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Training toolkit

MODULE 3
IMPLEMENTATION AND EVALUATION

همزة وصل

TRAINING MANUAL FOR MSM PEER EDUCATORS

Acknowledgements

This orientation manual has been developed jointly by the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for the Middle East and North Africa (UNAIDS RST MENA), the International HIV/AIDS Alliance (the Alliance) and its partners in the region: ATL (Association Tunisienne de lutte contre les MST/SIDA), APCS (Association de Protection Contre le Sida), SIDC (Soins Infirmiers et Développement Communautaire), Helem, OPV (Oui Pour la Vie), AMSED (Association Marocaine de Solidarité et de Développement), OPALS-Fes (Organisation Panafricaine de Lutte Contre le Sida, section de Fes) and ASCS (Association Sud Contre le Sida). Together with the NGO MSM Project Orientation Manual and two other modules for training MSM peer educators, it constitutes a training toolkit on MSM programming for the Middle East and North Africa (MENA) region available in English and Arabic.

The training manual for MSM Peer Educators was written by Nadia Badran, in collaboration with John Howson. Staff from the Alliance, UNAIDS RST MENA and USAID Middle East Bureau and the Office of HIV/AIDS provided feedback and inputs during the writing process and completed the toolkit.

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All the quotes in this manual have been collected from MSM living in different countries of the region. We believe they are representative of the regional context and reality, hence have chosen mostly to omit the specific countries where they were collected.

The MENA programme's partner associations

- APCS (Association de Protection Contre le Sida) in Algeria
- SIDC (Soins Infirmiers et Développement Communautaire), OPV (Oui Pour la Vie) and Helem in Lebanon
- AMSED (Association Marocaine de Solidarité et de Développement), ASCS (Association Sud Contre le Sida) and OPALS-Fes (Organisation Panafricaine de Lutte Contre le Sida, section de Fes) in Morocco
- ATL (Association Tunisienne de lutte contre les MST/SIDA) in Tunisia

Contents

MODULE 3
IMPLEMENTATION AND EVALUATION

Overall timing

30 hours

Objectives

This module is focused on:

- developing an enabling environment for programme implementation through partnership development and advocacy
- mapping
- reviewing the different components of an effective programme
- the importance of developing effective referral mechanisms
- how to develop indicators to measure progress and monitor programme outputs
- the importance of supervision
- programme documentation
- reflecting on an ethical framework to guide programme implementation.

SESSIONS IN MODULE 3	
TITLE OF THE SESSION	DURATION
Session 1: Designing a non-discriminatory programme free from stigma	3 hours
Session 2: Choosing places for intervention	2 hours
Session 3: Evaluating and testing places for intervention	1 hour 30 minutes
Session 4: Observing places for intervention	6 hours
Session 5: The referral system	1 hour 30 minutes
Session 6: Designing an MSM outreach programme	4 hours
Session 7: The roles and ethics of field supervisors and peer educators	2 hours 15 minutes
Session 8: An ethical framework for implementation	3 hours
Session 9: The M&E system and measuring impact	1 hour 30 minutes
Session 10: Documentation and evaluation: communicating results	2 hours 15 minutes
Session 11: Problems and challenges in data collection	1 hour 30 minutes
Session 12: Problems and challenges in the street	2 hours

Session 1

Time

3 hours

Objectives

At the end of this session, participants will be able to:

- understand the difference between advocacy, development of educational materials, community mobilisation, partnership building, and resource mobilisation
- discuss these different approaches and their limitations
- talk about the importance of advocacy and its challenges
- understand the importance of and challenges to building partnerships with decision-makers, service providers and society in general
- introduce the concept of "networking" and discuss its importance and challenges.

You will need

- Large sheets of paper, coloured markers, masking tape
- Five pre-prepared sheets (*see* Part 1, step 1)
- Real-life case studies (printed)
- Handouts (one per participant) of:

  Annex 1: Advocacy, networking, partnership building and resource mobilisation

  Annex 2: Questions

  Annex 3: Successful case studies on advocacy

Designing a non-discriminatory programme free from stigma

Overview

In this two-part session, the facilitator prepares real-life case studies and brings examples to analyse. Part 1 may be done in two ways.

The facilitator may invite an advocacy expert to moderate the session, and provide clarifications as needed and practical examples.

Note: Modify the session as necessary to suit the level of understanding of your participants.

Activity: Creating an enabling environment for intervention

Part 1: How to create an enabling environment and possible challenges (1 hour 30 minutes)

Step 1: Approaches to understanding the challenges faced by MSM (45 minutes)

1. To reach MSM through outreach, it is important to start by understanding their context and needs. Earlier in the training we used the Problem Tree methodology to better understand the root causes of the challenges faced by MSM. To respond holistically to these challenges, we need to use a number of approaches. These include using educational materials, community mobilisation, partnership building and/or resource mobilisation.
2. Split participants into five groups and assign each group to one of the large sheets of paper hanging on the wall entitled: advocacy, educational materials, community mobilisation, partnership-building and resource mobilisation. Ask them to answer following questions on their sheet:
   - *What does this method/approach encompass?*
   - *What can be changed through this method?*
   - *Who is the target group using this method/approach?*
   - *What methods and materials would you use?*
   - *How can I measure the effectiveness of this method?*

   Note: You could also prepare a list of questions and ask the groups to write responses to these (*see* Annex 2) depending on the ability of your participants.

Step 2: Feedback (45 minutes)

3. Ask each group to share the work they have done in their small groups. It is useful to provide a summary of the method/approach at the end of each group's feedback (*see* Annex 1).

Part 2: Examples from everyday life (1 hour 30 minutes)

Step 1: Group work and presentations (1 hour)

4. Prepare case studies in advance on advocacy and partnership building from other countries in the region (you can use the examples in Annex 3 for reference). These should be about HIV and AIDS and marginalised groups, and include activities carried out by local organisations, media, individuals, etc.
5. Create small groups to look at each case study and consider the following questions:
   - *What were the objectives of the intervention or project?*
   - *Who carried it out?*
   - *Who was the target group?*
   - *Was it successful and how do we measure its success?*
6. An alternative Step 1 is provided below.

Alternative Step 1: Potential problems (1 hour)

4. Highlight the most serious or frequent problems expressed on the Problem Tree and ask the groups to select one (e.g. "The group was exposed to HIV or other sexually transmitted infections"). To address the challenge, they will need to implement an outreach intervention programme. In order to do this, they first need the consent of the decision-makers, because without it they can prevent them from carrying out this activity.
5. Ask each of the five groups to identify a key advocacy message, the outcome they want to achieve and the approach they will take to discussing their message with the decision-makers (or those able to influence the decision-makers). For example:
   - Get approval for the street intervention.
   - Gain support for the programme rather than opposition to it.
   - Let the public health and human rights importance of the programme take precedence over any law enforcement issues.
   - Facilitate the work of the programme.
   - Collaborate with the organisation conducting the outreach and provide financial support.

Step 2: Discussion (30 minutes)

7. Wrap up by reminding participants of the concepts referred to in Annex 1. Give real-life examples, illustrating the:
   - importance of advocacy, support and resource mobilisation
   - importance of building partnerships with decision-makers, local associations and service providers
   - challenges of networking with different stakeholders, especially local institutions and associations.

Annex 1: Advocacy, networking, partnership building and resource mobilisation

Advocacy

Advocacy is usually a set of actions by individuals, groups or institutions seeking to bring about a change in policies, legislations and practices. It achieves these changes through winning the support of the decision-makers and those in positions of power.

Lobbying is an approach that uses the political system to influence the decision-making process. It is carried out by organised groups targeting the media or policymakers in order to defend a case or specific interests, or to influence public opinion. It is usually done quietly behind the scenes with key decision-makers, decision-making groups or committees. Advocacy work is often done publicly.

In order to respond better to the needs of MSM, the programme will need to engage local organisations, mobilise resources, produce educational materials, network and build partnerships, and gain the support of influential groups and people.

The table below illustrates the differences and benefits of each activity in relation to advocacy.[1]

	ADVOCACY	PRODUCING IEC MATERIALS	COMMUNITY MOBILISATION	NETWORKING AND PARTNERSHIP BUILDING	RESOURCE MOBILISATION	CHALLENGING STIGMA AND DISCRIMINATION
What can be changed	Policies, policy implementation, regulations and practices	Increase awareness and have a positive impact on behaviours	A community's commitment to supporting, or at least not discriminating against, MSM	Less isolation and duplication of work	Enhance the availability of helpful resources for the outreach programme	Reduce the impact of stigma and discrimination against HIV in general and MSM in particular
Target group	Policy- and decision-makers, or those who influence them	Addressing specific groups, e.g. religious leaders, politicians, the police	A local community group or society in general	Individuals, associations, organisations, groups	Associations, unions and funding agencies sharing the same goals or objectives	Addressing those who stigmatise and discriminate
Success indicators	Policies and practice that achieve the advocacy goal, often to create an enabling environment for outreach support, healthcare and legal protection of MSM	Intended audience using the key messages in the IEC materials in their public communication, either in print or in public speeches	Fewer cases within a specific group; more associations offering help from referral system services	Organisations, groups and networks combining efforts and openly supportive of work with MSM, and/or ensuring that MSM and people who work with them are free from harassment	Greater funding opportunities for MSM outreach programmes and MSM-friendly services	Fewer people disclosing confidential information; fewer MSM fired from their jobs; less discrimination in the workplace and healthcare settings

1. International HIV/AIDS Alliance, with ICASO (2002), *Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS*.

Annex 2: Questions

	RESOURCE MOBILISATION	PARTNERSHIPS	COMMUNITY MOBILISATION	DEVELOPMENT OF EDUCATIONAL MATERIALS	ADVOCACY
What does this method/approach encompass?					
What can be changed through this method/ approach?					
Who/what is the target group using this method/approach?					
What examples can you give of methods/ approaches that could be used to undertake this work?					
How can I measure the effectiveness of this method/approach?					

Annex 3: Successful case studies on advocacy

Example of a promotional campaign in Lebanon: Soins Infirmiers et Developpement Communautaire

Soins Infirmiers et Developpement Communautaire (SIDC) is a non-profit organisation founded in 1987 in Lebanon. In December 2012, SIDC organised a promotional campaign called "What are you waiting for?!" This included a documentary produced in Arabic and subtitled in English, and a television advertisement campaign with the same name. The documentary promoted three messages prepared by a group of politicians, religious leaders and public figures, aimed at correcting misconceptions and motivating communities to become more tolerant. The messages were targeted at:

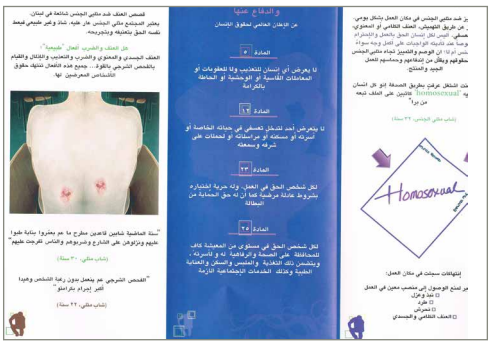
- people living with HIV
- young people in Lebanon, encouraging them to take responsibility for protecting themselves and others
- society in general to reduce stigma and discrimination against people living with HIV.

The SIDC videos are available here:

www.youtube.com/watch?v=-gH9QeIsDmA

www.youtube.com/watch?v=2SzW_890gTA

www.youtube.com/watch?v=4NoQnZ5jgHU



Annex 3: Successful case studies on advocacy

Aziz Tadjeddine is President of the Association de Protection Contre le Sida (APCS)

"This change is important for me, as in a difficult, hostile, aggressive context, the association, taking its time, was able to successfully develop such an issue in a country where it was impossible to discuss homosexuality without being insulted or verbally abused! We have succeeded in freeing speech. But the most significant change is the involvement of Imams in this project, while homosexuality is criminalized and forbidden by Islam […]. We were able to gather 18 Imams in September 2011 for a roundtable conducted under this project, where we discussed the care and support to vulnerable populations, especially MSM […]. Imams made a series of recommendations in which they share an important part."

"Sometimes at parties or gatherings and among friends, there are issues that may be overlooked. So stop, pay attention and protect yourselves. Protect yourselves from AIDS."
Actrice, Lebanon

"You are concerned when it comes to your health and responsible for it."

"Your life is entrusted to you, you need to protect it."

"Your health is entrusted to you, it is your duty to protect it."

"The health of others, and your own, is a responsibility. The life of others is a responsibility, just as your life is."

"How important it is to protect and love your life. The person that loves his life, protects it."
Muslim religious leader

"To all Lebanese youth, you should know by now that AIDS is not a taboo but you can protect yourselves against it. It is your responsibility; it is not destiny." **Parliamentarian**

Session 2

Choosing places for intervention

Time

2 hours

Objectives

At the end of this session, participants will be able to understand the importance of mapping by:

- identifying characteristics of MSM and their sexual partners, and the places where they meet
- identifying existing risk behaviours
- listing possible challenges and learning how to address them
- collecting information about past and present activities that take place in this environment
- identifying the frequency and timings of gatherings, and the presence of authorities and their relationship with the group.

You will need

- Large sheets of paper, coloured markers, masking tape
- Coloured papers to create mapping symbols
- **Annex 4:** The importance of mapping

Overview

This session requires interaction between participants and peer educators, as experts in the field.

During the exercise, participants will discuss in detail specific work locations and the people in those locations. It is important to emphasise that privacy and confidentiality regarding these locations and people must be safeguarded throughout, both during this session and any subsequent sessions. As facilitator, you should also stress to participants that they are the experts in this session, and when they talk about specific places you must listen without any judgment or bias.

Activity: Mapping

Step 1: Definition of mapping (15 minutes)

1. Explain the concept of "mapping" to participants (*see* Annex 4). Talk about the importance of developing maps and the stages involved, and remind participants about sub-populations and the places they frequent.

Step 2: Drawing the maps (45 minutes)

2. Divide participants into small groups. Ask them to choose a geographic area and a target group, and to describe the place by drawing maps using the following coloured symbols:

   - **Green square:** characteristics of the existing group (e.g. age, types of behaviours)
   - **Red triangle:** an area where there is evidence that risk behaviours feature
   - **Blue circle:** easy access to services
   - **Yellow diamond:** reference to the environment and certain services

   Other symbols that you and participants decide may be needed.

Step 3: Presenting the maps and discussion (1 hour)

3. Ask the groups to display their maps and then ask them:
   - *What are the characteristics of MSM and their sexual partners in this area?*
   - *How do you identify them?*
   - *Why is it important to meet this group in these places?*
   - *Is there another description of these places where this population meets?*
   - *What are the kinds of behaviours specific to these places that contribute to increased risk?*
   - *Is there exchange of money for services?*

- *Does this group prefer engaging in sexual relations or in other risk behaviours?*
- *Do they use condoms?*
- *What are the potential challenges faced when intervening and possible solutions?*
- *Are other specific activities occurring in these places?*
- *Are there other significant times in addition to the usual gatherings' times?*
- *Are the authorities present in these places, and if so what is their relationship with the groups?*

Annex 4: The importance of mapping

Mapping is an essential part of outreach programme planning. By identifying the places frequented by the target group and analysing characteristics and risks, you can better plan what needs to be done.

STAGES OF MAPPING	
Step 1: Observation	The team lists places for the intervention. Members of the team are allocated places. They visit the same places at several different times, recording what they observed: the target group, their characteristics, the number and nature of the activities, how they interact, presence or lack of authorities.
Step 2: Preparing the maps	The team acquires a copy of the relevant map from the local council/official or prepares their own accurate copy.
Step 3: Modifying the maps	The team plans follow-up meetings with peer educators to establish whether the map needs modifying or to see if there is a need to add new intervention places to reach other target groups. Allow for seasonal variations.

Session 3

Evaluating and testing places for intervention

Time

1 hour 30 minutes

Objectives

At the end of this session, participants will be able to:

- identify accessible and non-accessible places
- select appropriate places and available times for intervention.

You will need

- Large sheets of paper, coloured markers, masking tape
- Strips of small coloured stickers (an option in step 2)
- Handouts (one per participant) of:

  Annex 5: Summary of places

  Annex 6: List of places frequented by MSM that are important for the intervention

Overview

This session expands on the information collected in Session 2. The information that participants document in this session will be valuable to them in their working practice, as their real-life visits to outreach locations will be informed by what they learn in this session.

Activity: Identifying places to access as the first stage of the intervention programme

Step 1: Summary of places for intervention (45 minutes)

1. Ask participants to work in small groups and to refer to the mapping exercise in Session 2. Give each group two large sheets of paper and coloured markers. Referring to Annex 5, ask them to draw a table on one of the sheets consisting of five columns with headings as provided the annex.
2. Ask them to make a list of places frequented by MSM in the column headed "Sites". Then ask them to complete the information for each site in response to these questions:
   - **Column 1:** *Is it accessible? Are there any obstacles and what kind?*
   - **Column 2:** *If easily accessible, what existing behavioural patterns can you list?*
   - **Column 3:** *If not easily accessible, what existing behavioural patterns can you list?*
   - **Column 4:** *How can you address each area's problems?*

Step 2: Identifying important sites (45 minutes)

3. Ask participants in their small groups to use a marker to put a tick beside those sites they think particularly need awareness-raising activities to reduce stigma and discrimination and to influence local authorities. Each person may select up to three sites. (An alternative would be to give each person a strip of three small coloured stickers and ask them to place these against the three places they want to select.) Each person should choose for themselves, without discussion with other group members or feeling pressured by them.
4. When everyone has made their choices, ask the group to count the number of votes given to each place. Ask them to draw a table on their second sheet of paper like the one provided in Annex 6, and to enter the list of places they voted as most important for undertaking awareness-raising activities.
5. Ask all of the groups to attach both of their sheets of paper to the walls, and then ask the groups to walk around viewing them all. Back in the large group, invite comments, questions and suggestions from each of the small groups in turn.

Annex 5: Summary of places

SITES	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4
	EASY ACCESS	RISKY AREAS? TYPES OF EXISTING BEHAVIOURS	RISKY AREAS? TYPES OF EXISTING BEHAVIOURS	HOW TO FACE THE CHALLENGES

Annex 6: List of places frequented by MSM that are important for the intervention

SITES IDENTIFIED BY PARTICIPANTS AS IMPORTANT FOR CARRYING OUT ACTIVITIES TO ADDRESS STIGMA AND DISCRIMINATION
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Session 4

Observing places for intervention

Time

6 hours

Objectives

At the end of this session, participants will be able to:

- verify accuracy and effectiveness of the maps for future interventions
- modify maps according to their observations on the street
- apply the skills learnt in the observation exercise to their actual work of planning outreach interventions.

You will need

- Observation report forms (one per participant)
- Handouts (one per participant) of:

  Annex 7: Sample ID card for the peer educator

  Annex 8: Sample letter introducing the peer educator (for example, to police officers)

Overview

In this session, participants are required to take to the street to carry out a verification observation exercise. Programme developers may sit in on this exercise as it is important for planning. During implementation, peer educators will have opportunities to discuss the challenges encountered in the observation work and suggest solutions.

Activity: Verifying the map and making modifications where necessary

Step 1: Preparing for the street visit (1 hour)

1. Divide participants into the same small working groups as before. Ask them to refer to their earlier mapping exercises to identify sites that are easy to access. Ask them to prepare an observation report form to complete during their observation exercise, including:
   - the name of the team
   - the name of the intervention site
   - groups that were present
   - how easy or difficult it was to approach these groups
   - what were the best times to approach them
   - activities that happened or would usually happen
   - whether authorities or decision-makers were on site
   - types of services available around the site
   - potential problems or challenges.

Step 2: Site visit (3 hours)

2. Ask each group to go to the observation sites selected from the mapping exercise and observe the dynamics of the place. Remind them of the importance of privacy and confidentiality. Instruct them to stay within their team and walk around without drawing attention to themselves. Give each of them an ID card and a letter to show if they are stopped by police officers (*see* Annex 8).

   Allow them about three hours to carry out this exercise.

Step 3: The following day (2 hours)

3. Ask each group to present their observation reports under the headings listed in Step 1. Invite discussion of the challenges they faced in the field and how they dealt with these.

Annex 7: Sample ID card for the peer educator

The outreach programme on HIV and AIDS and other sexually transmitted infections

Name and surname: .....

Occupation: Peer educator

Valid until: .....

Signature: .....

Please facilitate the work of the holder of this ID card and in case of emergency please contact:

.....

Annex 8: Sample letter introducing the peer educator (for example, to police officers)

The association .....is conducting an awareness campaign for young people on HIV and AIDS and other sexually transmitted infections.

Please facilitate the work of Mr/Mrs/Miss/Ms ..... , the bearer of this letter, who has been trained in this field and is assigned to do this job.

Signature: .....

Title: .....

In case of emergency, please call the following numbers: .....

Session 5

Time

1 hour 30 minutes

Objectives

At the end of this session, participants will be able to:

- define the concept of "referral", its principles and limitations
- identify the services available
- identify the roles and requirements of those providing referral services
- understand the features of a hotline
- identify how to build partnerships with potential referral services.

You will need

- Large sheets of paper, coloured markers, masking tape
- **Annex 9:** Objectives and features of the referral system
- **Annex 10:** The referral system and using a hotline service

The referral system

Overview

This session is related to the Problem Tree exercise (Module 1, Session 3). The discussions on essential components of referral systems and codes of conduct will inform subsequent work.

Activity: Available services

Step 1: Group work, presentations and discussions (1 hour)

1. Explain what a referral service is In just a few sentences. Then ask participants to work in small groups of four or five people. Ask them to draw a table with four columns on a large sheet of paper, using the words in bold in the bullet points below as headings for the columns. Ask the groups to think about a specific initiative of their outreach programme (perhaps that proposed for the target group in the observation exercise of Session 4). Ask them to discuss:
   - **types of services** needed by this kind of programme
   - **fundamental principles** informing any referral
   - **requirements of the referral service providers**
   - **ways to build and strengthen partnerships**
2. Ask each small group to present their completed table.

Step 2: Presentation on referral systems and hotlines (30 minutes)

3. Give an extensive presentation on referral systems using Annex 9 and explain how they should be linked to the programme. Invite any clarifications needed.
4. Give a short presentation on hotlines and what qualities hotline operators need (*see* Annex 10). Invite clarifications.

Mourad, 21, is unemployed and single in Algeria

"Thanks to the support and perseverance of the association psychologist, I was able to overcome all those difficulties, I regained my self-confidence, I accepted my positive status and got free from all the dark thoughts that had haunted me.

With the benefit of hindsight, I thank God and the people involved in this project who enabled me to discover my positive status before I got more ill and who enabled me to receive early care and treatment against the virus […].

APCS helped me and supported me a lot, morally and financially, because without their support I would really have been lost in the wilderness, and especially in our Algerian context, it is even doubly more difficult to say that I am a homosexual living with AIDS."

Annex 9: Objectives and features of the referral system

Definition

The referral system is the means by which the programme responds to and addresses the needs of beneficiaries of their outreach work. It responds to efforts to identify, prioritise and provide the support services required by those who are to be reached by peer educators. It facilitates access to existing services, working with organisations/associations willing to provide assistance or services. This helps to pave the way for these organisations/associations to make their services as accessible to MSM as they are to their other clients, in an environment free from stigma and discrimination. In this way, the associations can become involved in capacity-building their staff and determining how they approach the target groups.

How to establish a referral system

- Review existing services and organisations in the area where the intervention will take place.
- Visit organisations, introduce the programme and suggest ways of collaborating.
- Develop a memorandum of understanding (MoU) and get it approved by the parties concerned.
- Train service providers from the organisation in accordance with the signed MoU.
- Organise regular evaluation sessions and follow-up meetings to monitor results.

Objectives of referral systems

- To ensure that populations at risk of HIV and other sexually transmitted infections (STIs) have access to available local services.
- To collect information about the type of services required by MSM, and those currently available.
- To provide services that respect the need for confidentiality and that understand the breadth of circumstances of MSM.

Essential principles for effective referral systems

- Respect for the privacy and confidentiality of MSM.
- Provision of comprehensive, accurate and relevant information.
- Ability to ensure easy access to relevant health and social services.

Referral service providers must:

- be well-trained and supervised
- offer preventive healthcare services and material appropriate to culture, age and sexual orientation
- provide services in line with the programme's referral system code of practice in an environment that encourages privacy and confidentiality, free from judgment, stigma and discrimination
- liaise with other available services and programme field supervisors
- document services provided and keep that information confidential.

Types of referral services

- Guidance on reproductive and sexual health
- Medical examination, prevention and treatment of STIs
- Support to parents to understand their children's sexuality
- Guidance and follow-up for people living with HIV
- Voluntary counselling and testing for HIV and other STIs
- Healthcare: medical clinics, laboratory and dispensary
- Social and psychological support and referral
- Social care: home visits and one-to-one sessions
- Legal aid and other specialised services
- Guidance, follow-up and rehabilitation of people who use drugs
- Support groups
- Hotlines

Annex 10: The referral system and using a hotline service

Definition and objectives of a hotline service

A hotline provides a response to callers' queries during calls of 10 minutes or less. A team experienced in counselling and follow-up assesses each caller's risks in relation to HIV and other STIs. The team:

- provides information on preventive measures to reduce the risk of HIV and other STIs
- provides the caller with information on appropriate available services within the local community
- encourages the caller to use services detailed in the referral system.

Ethical principles

The hotline service must:

- protect the confidentiality and privacy of every caller
- provide appropriate and accurate information, with respect and without prejudice, regardless of the cultural and social status, behaviour, sexual orientation and/or age of the caller.

Session 6

Time

4 hours

Objectives

At the end of this session, participants will be able to:

- define long- and short-term goals
- determine the best strategies for achieving the goals
- select target groups
- identify activities that can be implemented
- determine the team members required for a given initiative and their various responsibilities
- establish a structure for the intervention team
- identify the resources needed for the intervention
- refer to relevant organisations/associations.

You will need

- Large sheets of paper, A4 paper, markers, masking tape
- Handouts (one per group) of the table provided in Annex 11, with the second column left blank, plus a complete **Annex 11** (one per participant)
- **Annex 12:** Implementation of the outreach programme

Designing an MSM outreach programme

Overview

This session once again requires participants to draw on their experiences in the field.

The more varied the participants, the more interesting the exercise. If you only have peer educators attending, consider inviting field supervisors and programme planners along as well.

Activity: Development of the referral system

Step 1: The planning process (2 hours 30 minutes)

1. Ask participants to work in small groups. Give each group a large sheet of paper, a marker and a copy of the table provided in Annex 11 with the second column left blank. Ask them to discuss a programme initiative provided for MSM, drawing on their own work experience. They will need to identify content for each stage of the planning process that is listed in the first column of their tables.
2. Ask them to draw a copy of this table on to their large sheet and enter into the second column the content they have identified for each stage. Explain that their plans need to be realistic and not overambitious.

Step 2: Group presentations and discussion (30 minutes)

3. Ask each group to display their plans as a wall panel. Invite the groups to view each of the wall panels in turn. Ask for any clarifications needed.

Step 3: Presentation on programme planning (30 minutes)

4. Using the headings in Annex 11 as guide, take participants through the stages of planning an outreach initiative (long-term goals, short-term objectives, activities, etc.). Distribute the complete version of Annex 11 as an example of planning. Ask groups to visit their wall panels again and identify any corrections they might want to make following feedback from the other groups.

Step 4: Presentation on structures used to implement interventions (30 minutes)

5. Give a short presentation using the example of the organigram provided in Annex 12. Ask for any clarifications needed. Ask each group to revisit their wall panel and quickly identify the structures they would need to establish for their plan. Ask them to note these on an A4 sheet and stick it on to their wall panel.

Annex 11: Sample implementation exercise

PLANNING THE INTERVENTION PROGRAMME	
Overall objective: what are the long-term goals?	■ Reduce the number of HIV infections among MSM
Define the best strategy: what could be done to reduce short-term problems?	■ Raise awareness among the target group and in the gathering places of sex workers ■ Provide voluntary counselling and testing (VCT) services for HIV
Who is the target? Are there direct and indirect target groups?	■ Direct target groups: men who have sex with men in exchange for money ■ Indirect target groups: owners of venues where men have sex with men
What are the tasks/activities?	■ Awareness-raising during outreach about HIV and other STIs ■ Distribution of publications and business cards for the VCT services ■ Distribution of condoms
What are the messages that could help to alleviate the risks of this target group?	■ The use of condoms for self-protection
Who could give these messages? Who is the team?	■ A team of trained peer educators, some of whom are former sex workers
What supportive financial and human resources would the team need?	■ Male condoms ■ Flyers with messages ■ Awareness-raising publications ■ Support from the institutions concerned ■ Support (or at least no opposition) from decision-makers

Annex 12: Implementation of the outreach programme

Various structures are used to implement intervention programmes. However, all of them should seek to access MSM, their sub-groups and those most in need of the knowledge and skills necessary to adopt behaviours to reduce risk of HIV and other STIs.

A typical structure may include a:

- steering committee
- programme coordinator
- field supervisors
- peer educator
- professional team of social and health workers.

The steering committee

- Consists of decision-makers from the National AIDS Programme, representatives from United Nations (UN) agencies, representatives from ministries of health and social affairs, plus possible members from academia, media or churches/mosques/temples. It should also include some influential community members.
- Members come from different backgrounds with different languages and perspectives (legal, health, human rights, etc.).
- Members are appointed following individual meetings with steering committee organisers, who explain the importance and objectives of the programme. The organisers also probe any conflicts of interest among potential steering committee recruits.
- Includes meeting coordinators, who must be aware of the limits of the roles of the committee members and be vigilant for any possible interference and/or obstruction, or any breaches of confidentiality.

Responsibilities of the steering committee

- Oversee and participate in programme planning processes, discuss challenges and opportunities, and endorse the plans developed.
- Review and enable the programme to build on previous experiences/success.
- Ensure mechanisms are in place to address security issues.
- Ensure and support publication of programme results.
- Analyse street intervention results and use outcomes to establish the programme's future plans. Also ensure that programmatic experience informs national plans and strategies.

Roles and responsibilities of the programme coordinator

The programme coordinator may be the director of the organisation running the intervention programme, or an experienced staff member in an outreach or similar programme. They should have social work experience and be trusted by local organisations and authorities. They may participate in referral system training, and are in charge of steering committee activities, such as meetings. Their most important function is to provide support to the field supervisor and peer educators.

Session 7

Time

2 hours 15 minutes

Objectives

At the end of this session, participants will be able to:

- define the roles and responsibilities of field supervisors and peer educators
- identify a set of professional ethics for the programme and its staff

You will need

- Two large sheets of paper, one headed with the first question provided in Step 1 and the other headed with the second question
- Post-it notes and markers
- Flipchart
- **Annex 13:** Characteristics and duties of field supervisors
- **Annex 14:** Duties of peer educators
- **Annex 15:** The pledge

The roles and ethics of field supervisors and peer educators

Overview

This session clarifies the roles and responsibilities, and shared goals, of field supervisors and peer educators. Try to include programme developers in this session, as it will help them to set up the intervention's code of conduct in the field.

Activity: The roles of field supervisors and peer educators

Part 1: The roles of field supervisors and peer educators

Step 1: Group work (30 minutes)

1. Divide participants into two groups. Give each group a prepared large sheet of paper, one of them headed with the first question provided below and the other headed with the second question:
   - *What do you think are the responsibilities/limitations of the peer educator?*
   - *What do you think are the responsibilities/limitations of the field supervisor?*

Step 2: Sharing and discussion (30 minutes)

2. Ask the group to discuss their question and then write on Post-it notes all of the points they agree on. Instruct them to use a different Post-it note for each point. Ask the group to stick their Post-it notes on to their large sheet and to display this as a wall panel.
3. Invite each group to look at the work of the other group and ask for any clarifications needed. Ask participants to make any additions or corrections to their sheets that were agreed during this discussion.

Step 3: Presentation on the roles of field supervisors and peer educators (15 minutes)

4. Summarise the different roles and responsibilities using Annexes 13 and 14. Ask for any clarifications needed after each part of your presentation.

Part 2: Professional ethics

Step 1: Brainstorming ethical principles (30 minutes)

5. Ask participants to brainstorm the professional ethics that should be observed by any programme staff member from first point of contact with the beneficiary. For example, these should include principles such as privacy, confidentiality, safety, objectivity, non-discrimination.
6. Record these on a flipchart sheet. Review the list and check for appropriateness and understanding. Then finalise a list focusing on professional ethics in the field.

Step 2: The pledge (30 minutes)

7. Present the idea of a pledge and provide Annex 15 as an example. Discuss and invite questions and comments. Ask participants how they would feel about having to sign a pledge like this. Probe what they consider are the advantages and any disadvantages. Ask participants to work for a few minutes in informal groups (turning to their neighbour) to prepare pledges for both peer educators and field supervisors.

A peer educator from Oui Pour la Vie, Lebanon

"I believe in youth, who have to play a great role in society, but they have to protect themselves. I love social work. I can work with a team and I know how to communicate with others. I will respect the codes of the work and act as a responsible person."

Annex 13: Characteristics and duties of field supervisors

Selection criteria (adapt according to region/country)

Field supervisors should:

- have demonstrable experience of working with MSM
- have a sound understanding of the limits of their role and responsibilities
- have demonstrable commitment to and experience of protecting the rights of beneficiaries
- work in a manner that respects the local environment
- communicate self-confidence
- understand and respect the privacy and confidentiality requirements of the programme, and demonstrate their ability to maintain confidentiality
- have a sound understanding of, and be up to date with, current knowledge on risk/harm reduction information related to HIV and other STIs
- be experienced in dealing with the associations/ institutions participating in the referral system
- be able to establish demonstrable good relationships with associations/institutions participating in the programme.

The field supervisor may or not may not share the same identity as the range of MSM addressed by the programme.

Duties of field supervisors

- Coordinate and manage the teamwork.
- Develop and draft the street intervention plan.
- Be present with peer educators on duty as and when needed.
- Support peer educators through group and one-to-one meetings to assess cases.
- Provide support to peer educators when they are experiencing psychological pressure.
- Attend relevant events and programme committee meetings.
- Liaise with associations in the referral system.
- Document outreach work.
- Review the field reports submitted by peer educators.
- Organise additional intervention activities (e.g. a mobile unit to provide counselling and voluntary testing) as required and if resources allow.

Annex 14: Duties of peer educators

- Meet beneficiaries in their environment.
- Conduct awareness-raising sessions in the street.
- Ensure that beneficiaries receive the information they need, and that the centre where they work has the resources and capacity to provide support.
- Acquire appropriate and sufficient training on the core knowledge and skills required for their work, and take up any ongoing training provided by the programme.
- Acquire appropriate and sufficient training on the referral mechanism and referral techniques.
- Maintain a good working knowledge of services available within the referral system.
- Keep the programme coordinator up to date regarding peer educators' whereabouts through time schedules prepared for each outreach initiative and by attending regular meetings.
- Attend monitoring and evaluation (M&E) meetings.
- Share experiences with peers.

Annex 15: The pledge

The pledge

(Example of a peer educator oath)

I value my role in this programme, and in order to perform my role effectively I pledge to:

- respect my work environment and its confidentiality
- accept individuals' differences, including their choices that may differ from my own
- act as a leader, making healthy choices and being honest with myself
- appreciate difference in all its forms
- maintain confidentiality
- acquire as much information as possible about topics related to my work
- provide only information that I understand, with accuracy and credibility
- commit to the wellbeing of beneficiaries and the work team
- talk with beneficiaries about their daily issues and circumstances, and support them in making positive changes
- understand the importance of monitoring and follow-up
- not allow my role to expose me to any psychological, physical or legal harm.

I value who I am

I am a supportive, educated human being and a leader

Session 8

Time

3 hours

Objectives

At the end of this session, participants will be able to:

- discuss the programme's ethical framework
- list the basic principles of the programme
- describe how ethics function in the field.

You will need

- Large sheets of blank paper, markers
- One large sheet of paper containing the table from Step 2, for demonstration
- Flipchart
- **Annex 16:** Ethics and human rights

An ethical framework for implementation

Overview

In this session, participants will explore how an ethical framework operates in practice, and how wider attitudes towards MSM can either hinder or enable their ability to access effective supportive referral services.

Activity: Respecting the confidentiality of target groups

Step 1: Discussion (30 minutes)

1. Discuss important ethical considerations when planning the programme, such as respect for local culture. Talk about the challenges involved in protecting both the target group and the community against HIV and other STIs, while operating within human rights and public health rights boundaries.
2. Use Annex 16 to emphasise the particular importance of applying sound professional ethics at all times, since MSM are vulnerable in their different ways to stigma, exclusion and violation of their human rights.

Step 2: Identify the professional ethics that should apply to outreach work (1 hour)

3. Divide participants into small working groups. Hand each group a large sheet of paper and ask them to draw the table on your demonstration sheet.

STAGES OF THE INTERVENTION IN THE STREET	WHAT WE NEED TO OBSERVE IN TERMS OF PROFESSIONAL ETHICS
Planning	
Implementation	
Closing the session/wrap up	

4. Ask them to discuss and write in their table what professional ethics should be observed at each stage. For example, in planning there may be ethical considerations regarding relationships with referral services or selection of peer educators.

Step 3: Sharing and discussion (1 hour)

5. Ask each group to briefly present their work and then display it as a wall panel. As each group names the professional ethics they have identified, prepare a summary list of these on a flipchart page. These might include:
   - Privacy and confidentiality
   - Respect for the health of the group
   - Avoiding prejudice
   - Protecting the work team and the target groups
6. Invite comments and questions for clarification, and correct any errors or misunderstandings. Review the final flipchart list. Identify and discuss likely challenges that may arise. Remind the group of the pledge they developed in Session 7.

Step 4: Presentation (30 minutes)

7. Give a presentation on ethics and human rights using Annex 16. Invite questions for clarification at appropriate points as you work through the annex contents.

A peer educator from SIDC, Lebanon

During the outreach work we can encounter people who are homophobic and we can face sexual harassment.

I want to tell about an incident while I was doing outreach with my friends. While I was giving information to an MSM in the street, he started to say that MSM are sinners and dirty people, this is why they are more vulnerable to get infected with HIV. I was very nervous but I tried to relax, and I answered him with objectivity that HIV is transmitted through unprotected sexual intercourse with an infected person in all cases, whether the person is heterosexual or homosexual, if he is poor, educated, rich. Afterwards he started to say he knows many MSM friends who do orgies and unsafe sex, and it might be useful for them to use condoms. Then before we left, he put his hand on my shoulder and said that doing sex with a person like me who is "clean" is full of pleasure. I removed his hand gently and told him that I am not present here to have appointment but I am doing outreach only.

What I learned from this experience is that we might face people that do not encourage us and who can be offensive, we might encounter MSM who do not disclose themselves because of society and the misconceptions they have. We have to be always ready as peer educators to face these situations with courage and to deal professionally with harassment."

A peer educator from Oui pour la Vie, Beirut, Lebanon

Before we start the outreach work, we have to discover the place where we are doing the work. I encountered a lot of problems. I dealt with MSM who tried to steal from me, others were aggressive, they lied to me, and others were using drugs. It is important in my opinion that the peer educator should act wisely and to be trained to deal with vigilance with different situations and personalities."

Annex 16: Ethics and human rights

We use ethics to decide on what is right and what is wrong, assessing our obligations and modifying our behaviour to make informed decisions. Our fieldwork may involve working with individuals outside of mainstream society (e.g. street children, people who use drugs, homeless people), sometimes in risky or dangerous environments, but our approach to ethical working should always be the same whatever the context. To maintain a sound ethical base, we need to:

- understand the varied nature and needs of the group with whom we work
- appreciate the relationship between MSM and the wider community (however detached each individual may be)
- maintain a healthy respect for the dignity and personal values of each individual
- show an interest in the needs and circumstances of each individual
- maintain privacy and confidentiality
- appreciate and respect differences
- realise that relationships based on honesty, respect and trust are fundamental to self-fulfillment
- be aware of wider safety issues and threats to these for peer educators, target group members and the wider community.

Field supervisors, or the team carrying out the intervention programme, may have to handle situations that challenge their professional and personal ethics. These challenges may include:

- homophobia, harassment and insults
- disclosure of confidential information
- fraudulence in preparing reports, documenting names and recording project funding
- failure to protect those participating in research or sharing life stories
- manufacturing non-existent needs or exaggerating situations
- use of published or archived images of beneficiaries without their consent
- harassment of the target group and failure by staff to abide by their professional ethics
- human trafficking involving beneficiaries
- staff or beneficiaries getting into trouble with the authorities or the community.

Human rights

Any street intervention for MSM should be human rights based, incorporating principles of:

- respect
- self-sufficiency
- privacy and confidentiality
- protecting/respecting the body and mind of each person
- equality
- building friendly relationships with others.

Any attempt to help must respect the rights of everyone involved in the outreach work, throughout all stages of implementation. There are significant ethical considerations to take into account at each stage.

The peer educator should:

- self-assess and evaluate their own work, and consent to management supervision of their work
- maintain the privacy and confidentiality of beneficiaries
- ensure that documentation or reporting is done in a safe place in order to maintain confidentiality and privacy
- always protect the individual's rights, free from stigma and discrimination on the part of the peer educator
- avoid harassment and abuse (e.g. by repeating something that might offend)
- work with sensitivity to the feelings and problems of beneficiaries
- be aware of the various types of relationship that they may build with beneficiaries (some may last and require follow-up, time and energy, while others may just involve providing one-off information)
- avoid making the target group dependent
- allow beneficiaries to go to service centres
- perform their duties with integrity (e.g. do not accept gifts; do not participate in "unruly" activities, or activities that might jeopardise the programme's good name; address issues objectively and courageously)
- have a sense of responsibility, as conditions may change from week to week (the environment, emotions, policing, the level of alcohol abuse) requiring flexibility
- respect public principles and ethical standards
- maintain public support by respecting the rules of the places they visit.

Annex 16: Ethics and human rights

STAGES	POINTS INFLUENCED BY OR REQUIRING ETHICAL CONSIDERATIONS
Planning	■ Design and preparation: relationship building, understanding without pre-judging the problems, needs and situations of target groups ■ Decisions regarding team selection and training of peer educators ■ Working to identify referral services ■ Developing a "safe" operating framework for implementation that protects both peer educators and beneficiaries ■ Setting up a system and measures to mitigate risks and protect the safety and confidentiality of personal data of beneficiaries and implementers
Implementation	■ Informed consent ■ Providing information, and engaging in dialogue when distributing preventive resource material ■ Safety of beneficiaries regardless of ability (physical/psychological) ■ Safety of peer educators ■ Data safety and protection ■ Provision of on-the-spot services (peer educator intervention) ■ Provision of referral services that are holistic, ensure the effectiveness and efficiency of the intervention, and preserve its values
Wrap-up	■ Documentation and report writing ■ Working within the team (before and after the fieldwork) ■ Sharing results to improve performance

Informed consent

- Ensure that the beneficiary understands all the information related to their situation and the consequences of any decisions (time the visit so that the beneficiary is sober).
- Obtain the beneficiary's informed consent prior to the intervention (their right to refuse assistance).
- Take into account the intellectual and mental capacities of the beneficiary, and any inability to make informed decisions on their own.

Data protection

- Strictly abide by the procedures set up by your organisation to ensure that data, in particular personal data about your beneficiaries, is protected from access by individuals, groups or organisations that might cause harm to MSM.
- The procedures set up to ensure data protection should clearly address the challenges and risks of using real names and contact details, and define clearly what type of personal information should be recorded, preferably coded, how it should be stored (paper and electronic files) and protected from unwanted access. Wherever possible, data should use unique identifier codes rather than real names.
- Organisations should determine how long personal data will be kept and how it will be destroyed.

Confidentiality

- Ensure the beneficiary's privacy and confidentiality at all times.
- Do not share any information without the prior consent of the beneficiary.
- Do not share confidential information with the team and/or service providers except on a need-to-know basis and with the prior consent of the beneficiary.
- Inform the beneficiary of any change to the plan or agreement.
- Involve those with vested interest in the wellbeing of the beneficiary.

Disclosing private information is appropriate where:

- the beneficiary is intending to harm themselves or others (overdose, suicide attempt, harmful or violent behaviours, revenge, planning to infect someone with HIV)
- the beneficiary is incapable, for psychological reasons, of understanding the consequences of their risk behaviour or of making decisions that may adversely affect their life or the lives of others.

Session 9

The M&E system and measuring impact

Time

1 hour 30 minutes

Objectives

At the end of this session, participants will be able to:

- discuss the importance and objectives of the M&E plan
- identify the respective roles of the field supervisor and peer educator in data gathering
- understand the role and process of supervision.

You will need

- Flipchart
- One or more large sheets of paper with questions written on it that are listed in Step 2. Allow enough space between questions for participants to attach Post-it notes
- Masking tape
- Post-it notes
- **Annex 17:** Supervision, monitoring and evaluation of the work

Overview

This session helps participants to understand the process of clearly identifying the purpose and results of any intervention. It emphasises their importance as partners in monitoring and evaluation.

Activity: The objectives and importance of the M&E system and its impact

Step 1: Brainstorming (15 minutes)

1. Conduct a brainstorming session, asking:
   - *What types of activities are you are carrying out in the field?*
   - *What is the purpose of your work in the field?*
   - *What impact do you want to achieve?*
2. Record key points for each question on a flipchart page (for documentation purposes).

Step 2: Have we achieved our objectives? (45 minutes)

3. Pin up the large pre-prepared sheet/s of questions (see below). Ask participants to work individually. Give each participant a set of Post-it notes. Ask them to write their answer to each question on a Post-it note and to stick these on the sheet in the space below each question. Ask participants to read out their answers as they position their Post-it notes.
   - *Why is it important to know whether you have reached your goals?*
   - *Why is important to know whether your activities were appropriate?*
   - *Who has the answers?*
   - *How can you get the answers?*
   - *What sort of questions can you ask yourself in order to assess whether you have reached your objectives?*
   - *How can the programme help you to better perform your role?*
   - *Whose role is it to provide this help?*
   - *How can we measure your performance and the challenges you face?*

Step 3: Presentation on supervision, monitoring and evaluation (30 minutes)

4. Summarise the importance of monitoring and evaluation of outreach work using Annex 17. Discuss possible M&E tools, such as field reports, diary information and regular meetings.

Annex 17: Supervision, monitoring and evaluation of the work

Any intervention programme needs a protocol to outline how the work will be supervised with monitoring, evaluation and follow-up tools. This protocol must be in place before work begins and will develop as work is implemented and progresses, with changes made to the protocol based on international and national/regional-level guidance on possible modifications and improvements.

Supervision

The field supervisor oversees work progress, monitors on-the-job-performance and provides support and guidance where necessary, holding regular meetings with the peer educator either on a one-to-one basis or within the group. Peer educators can benefit from this access to someone with greater experience. They can turn to the field supervisor when faced with difficult or complex situations.

Supervision methods that can be facilitated by the field supervisor

The peer educator may:

- be asked to carry out an awareness-raising or wider education session in the street under the supervision of the field supervisor
- be invited to share any problems encountered by the beneficiary with the field supervisor, while maintaining confidentiality of the information
- share and review actual cases in group discussion under supervision of the field supervisor
- participate in training workshops designed to help workers to discuss challenges and difficult situations, and identify possible solutions
- consult an organisation specialised in fieldwork.

Monitoring

Peer educators are not responsible for monitoring work, but they should appreciate the importance of monitoring and may be involved in gathering related data.

The field supervisor monitors the programme's progress to ensure the quality of the work performed by the team in the field and to make any necessary adjustments. This also enables them to oversee the peer educators' progress.

Evaluation methods

- Case review and data analysis
- Individual interviews and within groups
- Separate group discussions with each category
- Team questionnaire to monitor on-the-job performance and to get feedback from beneficiaries
- Overall documentation and daily reports
- Record-keeping, including evaluation forms
- Assessment of quality of work and whether it was carried out according to the proposed standards

The peer educator should keep up-to-date with each beneficiary's progress and make sure that they understand any actions that are needed. In the case of referrals made to other services, the peer educator should follow up and get feedback from the service provider (e.g. whether the individual went to the appointment and what were the benefits of the visit) and record this. The field supervisor should ensure that the peer educator is on track with their work.

Annex 17: Monitoring and evaluation of the work

SUPERVISION AND EVALUATION			
WHO	**WHAT**	**HOW**	**METHODS USED**
The peer educator	■ Self-monitors. ■ Monitors the impact of their work in the field. ■ Monitors certain events in the street.	■ Reports.	■ Daily report with comments on job performance, the number of beneficiaries accessing services and any other matters. ■ Personal notes about fear, feelings and strengths.
The field supervisor	■ Checks results of the street intervention, analyses them and asks questions. ■ Evaluates job performance. ■ Monitors the results of the fieldwork. ■ Supervises the performance of the peer educators. ■ Supervises the performance of the peer educators. ■ Undertakes field/ outreach monitoring visits, completing the necessary forms and writing reports.	■ Regular meetings with the field/ outreach work team. ■ Evaluates an awareness session in the street.	■ Individual meetings and follow up with the peer educators. ■ Reviews the reports of the peer educator. ■ Organises peer educator meetings to look at recurring problems. ■ Evaluates peer educator awareness sessions at the end of their shift and shares results during team meetings. The field supervisor may also ask for a one-to-one meeting to discuss points raised. ■ Uses a few standard questions: – Did you have enough time to answer all the beneficiary's questions? – Did the meeting end on a good note? – What was beneficiary feedback? Would he come back? – As a peer educator, how did you feel the session went? – How can it be improved? – What is the best way to improve the awareness session?

Session 10

Documentation and evaluation: communicating results

Time

2 hours 15 minutes

Objectives

At the end of this session, participants will be able to:

- understand the importance of documentation and identify components
- make the link between documentation and communication in the street
- identify the challenges of documentation
- list key issues for documentation
- understand and identify indicators
- be familiar with the intervention documentation forms and their uses.

You will need

- Large sheets of paper, A4 paper, markers, masking tape
- **Annex 18:** Documentation and communication related to the outreach programme
- **Annex 19:** Guidance for contents of documentation templates
- **Annex 20:** Definition of indicators and methods of measurement

Overview

This session offers participants a chance to develop report-writing templates. It highlights the importance of documentation in identifying the effectiveness of the programme. The work during this session is just a first step, and the templates may be further developed after testing them in the field. The programme developer's involvement in the session will help in developing and evaluating template contents.

Activity: Observing, documenting and evaluating work

Step 1: Presentation and group work (1 hour)

1. Discuss the importance of documentation and present the specific role of the peer educator in gathering information for documentation (*see* Annex 18).
2. Ask participants to work in small groups of four to five people. Give each group a large sheet of paper, a supply of A4 or similar sized paper and markers.
3. Ask them to spend time in personal reflection to consider the information they should be recording as peer educators, from the first moment of an intervention until its conclusion and their return to base. Ask them to list the points they identify.
4. Ask each group to discuss their individual points and agree on a final set. Then ask them to use their large sheet of paper to design a template for recording these points. Ask them to enter the points on to their templates, and also indicate when and where different parts of the template should be completed.

Step 2: Sharing and discussion (30 minutes)

5. Ask groups to display their final template as a wall panel. Invite groups to inspect each other's proposed templates. Take questions for clarification of each template. Ask participants to say what they think are good features of each proposal and what areas might need changing, correcting, improving or removal.

Step 3: Presentation of guidance for developing templates (15 minutes)

6. Distribute and discuss guidance in Annex 19, followed by questions for clarification.

Step 4: Indicators – presentation and discussion (30 minutes)

7. Present the definition of "indicator" (*see* Annex 20). Give examples highlighting the importance of indicators as means of gathering evidence of the effectiveness of initiatives carried out to achieve the programme's objectives. Present the different types of indicators and ways of verifying or measuring these.

Annex 18: Documentation and communication related to the outreach programme

Documentation and communication allows us to monitor and promote the success of the outreach programme and ensure future support by sharing results with different partners.

The peer educator plays a key role in gathering this information objectively and precisely by:

- logging their activities (with whom, when, how and what you propose to do in the future)
- recording the details of any success stories
- documenting challenges encountered, how you dealt with them and any need for further action
- writing and submitting periodic reports to management.

Such information helps in planning the work of the organisation, and can provide information to stakeholders and decision-makers about new cases. It can also be used when referring the beneficiary to other services.

To be effective, all documentation should be:

- clear
- concise
- respectful of confidentiality and privacy.

Annex 19: Guidance for contents of documentation templates

Documenting the planning and implementation of interventions and their outcomes can require what sometimes seems like an overwhelming amount of paperwork. It is important to identify who has responsibility for each stage of documentation and to ensure that individuals do not get bogged down or absorbed by constantly filling in forms. The following table suggests the types of forms that may prove useful.

TYPES OF FORMS	TO BE COMPLETED BY
Specific form for the programme	Programme coordinator?
Work documentation form	Field supervisor?
Activity form (date of activity, workers, number of beneficiaries, etc.)	Peer educator
Peer educator report (per activity)	Peer educator
Field supervisor report (monthly)	Field supervisor
Case study form	Peer educator?
Follow-up form for beneficiaries	Peer educator
Template for daily journal	Peer educator
Template for follow-up on risk behaviours (as an attachment to the peer educator report)	Peer educator

Annex 19: Guidance for contents of documentation templates

The following table offers guidance on the contents of each type of form, and on security measures to implement related to storage of and access to information documented.

TYPES OF FORM	CONTENT
For work documentation forms, you should record	■ Date and time of intervention in the street ■ What was successful about what you did ■ What you would do differently next time ■ Feedback from the target groups
For peer educator reports, you should document	■ Date and time of intervention in the street ■ Name of peer educator/ID number/code ■ Place of intervention: cafe, public square, suburb etc. ■ Target group: age, sex, social status ■ Information provided ■ Risk behaviours that have been addressed ■ Resource materials that were distributed ■ Decisions made and questions not answered for some reason (write down the reason) ■ Services required and referrals made ■ Problems and obstacles encountered
For the process of report-writing and record-keeping, you should ensure these points are adhered to	■ Reports containing specific and personal information must be kept in a safe place ■ Have a lockable filing cabinet for keeping files, documents and M&E records ■ Use a computer for electronic record-keeping and data entry ■ Limit eligibility to access and refer to the reports ■ When working from home, take only documents that do not violate work privacy and confidentiality
Follow-up forms for beneficiaries can be one of two types	■ Information form – for use after several encounters with the beneficiary and after having studied his case (health condition, needs, etc.) ■ Case progress form – for taking notes after each meeting with the beneficiary (it helps to monitor the change in behaviour)
Template for daily journal	■ A notebook in which the peer educator writes their notes during or immediately after a street intervention. They may include thoughts, feelings, ideas emotions, reactions, strengths and concerns
Template for follow-up on risk behaviours (as an attachment to the field report)	■ Choose a group of beneficiaries and fill in an evaluation form about their knowledge before the intervention ■ Give them a code ■ Do weekly visits and document the quality of services provided ■ Fill out an evaluation form two months after the intervention to measure the level of any change in behaviours

Annex 20: Definition of indicators and methods of measurement

It is important that the intervention programme reaches the largest possible number of MSM, improving their knowledge on prevention, supplying them with resource materials, referring them to service centres as needed, and ensuring that they do actually visit the centre. The programme indicators are what help the programme planners to measure whether these objectives have been achieved.

- **Quantitative indicators** deal with numbers: the number of condoms distributed, people reached in the programme, street visits, rapid tests, etc.
- **Qualitative indicators** deal with the nature of the intervention in the street: condom demand from beneficiaries to the peer educator; asking additional questions; improvement in knowledge; what the ministry of health thinks about the programme; types of articles written about the programme or references in audio-visual media, etc.

The table below identifies three different indicator methods, and their advantages and disadvantages. These methods are regularly used by civil society organisations in MENA. Review them and discuss which is one is more suitable given the context, M&E experience and resources.

METHOD	IMPLEMENTATION METHOD	DOCUMENTATION AND THE BENEFITS OF INTERVENTION AND INDICATORS ANALYSIS	ADVANTAGES AND DISADVANTAGES
1	Identify the location of the intervention and determine the number of peer educators and the hours and days spent preparing before going to the street. The documentation should be based on multiple interventions and observation of the movements and type of target groups and their relationships. You can then ask peer educators to do awareness sessions in the street, recording the number of people they meet, what activities they have carried out, the number and type of condoms distributed, as well as other resource materials. They may revisit the same place, but should record the number of new people they encounter each time. This means remembering the people met previously, so sending the same team is useful. The group usually frequents the same place for a while before moving to another location.	A form to be filled out at every intervention.	■ Benefits are in accordance with needs. ■ Can provide counselling services in a mobile unit in some places. ■ Reach a large number of beneficiaries. ■ Speed of providing resources. ■ In some places it may not be possible to distribute condoms, so peer educators may have to make several visits, more than once a week, in order to give out condoms to the same people. ■ Intervention varies according to area rather than need. The environment affects the extent of the intervention.

Annex 20: Definition of indicators and methods of measurement

METHOD	IMPLEMENTATION METHOD	DOCUMENTATION AND THE BENEFITS OF INTERVENTION AND INDICATORS ANALYSIS	ADVANTAGES AND DISADVANTAGES
2	Ask the same peer educators to go to the same area and build relationships with just five people. Continue to see them for a month and then assess their knowledge, behaviour and needs. After that period, assess their levels of knowledge and behaviour, and assess whether a follow-up session is needed or not, determining the nature of follow-up (once a month, appointments outside of the area, and so on).	■ ID card for each beneficiary to keep. ■ Assessment form to measure knowledge and behaviours when handing the card to the beneficiary and before starting the awareness session. Follow up for a few months, after which re-assess and compare notes on the level of knowledge and change of behaviours. ■ A form for each intervention stating if any problems occur. Add the type of intervention on the beneficiary form.	■ Monitors development and behaviour changes. ■ Nurtures a good relationship with beneficiaries and raises their confidence. ■ Only a limited number can be reached. ■ The beneficiary must carry an ID card and present it when accessing services and when being visited by the peer educator.
3	Ask peer educators to find five people. Give each of them a means of identification. They in turn have to find five more, and so on until more and more people (from more diverse backgrounds and sub-categories) are attracted to the programme.	Has been successful in other countries. Used in our areas, and in particular in the studies.	■ Beneficiaries come looking for the peer educator and not the other way around. ■ Requires long-term perseverance. ■ Numbers may drop.

Session 11

Problems and challenges in data collection

Time

1 hour 30 minutes

Objectives

At the end of this session, participants will be able to:

- identify and address the types of challenges that a peer educator, a field supervisor and a programme developer may encounter when collecting data.

You will need

- Three large sheets of paper prepared with the questions for each of the groups
- Markers, masking tape

Overview

In this session, participants draw on their own or others' work experience to identify the challenges experienced by different staff members when attempting to collect data, and to develop workable strategies for addressing these challenges. The strategies proposed can be added to the programme's manual of good practice for awareness-raising and making referrals. The facilitator also discusses data protection and the challenges and risks around keeping the personal data secure.

Activity: The challenges of data collection

Step 1: Group work (30 minutes)

1. Divide participants into three groups. Ask each group to work on one of the questions below, and give them the relevant pre-prepared sheet. Vertically divide a flipchart sheet and ask them to discuss their question, then to list their answers on one half of the sheet, leaving the second half empty.

   Group 1: *What type of challenges might a peer educator encounter when collecting data and why?*

   Group 2: *What type of challenges might your organisation encounter ensuring that personal data is kept secure and confidential?*

   Group 3: *What type of challenges might a programme developer encounter when assessing data and why?*

Step 2: Responding to challenges (30 minutes)

2. At the end of Step 1, swap around the sheets of the three groups. Ask each group to read through the points listed on their new sheet. Ask them to answer the question below for each challenge recorded and to write their answers in the empty half of the sheet:
   - *How might they face each challenge on the list?*

Step 3: Presentation and discussion (30 minutes)

3. Ask each group to present the work recorded on the sheets they are currently holding. Invite comments and reactions from the other groups. Ask the presenting group to add to their sheet any further relevant points that emerge in discussion. Finish the session by stressing the important role of the field supervisor and the peer educator in terms of collecting accurate data, and the need to formulate strategies for addressing challenges encountered. Discuss the pros and cons (including feasibility, practicality, usefulness, security) of paper vs electronic records, and if electronic the ability to use secure cloud storage vs hard drive storage.

4. Remind of the absolute requirement to maintain confidentiality, and stress the challenges and risks of using real names, contact details and keeping these in paper as well as electronic records. Data that identifies locations or individuals, in particular personal details (real names, phone numbers) must be handled with strict confidentiality and protected from access by individuals, groups or organisations that might cause harm to men who have sex with men. Peer educators should strictly implement the procedures set up to ensure security, safety and privacy of personal data.

Session 12

Problems and challenges in the street

Time

2 hours

Objectives

At the end of this session, participants will be able to:

- identify potential challenges and ways of dealing with them
- analyse how to deal with difficult situations
- elaborate on the importance of safety for the peer educator and beneficiary/ target group, and how this is linked to the safety and credibility of the intervention
- identify and apply the measures that must be adhered to.

You will need

- Paper and markers
- Flipchart
- **Annex 21:** Some of the challenges that may present in the field
- **Annex 22:** Stress

Overview

This session helps the group to understand that this type of work causes stress and that they should be open to confiding in their managers. Don't over emphasise the psychological impact of the work. Highlight the fact that throughout the programme there will be meetings where they can talk about any stress they experience and how to overcome it. Involve programme developers in this session, as they should be aware of issues affecting the safety and effectiveness of the programme as a whole.

Activity: Challenges in the field and how to deal with them

Step 1: Brainstorming and preparation of the list (15 minutes)

1. Ask participants to brainstorm the possible risks/harms they may encounter in practice during their work. Jot down on a flipchart page key words for the risks they have named.

Step 2: Cases, presentation and discussions (1 hour 15 minutes)

2. Ask participants to work in pairs. Number off the risks listed in Step 1. Allocate one or more risks to each pair until they have all been distributed. Ask each pair to create a story of a work experience where the events lead to exposure to one or more of the risks allocated to them.
3. Ask each pair to review their stories and to propose ways that might help the peer educator to minimise or completely prevent the risk developing. Invite each pair to tell their story to the whole group, complete with the strategies they propose for addressing their potential risks. When all of the stories have been told, ask participants to offer short comments on any strategies that particularly struck them as workable or not applicable.
4. Give a short presentation on dealing with possible challenges that may be present for peer educators (*see* Annex 21)

Step 3: Talking about stress (30 minutes)

5. Explain the particular importance of the peer educator's health and safety and that of the project or the programme as a whole. Talk about the stress that a peer educator may encounter and discuss ways of dealing with this issue, highlighting the supportive role of the field supervisor (*see* Annex 22). Let participants discuss and identify potential sources of stress in their work, and how they and their organisation deal with it, or could deal with it.

Annex 21: Some of the challenges that may present in the field

The nature of the programme

Street intervention and risk/harm reduction initiatives are new and controversial concepts, and it is sometimes difficult for local communities to accept that MSM are entitled to such services. Some health institutions may refuse to collaborate with the programme, publish its results, or provide services. The special needs of MSM may mean that some services are unavailable or prohibitively expensive, causing problems for programme planners, field supervisors and peer educators. Staff retention and finding competent peer educators may sometimes be a challenge.

Logistics

Logistics may also be difficult. Issues that present real challenges may include carrying out awareness-raising on the street; choice of places; coordinating with decision-makers in the field; earning trust; difficulties in monitoring the work; and written reports that are not up to scratch. Further challenges can come from the influence of peers; pressure to take part in risk behaviours; getting involved with the beneficiary; and dealing with the security forces. In addition, much of the work is voluntary, and the nature of the job can cause a great deal of stress and frustration.

The nature of the target group

Target groups considered to be "illicit" pose a further challenge. MSM may feel uncomfortable asking questions and talking about their sexual orientation, and in some cases may not take the work seriously, provoking peer educators and/or behaving inappropriately. In addition, they may fear carrying condoms and lubricants, distrust police, and suspect peer educators of collaborating with the authorities. All these factors may hinder peer educators and cause MSM to deny their risky behaviour or refuse to discuss it. The police may also raid their gathering places from time to time, which will delay the work.

Dealing with challenges

- Obtain support and approval from decision-makers and local organisations.
- Choose a team of peer educators in accordance with the criteria set for this work.
- Form teams consisting of peer educators and members drawn from outside the target group.
- Carefully map and survey places well in advance, and start with safe and accessible locations.
- Obtain approved ID cards for peer educators from the national AIDS programme or ministry of health.
- Ensure confidentiality of records, reports and meetings at all times.
- Avoid so-called “hot” spots where violence and hostility against the team or target group may occur.
- Hold regular meetings with team members, key community figures and/or target group members to resolve problems before they escalate.
- Observe public safety regulations and avoid getting into trouble.
- Ensure that there are always at least two people in the field, and liaise with the field supervisor to keep them informed of the team’s in and out times.
- Manage stress and don’t get emotionally involved in the problems of the beneficiaries.

Annex 22: Stress

Definition of stress, its causes and how to manage it

Stress is a state of mental, physical or emotional tension manifesting over a long period of time. Causes include:

- working with people who are experiencing personal problems
- working hard without reaching the desired outcome
- work overload or working unsupported
- holding back feelings and chronic worry.

At more advanced stages, stress turns into burnout and inability to cope with and manage work.

Stress management strategies

- Develop strategies for maintaining enthusiasm and job satisfaction, perhaps through periodic reviews focusing on your successes and achievements, or finding opportunities to see the bigger picture and not just the present stress-causing situation.
- Seek support for dealing with and overcoming stressful feelings, in particular discuss your feelings with the field supervisor.
- Share concerns and causes of stress with your colleagues to help you put these into perspective and see how they deal with similar situations.
- Keep abreast of work developments.
- Participate in training and workshops on a regular basis.
- Adopt relaxation and exercise techniques.
- Get involved in out-of-work activities.
- Establish a healthy balance between your professional and personal lives.

Appendix 1: Sample daily evaluation form for the workshop

To be completed by participants

Daily evaluation form

Were you able to achieve your goals for the day? Yes ☐ No ☐

Why? .....

What did you like most about today's work? .....

.....

.....

.....

What didn't you like about today's work? .....

.....

.....

.....

Overall, how would you describe yourself (circle what most corresponds to your feelings)?

Angry Bored Nervous Happy Very happy

Appendix 2: Sample evaluation form for each module

To be completed by participants

Did you find the information useful?	Totally agree	Agree	Don't know	Disagree	Totally disagree
Were the exercises useful?	Totally agree	Agree	Don't know	Disagree	Totally disagree

What was the most important exercise for you?.....

Write down one new thing that you learnt.....

Write down an attitude that you wish to change.....

Write down a new behaviour that you learnt.....

Any other suggestions?.....

.....

.....

.....

Appendix 3: Sample toolkit evaluation form

To be completed by the facilitator after using the toolkit

Please fill out the form below after using the toolkit, answering the questions as objectively as possible. Your contribution will help us to improve it.

Name .....

Occupation and work address .....

.....

The toolkit was used: when..... where ..... with whom.....

Did you find the toolkit useful? Yes ☐ No ☐ Somewhat ☐

Please elaborate.....

Did the toolkit help you to prepare practical exercises for the training workshop?

Yes ☐ No ☐ Somewhat ☐

Please elaborate.....

Was the language and terminology clear? Yes ☐ No ☐ Somewhat ☐

If your answer was "no" to the above question, please indicate the term and the page number .....

.....

How did you find the exercises?

Varied	Yes ☐	No ☐	Somewhat ☐
Energising	Yes ☐	No ☐	Somewhat ☐
Practical/easy to use	Yes ☐	No ☐	Somewhat ☐
Suited the objectives	Yes ☐	No ☐	Somewhat ☐

Did you need additional exercises when preparing the technical contents of the training workshop and would you like to see them added to this toolkit? Yes ☐ No ☐ Somewhat ☐

If your answer to the above question was "yes", please say what you needed .....

.....

Were the exercises in a logical order? Yes ☐ No ☐ Somewhat ☐

How can we better produce this toolkit? .....

.....

Were any sections not useful and could be deleted? Yes ☐ No ☐

If "yes", please list them.....

Were there any exercises that you preferred over others? Yes ☐ No ☐

If "yes", please list them.....

Overall, what did you think of the toolkit? weak ☐ acceptable ☐ good ☐ very good ☐ excellent

Appendix 4: Sample module report

To be completed by the facilitator

Once you have completed the pre- and post-evaluation forms, and read the results of the module evaluation, you are ready to write your final module report. You may use the following questions to help you to structure it.

Which exercises were you able to do and which did you not manage to do?

.....

.....

.....

What feedback did participants provide on the exercises and the topics you addressed?

.....

.....

Were there any particular subjects they raised? .....

.....

What can you conclude from the pre- and post-evaluation of the sessions? .....

.....

.....

.....

How did participants interact with you as facilitator? .....

Which topics resulted in a longer debate during which you had to refer either to other resources or perhaps allow a longer time for discussion? .....

.....

.....

Did you encounter any barriers to delivering the module? If so, what kind of barriers? .....

.....

.....

What would you do differently if you had to facilitate the module again? .....

.....

.....

Are there any recommendations you would give to yourself?

.....

.....

.....

Appendix 5: Questions for testing peer educators before and after training

Read all these questions carefully and put a tick next to the responses you agree with. Please note that there could be more than one correct answer. You may also add other questions that you find essential depending on your context and responses to the toolkit modules.

1. On homosexuality

TICK THE APPROPRIATE BOX	TRUE	FALSE	DON'T KNOW
HOMOSEXUALITY IS			
A natural tendency			
A tendency to be corrected			
An attraction towards someone of the same sex			
Genetic			
Possible if a person has been raped at a young age			
Determined during adolescence			
WHAT DO YOU THINK ABOUT THESE STATEMENTS?			
Transgender people feel that their gender identity does not match their biological state			
Transvestites have male and female characteristics			
Homophobia is a natural response			
There are no gay men or lesbians in the Arab world, they only exist in the West			
Men having sex with other men is a perversion and needs to be corrected			
Homosexuals have female mannerisms			
Men become homosexual at a young age when they start hating women			
If parents were more strict about their children's upbringing they would be able to control their sexual orientation			
A homosexual may come to terms with his sexual orientation but will go through tough times			
It is impossible to help a person without taking into account the influence of their level of education and their immediate environment			
Vulnerability means that there are factors that expose a certain group to risk or to engage in risky behaviours			

TICK THE APPROPRIATE BOX	TRUE	FALSE	DON'T KNOW
WHAT MIGHT BE THE CONSEQUENCES OF NOT ACCEPTING OUR SEXUAL ORIENTATION?			
Feeling guilty			
Sexually abusing children			
Depression			
Undergoing a sex change operation			
Feeling unsafe with our own identity			
Overeating			
Developing a serious mental health problem			
WHAT DO YOU THINK ABOUT THESE STATEMENTS?			
MSM have to denounce their belief in God			
MSM are a social group more exposed to risk of HIV infection			
HIV testing should be compulsory for all MSM to stop the virus from spreading			
MSM tend to have similar problems			
Law enforcement measures against MSM will deter them and change their behaviour			
The media is usually unkind to MSM but this is good because it helps to stop HIV from spreading			
Some MSM engage in commercial sex and that exposes them to harm			
Homosexuality is the reason behind the spread of HIV			
It is the right of MSM to access social and health services as and when they need them			
A positive institutional response to the needs of MSM is a reflection of the wellbeing of the community			
When parents accept their son's sexual orientation they help him come to terms with it			

2. On HIV, AIDS and other STIs

TICK THE APPROPRIATE BOX	TRUE	FALSE	DON'T KNOW
WHAT DO YOU THINK ABOUT THESE STATEMENTS?			
You can tell if someone has HIV from their physical appearance			
You can find out if you have HIV by having a special blood test			
You can tell if someone has HIV from their behaviour and sexual conduct			
AIDS is considered to be a genetic disease			
AIDS is a cancerous disease			
AIDS is an infectious disease			
HIV IS TRANSMITTED THROUGH			
Insect bites			
Unprotected sex with an infected person			
Sharing eating utensils			
Breathing			
Objects that are sharp and contaminated with the HIV virus			
Mother-to-child transmission before or during birth and through breastfeeding			
Blood contaminated with the virus			
A passionate French kiss			
Hugging and kissing on the cheek			
AFTER BEING INFECTED WITH HIV, THE VIRUS IS FOUND IN WHICH BODY FLUIDS?			
Breast milk			
Saliva			
Sexual fluids (male and female)			
Tears			
Urine			
Blood			
Sweat			
WHAT DO YOU THINK ABOUT THE HEALTH OF PEOPLE LIVING WITH HIV AND THEIR TREATMENT?			
A person infected with HIV does not live long			
There is a special vaccine for people living with HIV			
There is still no cure for HIV			

TICK THE APPROPRIATE BOX	TRUE	FALSE	DON'T KNOW
WHAT DO YOU THINK ABOUT THESE STATEMENTS?			
Testing should be mandatory for all homosexuals, sex workers and people who inject drugs to stop the spread of HIV			
Having strict rules targeting homosexuals is the best way to stop the spread of HIV			
HIV is the sex workers' disease			
Testing for HIV should respect privacy and confidentiality, and be voluntary and available			
STIs INCLUDE			
Hepatitis B			
Syphilis			
Pubic lice			
Gonorrhea			
Chlamydia			
THE FIRST SYMPTOMS OF STIs ARE			
Discharge			
Headaches			
Pain while urinating			
Sores on the genitals			
Painful ejaculation			
Common cold			
Nausea			
WE CAN PROTECT OURSELVES FROM STIs BY			
Having multiple sexual partners			
Avoiding having sex with someone experiencing itchiness, pain, discharge or ulceration of the genitals			
Using the male condom			
Sharing towels, sheets and underwear			
Using clean toilets			
Using sterilised tools			

TICK THE APPROPRIATE BOX	TRUE	FALSE	DON'T KNOW
COMMON BELIEFS ABOUT STIs			
It is impossible to be protected from STIs			
There is no cure for every STI			
Untreated STIs cause complications			
STIs affect only men			
A person infected with an STI is more likely to develop AIDS			
COMMON BELIEFS ABOUT THE MALE CONDOM			
We can use two condoms at the same time for extra protection			
Using greasy moisturiser as a lubricant helps us when we have sex			
Lubricant has to be water based and good quantity			
Lubricant facilitates intercourse			
Lubricant kills sperm and therefore reduces the chance of HIV infection			
IMPORTANT THINGS TO LOOK OUT FOR WHEN BUYING A MALE CONDOM			
Rubber latex			
Valid date of manufacturing			
Water-based lubricant			

3. On drug use

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
A DRUG IS			
A natural substance that affects the respiratory system			
A natural substance that affects the central nervous system			
A natural substance that one can easily stop using			
PEOPLE WHO INJECT DRUGS CAN PROTECT THEMSELVES FROM HIV BY			
Using a clean needle every time			
Becoming knowledgeable about the effects of the drug they are using and avoiding mixing it with other drugs			
Carrying on using their own needle without sterilising it so long as they do not share it with others			
Always having protected sex			
Knowing how to use the drug without it affecting their behaviour			
Disposing of needles responsibly			
Visiting specialised harm reduction centres in their area			
Avoiding sharing sniffing tools			

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
RECREATIONAL DRUGS INCLUDE			
Cocaine			
Ecstasy			
GHB			
Medicine			
Poppers			
Heroin			

Choose the appropriate definition for each of these terms

TERM	DEFINITION
Drug addiction is	are often used at parties and are dangerous because the user tends to lose control over their behaviour
Recreational drugs	leads to death
There are three types of drugs	a voluntary impulse to take drugs in order to function normally
Drug dependency is	when the concentration of the drug is progressively reduced, requiring an increase in concentration to achieve the desired
Drug tolerance is	a compulsive behaviour that starts as casual use rather than for a medical reason effect
Overdose	hallucinogens, tranquilisers and stimulants

4. On behavioural change

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
WHAT DO YOU THINK ABOUT THESE STATEMENTS?			
A person who uses drugs will change their behaviour once they are provided with the necessary information			
Behavioural change happens in stages and takes a long time			
The information provided depends on the readiness of the person to make the necessary changes			
Behavioural change requires providing the necessary information, skills and dialogue			
THE STREET INTERVENTION AIMS TO			
Force the target group to change their behaviour			
Observe and report the target group			
Help the target group to change to safer behaviour			
Distribute preventive materials and refer the target group to health centres			

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
HEALTH EDUCATION IN THE STREET			
Is about giving accurate information			
Gives a free medical consultation to everyone			
Distributes leaflets on behaviour change			
Distributes free condoms			
Reduces the harm experienced by certain groups			
Involves meeting young people			
Refers the target group to medical, social and medical centres for follow-up			
Changes the sexual orientation of young people			
Involves going to the places frequented by the target group and providing them with information, educational and preventive materials for follow-up			
A PEER EDUCATOR			
Manipulates the police and can run away when in trouble			
Is trusted by his peers			
Is convinced of the importance of the programme he works for			
Is concerned about the health of his peers			
Has the proper health and prevention information, and is trained in providing them			
Has a good relationship with the police			
Is willing to assess his own work			
WHAT DO YOU THINK ABOUT STIGMA AND DISCRIMINATION?			
Stigma is a positive attitude			
Discrimination is a negative attitude			
Discrimination is unfair to an individual or group with unacceptable behaviour			
Discrimination could come from the law in some countries			
Stigma is a negative attribute given to an individual or a group merely for engaging in a behaviour that is not accepted by many in the community			
Stigma and discrimination have a negative impact on the lives of those discriminated against			
Vulnerability is a combination of factors that cause harm to a person and to those around him			

5. On advocacy

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
ADVOCACY IS			
A continuous process aimed at requesting a change in policy, legislation and practice by influencing decision-makers and those in positions of power and authority			
A sort of networking among various institutions to provide better and affordable services			
A kind of communication through distributing leaflets to raise awareness of HIV and other STIs			
Support offered to vulnerable people in difficult situations to protect their human rights			

6. On documentation, M&E and communication related to the intervention programme

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
DOCUMENTATION, M&E AND COMMUNICATION ARE ABOUT			
Finding practical ways to document the findings, the experiences, success stories and lessons learnt in the programme			
Learning from the challenges in the programme			
Ways of promoting the programme			
Creating supportive documents for advocacy			
REFERRAL HELPS US TO			
Control the behaviour of MSM			
Map MSM and available services			
Provide services that respect the privacy of these groups			
Collect data about the kind of services needed and their availability			
WHAT DO YOU THINK ABOUT THESE STATEMENTS?			
One of the selection criteria for a peer educator is his ability to control the target group in the street			
The peer educator adheres to a set of professional ethics that respects the privacy and confidentiality of the target group			
In order for the field supervisor to monitor the performance of the peer educator, he has to assign the role to someone close to him so he can keep an eye on the behaviour of his friends and report them			
The field supervisor is someone who is knowledgeable about the specifics of working in the street			

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
The hotline is available to receive calls from beneficiaries when they are in trouble with a peer educator			
The referral system is a set of services needed by beneficiaries and it is important to refer them to these services			
One of the principles of the referral system is to maintain the privacy of the beneficiary			
Referral services have to cooperate with the authorities by arresting people living with HIV on arrival at the centre in order to prevent them from having sexual relationships and thereby reduce the spread of HIV			
When a social worker at the centre encounters an MSM, he must report him to his family			
SUPERVISION IS			
To help a peer educator to be successful by discussing his work with a field supervisor, who is an expert trainer in the same field			
Unnecessary for those who have more expertise in the field			
Inappropriate for identifying and discussing difficult cases			
WHEN SUPERVISING AND EVALUATING AN INTERVENTION, THE FIELD SUPERVISOR HAS TO			
Supervise the quality of information provided by a peer educator and the way it is offered			
Lecture a peer educator on how to behave properly			
Give orders on how to take appropriate action			
Reprimand a peer educator and fire him if necessary			
Evaluate the work and its suitability for the target group			
Change the implementation plan when necessary			
DOCUMENTATION IS ABOUT			
Following up thoroughly on programme activities and monitoring the implementation process			
Helping to remember what was done, with whom, when and how, and what needs to be done in the future			
Helping with the design of new programmes			
Taking photographs and recording conversations with beneficiaries in the street, and publishing them later in the media			
Interviewing beneficiaries			
WHAT DO YOU THINK ABOUT THESE STATEMENTS?			
The number of condoms distributed and the number of those reached by the programme are qualitative indicators			
The nature of the programme, and beneficiaries waiting for a peer educator to ask for condoms are quantitative indicators			

TICK THE APPROPRIATE BOX	AGREE	DISAGREE	DON'T KNOW
The number of peer educators working in the programme is an indicator of the success of the programme			
Programme evaluation is only carried out with beneficiaries, as what they have to say indicates whether the programme has been successful or not			
The indicators have to be analysed by national AIDS programmes to determine what has been useful			

www.aidsalliance.org

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

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About UNAIDS

UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative joint venture of the United Nations family, bringing together the efforts and resources of ten UN system organisations in the AIDS response to help the world prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic. UNAIDS helps mount and support an expanded response to AIDS – one that engages the efforts of many sectors and partners from government and civil society. Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, UNWOMEN, WHO and the World Bank.

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