of each other, our communities and our natural environment. Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Strengthen community action

Health promotion works through concrete and effective community action, in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, creating opportunities for health, as well as funding support.
Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments and to make choices conducive to health. Enabling people to learn throughout life, to prepare themselves for all its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies and within institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system that contributes to the pursuit of health. The role of the health sector must move increasingly in the direction of health promotion beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate that is sensitive to and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change in attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.
Appendix 3: Hepatitis C Brochure

Understanding Hepatitis C

1. What is Hepatitis C?

- Hepatitis C is a tough blood-borne virus that affects your liver. It can live for up to a month in dry blood.
- Hepatitis C lives in your body and for most people (85%) it does not go away. This is called a chronic or long-term infection.
- Hepatitis C is slow acting and can take up to 13 years before symptoms develop.
- Some of the effects of Hepatitis C are:
  - A person cannot drink as much alcohol.
  - A person might not be able to take as many drugs.
  - A person might feel sick if he or she eats fatty foods (most take-away meals).

- THE MAIN SYMPTOM OF HEPATITIS C IS FATIGUE

2. How do you get it?

- Hepatitis C gets into your blood through someone else’s infected blood. Injecting drugs is the easiest way to get Hepatitis C.
- Hepatitis C is transmitted by:
  - Using other peoples’ needles and syringes.
  - Using other injecting equipment from someone else.
  - Touching anything that can get blood on it: hands/skin/table tops.
  - Using another’s spoons/filters/swabs/mixing or rinse water/tourniquets.
- You can be re-infected with a different strain of Hepatitis C.
- Some personal items can transmit Hepatitis C from an infected person to an uninfected person: toothbrushes, razor blades, used dressings, menstrual blood, nail clippers.
- BE BLOOD AWARE: ALWAYS USE YOUR OWN STUFF
3. How do you avoid it?

➤ Use all new injecting equipment.
➤ Use your own:
  ➤ needles, syringes, spoons,
  ➤ filters, mixing water, rinsing water, tourniquets.
➤ Wash your hands before and after using.
➤ Wash your hands before and after helping someone else use.
➤ Keep a supply of new injecting equipment.
➤ If you cannot get new equipment:
  ➤ reuse your own
  ➤ use another method - SNORT, SWALLOW, SMOKE, SHOVE
Appendix 4: HIV Brochure

Understanding HIV

1. What is HIV?

» HIV - Human Immunodeficiency Virus – is the virus that causes AIDS.

» People with it are said to be HIV positive.

» If you get HIV your body will try to fight it and will make antibodies. A special blood test can detect these antibodies.

» This does not mean a person has AIDS. AIDS is the sickness that develops over time, as a result of having HIV.

» HIV can multiply quickly in the body.

» Over time, it attacks and wears down the body’s immune system, so that the body cannot fight diseases as it normally would.

» Many people can have HIV but not get sick for many years. They will look, and feel, perfectly healthy.

» When the immune system has been badly damaged by HIV, people can become very ill from infections or cancers.

» At this stage, a person has AIDS.
2. How do you get it?

HIV is not spread easily. A person has to get infected blood or sexual fluids into his or her body.

These are the main ways that people can become infected with HIV:

- Using drug-injecting equipment that has been used by someone who is infected.
- Having sex – vaginal, anal, and also oral.
- From an HIV positive mother to her baby through pregnancy and breastfeeding.
- In some countries, through blood transfusions and organ transplants.
- Any other activity where blood (including menstrual blood), semen, vaginal fluid or breast milk from an infected person can enter the bloodstream of an uninfected person.

Basic factors that must be in place for transmission to occur:

- HIV must exit the body of an infected person.
- HIV must remain ‘alive’ in the environment.
- HIV must enter the bloodstream of an uninfected person.

REMEMBER, HIV IS MAINLY TRANSMITTED THROUGH BLOOD, SEMEN, AND VAGINAL FLUID.
3. How do you avoid getting it?

Remember! HIV is not spread easily. A person has to get infected blood or sexual fluids into his or her body.

These are the main ways that people can avoid becoming infected with HIV:

- DO NOT EVER USE THE SAME INJECTING EQUIPMENT AS SOMEONE ELSE.
- ALWAYS USE A CONDOM WHEN HAVING PENETRATIVE SEX.
- AVOID UNPROTECTED CONTACT WITH ANOTHER PERSON'S BLOOD, SEMEN, OR VAGINAL FLUID.
- MAKE SURE THAT SKIN PIERCING OR TATTOOING EQUIPMENT IS NEW OR STERILIZED.
Appendix 5: Evaluation of the programme: Expect these responses

The following provides the programme manager in each setting with a brief summary of the responses that should be obtained from staff and residents if the project has achieved its desired outcomes. This summary is a guide only and a broader range of responses may be obtained. Note that where the questions in the evaluation form involve a choice from a list of alternatives, the expected response has been indicated in bold.

Box 5: Staff quiz: Expected responses

<table>
<thead>
<tr>
<th>Inside Out Staff evaluation form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is HIV?</strong></td>
</tr>
<tr>
<td>HIV is a virus that lives in someone’s body.</td>
</tr>
<tr>
<td><strong>Does everyone with HIV have AIDS?</strong></td>
</tr>
<tr>
<td>No. People can be infected with the virus for some time before they get sick.</td>
</tr>
<tr>
<td><strong>What is the difference between HIV and AIDS?</strong></td>
</tr>
<tr>
<td>HIV is a virus that lives in someone’s body. A person can have HIV and not feel sick. They can still infect other people.</td>
</tr>
<tr>
<td><strong>When a person has AIDS they have had HIV in their body for some time and it has limited their ability to fight off other diseases.</strong></td>
</tr>
<tr>
<td><strong>How do people get HIV?</strong></td>
</tr>
<tr>
<td>By re-using needles (injecting equipment) when they inject drugs.</td>
</tr>
<tr>
<td>By having sex without a condom.</td>
</tr>
<tr>
<td>By getting blood or other fluids onto an open wound. This might occur when staff clean up a blood spill, break up a fight between residents etc.</td>
</tr>
<tr>
<td><strong>Which of the following people are not at risk of getting HIV?</strong></td>
</tr>
<tr>
<td>- A person who does not inject drugs and uses a condom every time he/she has sex.</td>
</tr>
<tr>
<td>- A person who does not inject drugs and is married or has a regular sexual partner</td>
</tr>
<tr>
<td>- A person who injects drugs but does not reuse equipment and has sex with a number of partners without using a condom.</td>
</tr>
<tr>
<td>- Someone who only reuses needles with their friends.</td>
</tr>
<tr>
<td>- A person who uses the same injecting equipment as others.</td>
</tr>
<tr>
<td><strong>As a staff member of a Drug Treatment and Rehabilitation Centre to what extent are you at risk of HIV?</strong></td>
</tr>
<tr>
<td>- At very high risk</td>
</tr>
<tr>
<td>- At high risk</td>
</tr>
<tr>
<td>- At risk but neither high or low</td>
</tr>
<tr>
<td>- At low risk provided proper infection control procedures are followed</td>
</tr>
<tr>
<td>- Not at risk at all</td>
</tr>
</tbody>
</table>
If you think you are at risk why might this be the case?
Because you are not sure whether any of the residents or your fellow staff have HIV.
You have to break up fights/ clean up blood spills etc.

How do you minimize your risk in the future?
By acknowledging you might be at risk.
By following all of the procedures in the workplace fully.
By being sensible but not frightened.

The correct way to clean up a blood spill is to...
1. Wash your hands with soap and water.
2. Cover any cuts or wounds on your hands.
3. Put on disposable gloves.
4. Using paper towel, mop up blood or other body fluid and splashed surfaces with detergent and water.
5. Remove any clothing splashed with blood or other body fluids and wash as normal.
6. Safely dispose of materials used to wipe up blood or other body fluids (e.g. put them in contaminated waste disposal or double plastic bags and place in bin.)

The correct way to handle needles is:
By the barrel and with care.

Describe universal infection control procedures
HIV is only one of a number of communicable diseases to which staff may be exposed. Because the infectious status of others may often be unknown:
- The best way to prevent the transmission of blood-borne infections is to consider all people as potentially infectious, that is, to treat all blood or bodily fluid as possibly infectious.
- This means all people are treated equally.
- Do not allow blood or body fluids directly into your bloodstream.
- Isolate the possibly infectious body fluid, not the person.

Why is it important not to discriminate against people with HIV?
It does not help protect against HIV. In fact it makes it worse because people will not seek testing or treatment. Also, it is a violation of basic human rights.

How important is it for you to support the resident education programme?
- Very important
- Important
- Neither important or unimportant
- Not important
- I don’t/wont support it

How can you support the resident education programme?
By recognizing that it is essential to reducing the risk of the spread of HIV.
By talking with residents at every opportunity about the need to protect themselves against HIV.
By showing residents the correct way to clean up blood spills etc.
Box 6: Staff quiz: Expected responses to follow-up training

**Inside Out: Evaluating follow-up staff training**

Additional evaluation questions to be used in update training:

To what extent did this additional training programme help you to understand HIV better?
  - A lot
  - A little bit
  - Not at all

Why was this the case?
HIV is difficult to understand and I needed to know more about it.

Did you need update training about HIV?
Yes

As a staff member how do you support the resident education programme now?
Yes

Did this extra training help you to support the resident education programme? How?
It helped me to understand why we need a resident education programme in this centre.
It helped me to be able to talk to residents more about HIV and AIDS.

Box 7: Resident quiz: Expected responses

**Inside Out quiz for residents on release from the Centre**

What is HIV?
HIV is a virus that lives in someone’s body.

Does everyone with HIV have AIDS?
No. People can be infected with the virus for some time before they get sick.

What is the difference between HIV and AIDS?
HIV is a virus that lives in someone’s body. A person can have HIV and not feel sick. They can still infect other people.

When a person has AIDS they have had HIV in their body for some time and it has limited their ability to fight off other diseases.

How do people get HIV?
By reusing needles (injecting equipment) when they inject drugs.
By having sex without a condom.
By getting blood or other fluids onto an open wound or into their bloodstream.
Which of the following people are not at risk of getting HIV?

- A person who does not inject drugs and uses a condom every time he/she has sex.
- A person who does not inject drugs and is married or has a regular sexual partner.
- A person who injects drugs but does not reuse equipment and has sex with a number of partners without using a condom.
- Someone who only reuses needles with their friends.
- A person who uses the same injecting equipment as others.

When you leave the centre, what are you going to do if...

- Someone offers you drugs? **Say "No"**
- Someone offers you drugs but does not have clean equipment? **Say "No". Tell them about the risk of HIV and that they should never use someone else’s equipment.**
- Someone encourages you to use the same needle as him or her because “you are hungry for the drug?” They tell you they don’t have HIV. **Say "No". Tell them about the risk of HIV and that they should never use other people’s equipment.**
- Someone wants to have sex with you but neither of you have a condom? **Say "No" unless you can get a condom.**

When you are back in the community, what are you going to do if....

- A friend of yours who has AIDS asks you to move in with them and be their carer? **Think about it and if it is possible to help then do so.**
- You have put yourself at risk of HIV by using someone else’s needle or having sex without a condom? **Go to the medical centre for an HIV test. Do not ever put yourself at risk in this way again.**

How much did the information you received in the Drug Treatment and Rehabilitation Centre help you to understand HIV and AIDS better and protect yourself against infection?

- A lot. I did not know anything/ knew very little, before I got here.
- A lot. I knew something about AIDS before I got here but I have learnt more.
- I little bit. I know more than I did before I got here.
- Not too much.
- It did not help.
Appendix 6: Glossary of Terms

**Antibodies:** Molecules in the blood that tag, destroy or neutralize bacteria, viruses or other harmful toxins. An antibody is specific to an antigen.

**Antigen:** A substance that, when introduced into the body, is capable of inducing the production of a specific antibody.

**Antiretroviral drugs (ART):** Substances used against retroviruses such as HIV.

**CD4 (T4) cells:** White blood cells killed or disabled during HIV infection. These cells normally orchestrate the immune response, signalling other cells in the immune system to perform their special functions. Also known as T helper cells.

**Combination therapy:** The use of two or more types of treatment in combination to achieve optimal results in suppressing HIV/AIDS and reducing the virus’s toxicity.

**Condom:** A thin protective sheath that fits over the penis during vaginal, anal or oral sex to prevent sexually transmitted disease or pregnancy. There are also female condoms that fit inside the vagina.

**Epidemic:** A disease that spreads rapidly through a demographic segment of the human population, such as everyone in a given geographic area, a military base, or similar population unit, or everyone of a certain age or sex, such as the children or women of a region.

**Harm reduction:** Harm reduction is a comprehensive package of policies and programmes that attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances.

**Health promotion:** A broad, holistic and environmental understanding of health, with an emphasis on equity and social justice, as a means of improving health via education, social mobilisation and advocacy.

**HIV positive:** A person who is infected with HIV is said to be HIV positive.

**Incidence:** The number of new cases occurring in a given population over a certain period of time.

**Immune system:** The parts of the body that fight germs in order to maintain health.

**Needle and syringe programmes:** Authorized programmes that distribute, safely dispose of, or sell needles, syringes and other injecting equipment, as well as provide public health information to people who inject drugs.

**Peer education:** Any educational process devised and implemented by members of a population group that aims to alter the behaviour and attitudes of other members of the group.

**Prophylaxis:** Treatment that helps to prevent a disease or condition before it occurs or recurs.

**Safe sex:** Sexual activity in which there is no exchange of body fluids such as semen, pre-ejaculate, vaginal fluid or blood.

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**Sources:** The descriptions of terms used in this glossary have been drawn from a variety of sources including:

References and Resources

References


FPA Health. *HIP Health in Prison*. Published by FPA Health Australia 2003.


WHO Regional Office for the Western Pacific. *Regional vision of health promotion 2001.*


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