



Involve me ... I understand

Peer education handbook on sexual and reproductive health and rights:

teaching vulnerable, marginalized and
socially-excluded young people

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"The aim of education is the knowledge not of facts but of values."

**–"The Training of the Reason" in A.C. Benson (ed.) Cambridge Essays on Education (1917)
Chapter 2**

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Preface

Young people: Taking action to make the world a better place

In 1995 the International Planned Parenthood Federation European Network (IPPF EN) chose the motto 'Make it happen ... Make it now' for our European Youth Strategy. Since then, those of us in the IPPF European Network Regional Office (RO) have shown our commitment to it with several successful initiatives that have informed the world of what young people can do and be. They can take charge, be part of a serious debate on sexual and reproductive rights including HIV/AIDS, and take up a cause to make the world a better place. They can tackle the ignorance surrounding their lives and inspire the adult world by their actions.

This was manifested most recently in the regional project 'Promoting Sexual and Reproductive Health Services and Human Rights for Youth and Adolescents in the Balkans'. This handbook is a reflection of the participation in the project of five youth organizations based in Serbia, Montenegro, Croatia, Macedonia and Kosovo and the IPPF member association in Bosnia and Herzegovina. Much of the text resonates with the voices and experiences of the staff and volunteers from these organizations. It reinforces their self-taught beliefs that sexual and reproductive health choices must be respected and that diversity must be valued and celebrated – beliefs that are more than just poignant in the Balkans.

Our collective understanding, promotion and defence of issues related to gender, culture, rights and equity have motivated this handbook. The handbook explores the frailty of human lives, the embarrassment of vulnerability, the fear in denial, the loneliness of shame, the anger of someone involved in substance abuse, the pain of a person living with HIV/AIDS and the bafflement of growing up. The underlying message is that human life is precious.

The handbook goes behind the infection and disease and helps present the situation through other people's eyes. It encourages understanding, love and hope as it answers the question 'where do we go from here?' And it provides skills that empower all people to take charge of their own life while allowing others the right to live in dignity.

Through this project, our experience in the Balkans went beyond ordinary youth programmes. It challenged young people to learn differently by stepping into a more vulnerable world than their own – that of the young poor, the young marginalized and the young socially excluded. The essence of peer information and education is simplicity. Who else would you open up to but a friend, someone you know and trust, and who is in similar circumstances and has similar experiences? For this reason, every time we use the peer concept it remains groundbreaking in uniting people. For the project, it proved a great way to communicate with straightforward messages about the reality of life and its complexities, while still putting everybody at ease. The most heart-warming part is that the young people involved in the project, 'the lucky few' as one participant described it, are geared up to take the issues and the dialogue about the issues beyond the project and make them integral elements of their work and lives.

To the many brave individuals 'fighting the fight' we say: you are not alone in your search for solutions. We are there with you every step of the way. ■

Vicky Claeys
Regional Director
IPPF European Network

Acknowledgements

When we first met Liuska Sanna, it was clear that she had a lot of promise and the old 'ticker' told us to go with our hunch. As our project co-ordinator she has more than upheld that promise in the face of the challenging times that IPPF EN has encountered in this project. Liuska, we applaud your willingness to learn, your belief in the cause, your gentler pursuits and your much-needed 'grit', all of which were indispensable to the success of this groundbreaking regional project. With courage and professionalism you grappled with the inherent contradictions of trying to reconcile an ideal with the realities on the ground. Thank you for your contribution to the handbook and for upholding our ideal of a wider level of inclusiveness among youth.

Robert Zielony, you proved the age-old saying 'a little self-doubt is at the centre of all wisdom', which was important to remember in our interactions with young people on the controversial issues addressed in the project. Thank you for throwing out the usual 'rule book' and affirming that it is worth our while never to give up trying to understand each other with small, intimate actions. We appreciate the time you have put into the many challenging workshops and appreciate your words as they have been put together for this handbook. You have helped us reflect a kaleidoscope of voices and ideas that represent peer education as it applies to young people, and especially those who are in vulnerable, marginalized and socially excluded groups.

To Patrick Levy – thank you, thank you and thank you for sharing your common humanity and compassion. You have touched our lives in more ways than one and changed us forever.

Our heartfelt thanks also goes to all of you who helped make this handbook possible by reflecting the voices of the young people involved in peer education in our partner organizations: **Tijana Medvedec** (BiH APP XY) for her open nature and what was visible to us from the beginning – her ability to relate to people who are very different from herself; **Maja Dzockova** (Macedonia – HERA) who motivated us with her strength of personality and leadership qualities that people found most attractive; Marija Rakovic (formerly with YVIC), whose commitment and expertise the project relied upon in Serbia; **Zlatko Vujovic** and **Ivana Vojvodic** (Montenegro – YCC Juventas), the former for his sociable and communicative way of engaging young people to participate and the latter for her dynamism and results-oriented approach. You all confirmed our belief that civil society in a country can be the agent of change and the one true guidance that IPPF EN needed in this project.

To Helen Martins, our consultant editor – we applaud your discipline and the deadlines never missed, and thank you for taking up the editing of this handbook at such short notice. Last but not least we would like to thank Mrs Niemann-Jordan and the German Ministry of Economic Co-operation and Development for their support of the project through which this handbook was created. We appreciate your trust and your commitment to young people and their future.

The opinions expressed in this publication reflect those of International Planned Parenthood Federation European Network, which takes full responsibility for the views expressed. ■

Abbreviations

AIDS	Acquired immune deficiency syndrome
CSR	Children at special risk
FGM	Female genital mutilation
FHI	Family Health International
HIV	Human immunodeficiency virus
IDP	Internally displaced people
IDU	Injecting drug user
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IPPF EN	International Planned Parenthood Federation European Network
IUD	Intrauterine device
MSM	Men who have sex with men
NGO	Non-governmental organization
PLWHA	People living with HIV/AIDS
SIECUS	Sexuality Information and Education Council for the United States
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
VMSE	Vulnerable, marginalized and socially excluded
WHO	World Health Organization

Section I – Introduction

Peer education programmes for vulnerable, marginalized and socially excluded young people

Who is this handbook for?

This handbook is for peer educators, master trainers and non-governmental organizations (NGOs) that wish to run peer education programmes for young people, especially those from vulnerable, marginalized and socially excluded (VMSE) groups and communities.

Why use this handbook?

This handbook is intended as a useful resource. It contains concrete tools, approaches and strategies – with real-life examples – that may help when working with VMSE populations.

How is this handbook different?

While there are many documents and manuals on the subject of peer education generally, there is an increasing need to improve programmes by addressing the specific issues facing VMSE groups around the world.

This handbook is designed to meet that need. Most importantly, it provides ideas for encouraging young people to participate and engage in the peer education process as fully as possible, so that the programmes which are developed, best match their needs.

The writing style

This handbook reflects the contributions and ideas of many people (which is how peer education works in real life), including peer educators, health professionals, people from VMSE groups and those who have experience working with them.

'Us' and 'them'

You will notice that the writing is sometimes in the first person (using 'we' and 'us') and other times in the third person (using 'them' or 'they'). The reason for this difference is that much of the writing and ideas come from peer educators in various countries and from a variety of groups, including the VMSE populations targeted by the programme. Thus, the first person writing represents the experiences of and lessons learned by peer educators from

around the world, while the third person writing comes from other sources.

Who are 'stakeholders'?

We use the term 'stakeholder' and the type of stakeholder – primary, secondary and key – instead of phrases such as target populations and groups, beneficiaries or audience. In this handbook:

- primary stakeholders are young people aged 10–24 years, including the vulnerable, marginalized and socially excluded
- secondary stakeholders are those who work directly with young people
- key stakeholders are those whose indirect support is critical for the success of a programme or project.

For a more detailed description of stakeholders, see Section 5.

A rich collection of voices

We hope this rich collection of voices and perspectives brings this handbook to life and reflects real people in real situations. It reflects the way that peer education dialogues and training often do and should take place. As mentioned, the peer educators are sometimes from vulnerable, marginalized and socially excluded groups themselves. In the end, if this writing style gets or keeps us involved so that we understand, we will have done our job successfully.

Why do we need peer education programmes?

People relate best to the experiences of their own peer group, and young people are no exception. They can understand each other's life experiences, stresses, challenges and vulnerabilities, as well as the barriers and obstacles to better health faced by their peers.

In formal educational settings, it is the adult education 'experts' or teachers who usually teach academic subjects, yet the peer group may play a more important role in personal, social and psychological matters. They may also have something unique to offer.

Sexual and reproductive health (SRH) is an area in which social and psychological factors – such as perception of 'social norms' (what we think is most usual for our peers to do) and 'behavioural modelling' (following the examples set by peers) – play an important role. Peer education programmes are needed to pave the way for social change and to guarantee that there are responsible peers and leaders within communities of young people, some of whom can act as role models and provide on-the-spot interventions when needed.

What is in the handbook?

Although written mainly for peer educators, the handbook is also intended as a useful tool for trainers (those who train peer educators), master trainers (those who train the trainers) and the NGOs that run peer education programmes. It is divided into nine sections.

You are now in **Section 1**, the introduction, which explains the purpose of this handbook.

In Section 2 you will find an overview of peer education covering the basic concepts, goals and objectives, advantages and disadvantages of using peer education, and the role of a peer educator.

Section 3 provides definitions of some of the most important issues in peer education as they relate to sexual and reproductive health and rights (SRHR). This section includes concepts such as human rights, sex and sexuality, and social issues such as stigma, discrimination, gender and culture.

Section 4 defines and explains issues that are central to sexual and reproductive health.

Section 5 describes phases in the management of peer education programmes:

- **Phase one** tells how to plan your programme with stakeholders that may be interested, how to recruit peer educators and how to build a curriculum

- **Phase two** focuses on implementation, explaining models and theories relating to peer education and some of the techniques used
- **Phase three** tells how to monitor or track and evaluate the progress of your peer education programme.

Section 6 discusses ways of reaching and working with VMSE groups, beginning with general definitions and ideas about vulnerability and social exclusion and including seven specific groups:

- People living with HIV/AIDS (PLWHAs)
- Injecting drug users (IDUs)
- Children at special risk (CSR), including orphans and street youth
- Sex workers
- Sexual minorities (gay, lesbian, bi-sexual, transgender)
- Ethnic and cultural minorities
- People with physical and mental challenges.

In each case, there is a description of the group, barriers and obstacles in working with the group, best practices and lessons learned.

Section 7 provides a training kit that gives examples of how to organize a specific workshop, icebreakers and exercises that peer educators can use, examples of forms or surveys used for evaluations, pre- and post-tests and workshop reports.

At the end of the handbook there are several **annexes** with, for example, templates for training sessions and questionnaires; and a list of useful **resources** for peer education, including Websites and manuals. ■

Section 2 – Overview of peer education

Conveying and sharing knowledge - developing essential skills

What is peer education?

Peer education is a method of education that allows people who have something in common – such as age, gender, social group, vocation or role – to communicate with each other to convey knowledge or teach skills. The aim is to change motivation and behaviour.

We learn to be peer educators through programmes that help us develop the skills we need to carry out formal and/or informal peer education.

It's a fact ...

Through peer education, adolescents and young adults can teach other young people about health issues such as:

- sexual and reproductive health
- prevention of HIV/AIDS and sexually transmitted infections (STIs)
- gender violence
- prevention of substance abuse
- ... and lots more.

Peer education is not restricted to young people. It can occur among all sorts of groups that have something in common.

Our aims in peer education

One of our aims in peer education is to make changes in the lives of young people by positively affecting their attitudes, beliefs and behaviours. Another aim of peer education is to help support and reinforce healthy attitudes and behaviours where they already exist.

Formal vs informal settings

Peer educators are trained for various types of work in different environments, both formal and informal.

Formal settings

In **formal** settings, there is usually a specific audience or group of people, such as a class of students or military recruits. Formal education can occur in schools, universities, community organizations such as clubs or summer camps, military institutions or other similar environments. Dates and times are usually set for a single session or a multi-session programme.

The educator is likely to plan the curriculum or agenda and agree upon objectives with the group. Many will carry out a formal evaluation using a pre- and/or post-test design to assess the impact of the programme.

Informal settings

Peer education can also happen in an **informal** manner, such as an encounter on the street, at a club, café, party or disco, where potential primary stakeholders tend to get together socially, or for other reasons. This kind of peer education tends to be more spontaneous, less structured, of shorter duration and more individualized.

Some use the term 'peer outreach', which can refer to various levels of intervention out in the communities of the target population. Peer education happens when there is real education during an encounter, rather than a simple action such as handing out a pamphlet or condom.

The goals and objectives of peer education vary depending on:

- the stakeholders
- the focus of the particular programme
- the scope of the project
- the context of the interaction or intervention

The goals of a peer education programme usually include:

- **conveying knowledge** through teaching information and facts to raise awareness about an issue such as health (for example, sexual and reproductive health, substance abuse, gender violence)
- helping primary stakeholders to **develop essential skills** (for example, negotiation, decision making and methods of safer sex)
- **motivating** primary stakeholders to maintain or engage in some kind of (safe/r or healthy) behaviour (for example, reducing the risk of exposure to HIV or STIs).

Impact of peer education

A good peer education programme will help a young person develop and reinforce:

- self-confidence
- responsibility
- firm attitudes based on rational thinking
- communication skills
- ability to listen to others
- organization and management skills (for leaders).

Advantages and disadvantages of peer education

What makes peer education worthwhile?

There are lots of advantages of a peer education programme.

- **It is culturally appropriate** – peer education delivers culturally sensitive messages from within the culture. The education works carefully within certain rules so as not to offend people in their culture, while still challenging norms that stigmatize or discriminate.
- **It is community-based** – peer education works at a community level, supporting and supplementing other programmes and linking to other community-based strategies. This makes it more personal for the community where it takes place.
- **It is accepted by our primary stakeholders** – many report that they are more comfortable relating to a peer about personal concerns such as sexuality. This is particularly true when members of the same generation exchange helpful thoughts and ideas about similar problems.
- **It is economical** – peer educators can provide an important service very effectively at low cost.
- **It has a friendly approach** – in informal settings, a peer educator may be in 'the right place at the right time' to notice a risk behaviour or a problem, and respond to it. Peer educators can sometimes encourage and escort friends, supporting them when they need to go to a clinic.

What are the problems or risks?

Peer education can have some disadvantages, particularly if it is poorly implemented.

- **Peer pressure** – peers can affect people, especially the young, in a negative way if peer pressure is used for improper purposes. We can pressure somebody to gain acceptance in a group by using drugs, smoking, drinking alcohol or having unprotected sex.
- **Lack of experience** – as peer educators, we will face a lot of problems we might not know how to deal with when starting our work in the community, and may deliver incorrect information.

- **Socio-cultural boundaries** – these may become apparent when young people talk about sex. In some communities it is hard to talk about sex and sexuality, especially if adults think that young people are encouraging the idea of promiscuous behaviour; and taking unacceptable risks.

- **Lack of recognition** – until now, peer education has not been recognized in some places as an effective, sound and legitimate way of making a difference.

What is the role of a peer educator?

Peer educators play a very important part in promoting health to young people. We can serve as 'role models' by giving essential and accurate information, and by promoting attitudes that lead to healthy, responsible behaviour among our peers. One of the ways we can do this is by living in a healthy manner ourselves.

Our roles and knowledge may differ, depending on the programme and the target populations. Many of us are trained and involved in more than one discipline or activity. Once we are familiar with peer education techniques, we can apply them to a variety of issues and situations. Using the same peer educator for more than one type of activity instead of training someone new each time can help to reduce costs.

Examples of activities for HIV prevention programmes with peer education

- Increasing awareness of HIV and sexually transmitted infections among our peers
- Motivating and supporting abstinence or risk reduction behaviour
- Education about condoms and their availability
- Care and support of our friends who are living with HIV/AIDS

Section 3 – Cross cutting issues in sexual and reproductive health and rights

Understanding the issues

People who create policies and programmes need to understand all the issues – both theoretically and in practical terms – when implementing peer education programmes that promote sexual and reproductive health. In this section, we will explore a number of these issues, including:

- access
- human rights
- reproductive rights
- sexual rights
- concepts of sex and sexuality
- discrimination and stigma
- religion
- gender
- culture
- risk
- empowerment
- self-development
- behaviour skills.

Access

A definition: ways or means or act of approach; the condition of allowing entry; the right or privilege to approach, reach, enter or make use of something; designating programmes that are made by and for the general public and making them available.

In the field of SRHR, access refers to...

"...provision of information and education on sexual and reproductive health and rights and services to all regardless of age, sex, marital status, ability to pay, ethnic origin, political and religious beliefs, disability, sexual orientation or any other factor that could make an individual the object of discrimination."

IPPF European Network Strategic Plan 2004-2008

Young people might not have access to information and education if the family, education institutions and civil society do not provide the means for it.

Implications of inaccessible services

"Many adolescents (boys and girls, married and unmarried) could and do become sexually active before the age of 20, but generally lack access to contraceptive services, prevention and care of sexually transmitted diseases, pregnancy care or counselling. For many young people, the opening times or location of services make them inaccessible, or the care is too expensive. Many health care facilities require the consent of parents or spouses, or may be forbidden by law to provide services to adolescents. In addition, the somewhat judgmental attitude of many health care professionals could often discourage adolescents from seeking advice and treatment related to sexual and reproductive health."

WHO, Department of Child and Adolescent Health and Development

The rights-based approach to sexual and reproductive health

Universal Declaration of Human Rights, Article 1

"All human beings are born free and equal in dignity and rights."

Each individual is entitled to human rights, whatever their colour, race, sex, age, sexual orientation, religion or political participation. Sexual and reproductive rights are an integral part of human rights, which means that each person should be able to live a fulfilling, non-coercive and risk-free sexual life.

Reproductive rights

"Reproductive rights embrace certain human rights that are already recognized in many national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all individuals and couples to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so".

UN, Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, paragraph 7.3

An individual's right to choose

Sexual rights are rights in relation to sexuality. The IPPF International Women's Advisory Panel has stated that sexual rights must ensure sexual autonomy or, in other words, the right to decide whether, when, how and with whom to have sex.

This means that women, men and young people have the right to refuse sex and that bodily integrity must be respected.

The vision, values and mission of the IPPF European Network reflect the core belief that health and choice about sexual and reproductive life are the human rights of every individual.

IPPF European Network's initiatives for young people

These principles also apply to young people and guide IPPF EN in its commitment and work to promote and advance the sexual and reproductive rights of young people. This commitment has inspired a series of initiatives for youth.

In June 2001 young volunteers working with IPPF EN developed a policy paper about the sexual and reproductive rights of young people. It recognized that although not all young people are having sexual intercourse, most young

people are sexually active and have the same sexual and reproductive rights as adults. These rights include information and access to services, which enable young people to experience their sexuality safely and confidently. This does not mean that the rights of parents of minors are not recognized or taken into consideration. Within programmes, children must be given a 'safe' environment for their very personal discussions, even when their parents are involved. IPPF European Network believes that young people should have access to sexual and reproductive services in relation to their:

- **Health** – to safeguard their sexual health through access to comprehensive services
- **Choice** – to have access to accurate information and education, to make free and responsible choices
- **Rights** – to ensure their rights to enjoy their sexuality and relationships.

Helping other young people

"I feel so lucky that I discovered how wonderful it is to be happy with my sexuality despite the poor sex education I received while growing up. Now I want to be actively involved in helping other young people avoid the pitfalls and experience that pleasure."

Volunteer, aged 23, 'Make it happen ... Make it now', European Strategy Working Group, 1995

'Make it happen ... Make it now'

Another benchmark was the development in 1995 of the European youth strategy 'Make it happen ... Make it now'. This strategy was the result of a group of young people brought together to explore, review and consider young people's sexual health needs, and suggest the way that future programmes and policies might improve young people's lives and address their concerns. The recommendations in that strategy are still a valuable tool for assessing if and how the sexual and reproductive needs and rights of young people are being met.

Strategic plan 2004–2008

All of these stepping stones have contributed to IPPF EN's strategic plan 2004–2008. With adolescents and young people forming one of the programme themes, IPPF EN is working to ensure that:

"...all adolescents and young people are aware of their sexual and reproductive rights, are empowered to make informed choices and decisions regarding their sexual and reproductive health, and are able to act on them".

Planners and providers of peer education programmes on sexuality and sexual health need to know about these rights and their implications. These rights should in turn form part of life skills education for young people.

Legal framework

The International Conference on Population and Development (ICPD) in 1994 affirmed the shift from demography to a rights-based approach to sexual and reproductive health. IPPF then interpreted and applied human rights language to strengthen and make more explicit the link between rights and SRH in its 'Charter on Sexual and Reproductive Rights'.

This charter, which is legal in character, expresses basic human rights as they apply to an individual's sexual and reproductive life, based on internationally recognized human rights treaties that have been ratified by many countries world-wide. Although not legally binding, the Charter has become a tool for advocacy to challenge cases where governments do not translate agreements signed at international level to commitment at national level.

Tool to advocate for SRH

"In every country, a variety of laws, policies and practices exist, which affect sexual and reproductive health and rights. They may relate to the provision of information and education on SRH, and/or regulate access to family planning and other basic reproductive and sexual health services. Unfortunately, these laws, policies or practices often obstruct, limit or prohibit the enjoyment of the SRH rights. A government's failure to act on a certain issue may also negate, or adversely affect the enjoyment of these rights. In either case restriction of sexual or reproductive rights amounts, in international law, to a violation of human rights, if a government has ratified treaties which recognize these rights."

'IPPF Charter on Sexual and Reproductive Rights – Guidelines'

Organizations and professionals working in sexual and reproductive health need to understand their national legislation on sexual and reproductive health rights, as it can restrict the scope of their work. When they are aware of the legal framework, organizations can plan strategies and programmes and hold governments accountable for the commitments they have made.

Concepts of sex and sexuality

Definitions, language and norms related to sexuality have to be placed in the context of culture because sexuality can be culturally specific. While the meaning attributed to the definitions given in this section might differ from culture to culture, and also within communities, it is important to recognize that culture is not a 'given', but a dynamic and evolving process. Any form of violence, discrimination, stigmatization or coercion done in the name of culture and tradition cannot be justified. These actions have been and will continue to be challenged in any rights-based development agenda. This is particularly significant in the field of sexual and reproductive health.

Sex

In the context of sexual and reproductive health, sex is defined as an individual's biological status as male or female¹. The term 'sex' may also have the following meanings:

- the sexual urge or instinct as it manifests itself in behaviour
- sexual intercourse
- the genitalia.

Sexual identity

Sexual identity is someone's sense of himself or herself as a sexual being, including gender identity and sexual orientation. Gender identity refers to an individual's internal sense of being male or female.

Sexual orientation refers to erotic, romantic and affectionate attraction and feeling towards people of the opposite sex, the same sex or both sexes.

Scientifically speaking, sexual identity is an integral part of human sexuality which, in turn, is a natural part of human development through every phase of life and has physical, psychological and social components².

Sexual and reproductive health programmes need to be comprehensive and holistic. They must also recognize the diversity of the human sexual condition to help abolish stigmatization, discrimination and social exclusion.

Sexuality

Human sexuality is a natural part of human development through every phase of life and includes physical, psychological, and social components³.

Sexual health implies a positive approach to human sexuality and is an essential part of sexual and reproductive health. It is the integration of somatic (physical), emotional, intellectual and social aspects of an individual in ways that are positively enriching and enhance personality, communication, love and human relationships⁴.

The people who plan and deliver peer education need to know what these terms mean in their own communities, languages and cultures. A clear understanding of how young people and adults perceive sex and sexuality can lead to questions about practices that influence the enjoyment of a fulfilling, safer and responsible sexual life.

Social issues

Discrimination

The word 'discriminate' refers to seeing or noticing the differences between things. In a social context, 'discrimination' often refers to the times when we treat people unfavourably because they are different from us.

Treating some people better than others because of race, ethnicity, religion, gender or sexual orientation is also a form of discrimination. As peer educators, it is our job to try to make sure that everyone is treated with equal respect and has equal opportunities. We also aim to learn and to educate without discrimination.

Stigma

'Stigma' is a word used to describe shame or disgrace.

People in certain groups are sometimes regarded as shameful or disgraceful by the society in which they live. When this happens, we say they are being 'stigmatized'. An example is when people decide that certain lifestyles or characteristics are shameful in some way or not respectable to their culture or society. They then use a judgmental attitude to stigmatize the people who have these apparently 'shameful' characteristics.

These characteristics are sometimes determined by behaviour which might be something the stigmatized people cannot control.

It's a fact ...

People living with HIV/AIDS may experience stigmatization, regardless of how they contracted the condition.

Religion

A religion is usually a belief system based on a supernatural, controlling being, or 'God'. There are a lot of religions in the world, based on different sets of beliefs and with systems of worship for demonstrating devotion to their god (or gods). Christianity, Islam, Judaism, Hinduism and Buddhism are the most common religions practiced around the world, and each has different sects, types or 'movements'.

There is a huge variation in the way that people observe, interpret and follow the rules or laws of their religions. These rules and laws can prescribe lifestyles that often relate to sexual and reproductive health and rights.

Examples of the impact of religion on SRHR

- Sexual intercourse before marriage is forbidden in many religions.
- In some religions, sexual intercourse is forbidden between members of the same sex.

What is common to several religions is that some laws and rules take precedence over others. For example, the obligation to preserve a life is more important than adhering to other laws.

What we need to know

As peer educators, we need to understand the main rules of the religions of the stakeholders with whom we are working. This will tell us what is important with regard to SRHR within these groups.

If trained by well informed people, peer educators can also learn where the religion justifies open communication and can learn risk reduction or harm reduction practices.

2 - WHO and SIECUS definitions

3 - WHO and SIECUS definitions

4 - WHO – *Definitions and Indicators in Family Planning, Maternal and Child Health and Reproductive Health* used in the WHO Regional Office for Europe

Gender

The word 'gender' is used to classify a person's sex, either as male or female. Beyond this, there are other definitions that lead to a deeper understanding.

Gender identity

'Gender identity' is how people identify themselves, and is part of their personal feelings and judgment about who they are.

Gender roles

Within cultures, there are 'gender roles' which are considered to be either more typically male or more typically female. Attributes considered typical to the male or female role may be clear within many cultures, or shared by both in others.

Examples of stereotyped roles upheld in the name of tradition

- Male – aggressive, dominant, sporty, money-earner.
- Female – sensitive, submissive (to the male), caretaker of children.

As societies evolve, strict gender roles are blurring. In periods of transition this can create tensions regarding gender roles, and there are programmes designed to address issues about changing gender roles.

Understanding gender roles, transition and change is very important in peer education. Discrimination based on these roles, in the name of tradition, often leads to unsafe social and sexual practices and vulnerability, especially for girls and women. Peer educators need to learn how to support gender identity, but also recognize where people may be more vulnerable to discrimination and abuse of rights.

Culture

'Culture' refers to the customs or achievements of a particular civilization.

Customs tend to change over time. Some may be part of an older, more traditional culture, and others part of a more modern or adapted culture.

In many cultures, gender experience leads to very different expectations and a very different understanding of rights. An increase in the rights of women is one of the changes now taking place in many cultures, and one that has many implications for both genders. Since 'no one is an island', negotiations and reasonable agreement between men and women is an important part of society and development.

What we need to know

To be good peer educators, we need to understand the culture in which we work. This will show us what the strengths and vulnerabilities are within cultural norms or expectations. For example, in the past a woman may not have been

expected to talk openly about sex or the use of contraception. A peer educator can help to deal with this issue and show how cultural norms can be challenged and changed when they affect individual rights. Threats to sexual and reproductive health, such as HIV/AIDS, other sexually transmitted infections, or gender-based violence would also qualify as reasons for change.

Risk

'Risk' is used to refer to a situation that could lead to a loss, injury or danger of some kind.

There is more than one type of risk. It does not have to be physical, as in the risk of infection (such as STIs or HIV), or physical injury (such as a broken limb). Some risks are psychological, for example, where a person does something or has an experience that leads to the risk of a psychological injury or 'trauma'.

Peer education teaches primary stakeholders 'risk reduction' techniques by demonstrating, for example, proper use of protection such as condoms.

Empowerment

The term 'empower' means to give a sense of power or authority to a person or a group.

Peer education often 'empowers' young people or other vulnerable groups to assume more authority over their health and personal lifestyles. It is often a question of making young people aware of how they can help each other learn, instead of leaving it to more traditional systems where authority figures such as school teachers, parents and doctors are responsible for teaching.

Sexual behaviour and practices

These are the sexual activities that people take part in, which can range from self-stimulation or masturbation to physical encounters with others.

Sexual behaviour can include stimulation of body parts and intercourse of various kinds, including oral, anal and penile/vaginal. It is often the expression of someone's sexuality, including sexual drive and attraction. Behaviours and practices are determined or provoked by a complex set of biological, psychological, social and environmental factors. Some people have less choice of sexual practices because of life circumstances, including cultural expectations and norms. Being unaware of choice about sexual practices often leads to greater vulnerability.

What we need to know

As peer educators, we can be more effective when we understand the ways in which primary stakeholders are vulnerable. If we only focus on the dangers and threats associated with sex, we may not be 'sex-positive' enough. Being sex-positive means conveying the message that, in an appropriate, healthy and safe context and at the right time in our lives, sex can be a wonderful expression and aspect of being human. We can learn to be sex-positive, and a sound sexuality education programme is a good place to start.

Remember ...

Be sex-positive.

Young people and sexuality

Self-development

It takes time for a person to understand and know him or herself as a sexual being. By learning what is personally important and how best to express oneself, a person can become a highly effective peer educator.

Many people go through a period of months or years (usually during adolescence) of questioning who they are, what their sexual identity and orientation are, how they can express themselves as sexual beings and what drives and attracts them. A peer educator who has looked inside his or her heart and mind and is non-judgmental about others is best qualified to help other young people in their search to understand their path to adulthood.

Understanding oneself can be a scary and difficult process. If, for example, a person lives within a culture that strongly discriminates against and stigmatizes people who are homosexual, it can be difficult and frightening to recognize

and accept that he or she is attracted to members of the same sex.

A good peer educator, whatever his or her sexual orientation, will be able to teach in ways that allow people to feel safe to be who they are.

Behaviour skills

For the best chances of growing up with the optimal sexual and reproductive health, a person needs a range of skills.

- He or she will need the ability to make healthy decisions about sexuality and relationships.
- Negotiation skills are also important in this area of life. This is someone's ability to ask for and get what they need from partners or friends to remain as healthy and safe as possible.
- Some may wish to remain abstinent or wait to have sex, and so may need to have what are called 'refusal skills' – knowing how and when to say 'no' effectively.
- Others may have decided to have sex, but need to know how to get their partner to agree to keep it safer; for example, by using condoms. ■

Section 4 – Sexual and reproductive health issues:

Concepts and definitions

Peer educators working to promote sexual and reproductive health and rights will find it helpful to understand basic concepts and terminology, such as what is meant by:

- Sexual health
- Reproductive health
- Conception
- Contraception
- Abstinence
- Abortion
- Sexually transmitted infections and HIV/AIDS.

In this section, we look at each of these in turn.

Concept of sexual and reproductive health

Sexual health

Sexual health is the integration of the somatic (physical), emotional, intellectual and social features of sexuality. It enriches an individual's life in a positive way, and enhances personality, communication and love.

Sexual health implies a positive approach to human sexuality. Therefore sexual health care should be about enhancing life and personal relationships, not just counselling and care for procreation or sexually transmitted infections¹.

Reproductive health

Reproductive health is physical, mental and social well-being in all matters relating to the reproductive system. It is not simply the absence of disease or infirmity (particularly physical weakness). Reproductive health implies that people can have a satisfying and safer sex life, with the freedom to decide if, when and how often to reproduce.

Both men and women have the right to be informed of and have access to:

- safer, effective, affordable and acceptable methods of family planning of their choice;
- other methods of their choice for regulation of fertility, which are not against the law;
- health care services that allow women to go safely through pregnancy and childbirth and that provide couples with the best chance of having a healthy infant².

Conception

Conception is the act of conceiving in the womb. It is the process of a sperm fusing with an ovum, which leads to the development of an embryo.

To deliver the sperm to the female, the male inserts his penis into the woman's vagina, the passage that leads to the womb. Once the male ejaculates, a large number of sperm swim toward the ovum. When one of them penetrates the ovum's coat, the ovum is fertilized and the female is pregnant.

Contraception

Contraception is defined as any means of preventing pregnancy.

There are temporary and permanent methods of contraception.

Temporary methods³

- Periodic abstinence during the fertile period
- Coitus interruptus (withdrawal)
- Using natural periods of infertility (for example, during breastfeeding and postpartum amenorrhoea, when there is no menstruation after giving birth)
- Using reproductive hormones (for example oral pills and long-acting injections and implants)
- Placing a device in the womb (for example copper-bearing and hormone-releasing intrauterine devices)
- Using a barrier that prevents the upward movement of the sperm into the upper female genital tract (for example condoms, diaphragm and spermicides).

Permanent methods

Male and female sterilization.

The impact of HIV/AIDS

The advent of HIV/AIDS has added a new dimension to contraception. It is now necessary to prevent transmission of STIs, including HIV/AIDS, as well as pregnancy.

Preventing infections and unwanted pregnancy at the same time is called 'dual protection'. This can be achieved by consistent use of condoms on their own, or by the simultaneous use of two methods – one of which must be condoms.

Abstinence

Sexual abstinence means voluntarily not having sex.

Sex has different personal meanings for people. To some it may only mean intercourse with the penis in the vagina; to others, it may include anal sex, oral sex and other forms of sexual activity like kissing, caressing or 'petting'.

1 - Adapted from the World Health Organization – *Education and Treatment in Human Sexuality: the Training of Health Professionals, A report from a WHO meeting, Technical Report Series 572, 1975*

2 - Adapted from the UN, Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, para. 7.2

3 - Adapted from WHO – *Working definition used by the Special Programme of Research and Research Training in Human Reproduction, and the Division of Family Health*

The definition of sex determines the meaning of abstinence, and there are a lot of discussions now on the real meaning of abstinence. Should it be considered as abstaining from intercourse, or from any form of sexual behaviour?

Abstinence is also the subject of debate in sexuality education. In the United States, for example, young people are increasingly being taught that abstinence until marriage is the only acceptable sexual behaviour. Such programmes do not give information on other contraceptive methods, nor on prevention of HIV. In addition, their definition of marriage is heterosexual marriage in a traditional family, which fails to meet the needs of people with a different sexual identity, such as homosexuals and bisexuals.

Abortion

Induced abortion, or the voluntary termination of pregnancy, is used to end an already established pregnancy. Most abortions – nearly 90% – take place in the first three months of pregnancy. Fewer than 11% take place in the second trimester. In general, after 24 weeks (the number of weeks might vary according to country legislation), abortion is very rare and is nearly always done for serious health reasons. It can be done in one of three ways:

- with medicine
- by vacuum aspiration
- through surgery.

Unsafe abortion is a procedure for terminating an unwanted pregnancy that is carried out either by a person who lacks the necessary skills or in an environment that lacks the minimal medical standards, or both¹.

Spontaneous abortion is when the body terminates the pregnancy by expulsion of the embryo/fetus before 22 weeks of pregnancy or below 500g of weight².

In many parts of the world, abortion is still an important area of discrimination against women, and the legal right to choose is a major political issue. Unsafe abortion is one of the biggest health hazards for women as it can kill or maim them for life.

STIs and HIV/AIDS

STIs are infections passed from one person to another through sexual intercourse or intimate genital contact (during foreplay or 'petting' by fingers or mouth).

There are at least 25 different sexually transmitted infections. These can be caused by bacteria, viruses or parasites. The infection with the highest impact is that caused by HIV (human immunodeficiency virus), which leads to the development of AIDS (acquired immune deficiency syndrome). The other most important infections are chlamydia, genital warts, gonorrhoea, herpes and hepatitis.

- Some STIs can be treated or controlled by medicines such as antibiotics.
- Some cause long-term damage to health and can even kill (for example AIDS). There is no cure for HIV but there is treatment for its effects.
- Some infections do not show symptoms for a long time. When this happens, someone who is not aware that they have an infection may transmit it to someone else.

The following chapters pass from theory to practice by explaining the different elements of peer education programmes and by providing tools and useful examples. ■

1 - Adapted from: Division of Family Health and Special Programme of Research and Research Training in Human Reproduction – International Conference on Population and Development, Cairo, Egypt, 5–13 September 1995

2 - WHO/FHE/MSM/94.11

Section 5 – Managing a peer education programme

Phase 1: Planning the programme

Who, why and where?

As with many other issues in technical assistance, one of the most common errors in the early years was to allow 'experts' from countries where peer education had been developed to impose their ideas about what should be done in other countries and regions. Although this kind of mistake has been repeated many times, it is now acknowledged that for peer education programmes to be successful, they must be 'owned' by the people that they target – the local stakeholders. The stakeholders are the people who should benefit from the work and who may have a role to play in the success and sustainability of the programme.

"Stakeholders can be gatekeepers (e.g., government officials, brothel owners) as well as people who have a vested interest in the peer education programme, such as the intended audience. Since they are key to the success and the sustainability of the programme, they should be involved from the design phase onward in order to address their concerns, needs, and priorities, and instil a sense of ownership of the programme. Early involvement also helps peer education programmes capitalize on stakeholders' potential contributions, such as financial and human resources. Peer education programmes need to clearly establish how the programme will benefit stakeholders in order to enlist their support. They also need to develop complementary interventions for educating and mobilizing stakeholders to support behaviour change in the intended audience."

Defining stakeholders

The following definition of stakeholders was devised by partners working on the peer education and HIV/AIDS programme, coordinated by the IPPF European Network in 2001-2003. This handbook is one of the outcomes of the project.

Primary stakeholders – people to whom the information is targeted and whose behaviour and practice the project is seeking to influence.

Example:

- All adolescents and young people aged 10–24, with a special focus on marginalized and socially excluded groups, such as HIV infected young people.

Secondary stakeholders – intermediaries whose skills and capacity will be improved in order to provide information and services to the primary group.

Example:

- Relevant youth non-governmental organizations (NGOs) in the country.

Key stakeholders – alliances within the project without whose support the project may not be able to function.

Example:

- Policy makers, civil servants, legislators, judicial representatives.

Why support is important

Sexual health education for young people has become a controversial subject around the world in recent years. Fierce battles have been and continue to be fought while political and religious positions are debated. Although the job of many governments and health ministries is to 'save lives rather than souls'², there is still a strong and urgent need for advocacy for sexual and reproductive rights in many regions.

Advocating for sexuality education

Organizations that advocate for the right to comprehensive information and sexual information are a source of significant research and technical data. These organizations include:

- The [International Planned Parenthood Federation](#). IPPF has 148 member associations around the world. There may be a member association in your country
- The [Sexuality Information and Education Council for the United States](#) (SIECUS). Their valuable publications show the need for, and value of, comprehensive sexuality information and education for young people.
- Other global organizations in the United Nations system, such as UNFPA, UNICEF, UNESCO, WHO and UNHCR, are valuable sources of information for building support for peer education – and also sexual and reproductive health education – as part of a larger programme.
- There are also several non-governmental organizations, such as ASTRA and EPHA in Europe, PathFINDER and Engender Health in the US.

Showing the value of the work

Reputable evidence-based research repeatedly shows that sexuality education for young people helps them to make healthier choices. It does not promote more sexual partners or earlier sexual involvement. On the other hand, it does show that young people are more likely to use protection when sexual activity does begin.

Certain conclusions have been drawn as a result of international meetings on human rights, including that young people have a basic right to have access to sexual and reproductive health information, education and services.

1 - *Peer Education and HIV/AIDS: Past Experience, Future Directions*. Horizon, Population Council 2001 from Executive Summary

2 - Dr Neil Schram, LA AIDS task force: "Until the government sees that its duty is saving lives, not saving souls, we'll continue to see the virus spread." From the documentary *Common Threads: Stories From the Quilt*, 1989 HBO and 2003 *Telling Pictures*, Couturie, B, Epstein, R, and Friedman, J.

Involving representatives from vulnerable, marginalized and socially excluded groups Get out to get them in!

It is vital to involve representatives of VMSE groups at all levels of programme development. Although widely accepted in theory, it does not happen often enough in practice.

The difficulties ...

In practice, representatives from these groups are often excluded.

Someone from the organization administering the programme may need to leave the office and go into the field to identify and involve people from these groups. Incentives may be needed to generate consistent and sustainable involvement.

It may also take time and effort to gain the trust and confidence of people from VMSE groups and to encourage them to become involved in a peer education programme.

... and the benefits

Representatives of VMSE groups are likely to have the best idea of how, when and where to reach the populations and communities they represent. There are enormous gains to be made when they are involved in the programme team.

Case study

Feedback from an IPPF EN workshop in Sarajevo in August 2003 shows the value of involving someone from a VMSE group. One of the workshop facilitators was a gay person living with HIV, and the following were some of the participants' responses to his involvement:

"I really appreciated the testimony of the person living with HIV. It was the first time for me; I was shocked and touched deeply. It played and will play a huge role in my further work in this field. I think it was very brave from him and I will always remember him for teaching me a lot in life."

"The testimony of the person living with HIV really helped me to understand better and to have fewer prejudices regarding many things. Thanks very much to him!"

"The testimony of the person living with HIV was very sad but also full of life. I was happy to have met someone like him. He is proof that people living with HIV/AIDS and gay people are no different from others and that we should never point to them and make them feel rejected."

In the case of the workshop in Sarajevo, the person who gave the testimony was also involved in the planning and design of the workshop. A particularly talented trainer, he had a strong sense of how, when and on what issues to speak.

It is important to select and prepare the guest speakers who will give personal testimony carefully. Just because someone has HIV or is in some other way vulnerable, marginalized or part of a socially excluded group, it does not automatically qualify them to speak on the subject. In some places there are organizations with speakers' bureaux, which help train and support people to

speak at events such as these. The person who speaks about a vulnerability or life experience must be well prepared and have an understanding of the type of situation s/he addresses.

Get to know potential team members or guest speakers first to make sure that they are suitable for the task. For example, ask questions to determine their level of open-mindedness with regard to discriminatory or unhealthy attitudes, such as, 'if a close friend told you he was HIV positive, what would you say to him?'

Building the team

While some programmes give precious little time to developing the skills of their peer educators, others dedicate significant resources to the task. Consequently, the reputation that peer education gets often reflects the quality of the particular programme through which peer educators are trained and supervised. A thorough, comprehensive curriculum can take more than 50 hours of training in order to get highly competent, qualified peer educators.

What do you need to create a good team?

- A supportive training environment that is also non-judgmental, accepting, open and safe
- Motivational experiences (such as meeting people living with HIV)
- Experiential learning (games, exercises, brainstorming)
- Opportunities to perform as peer educators in the field
- The time and resources to sufficiently prepare and rehearse before going into the field
- Strong team- and trust-building
- An environment that includes some fun
- Retreats or field trips that enhance group bonding
- To convey the feeling to participants that they can and are making a difference
- The ability to explore and resolve conflicts within the group
- Attention to incentives (these can include snacks, certificates, group outings, credit for community service, praise and thanks from recipients of the education, media attention and more)

What does it take to be a good peer educator?

Potential for leadership is one of the best indicators of a good peer educator. By 'leader' we do not mean a person who likes to show himself or herself off, but someone who has the ability to lead and share with his or her team mates.

What are the characteristics of a good peer educator?

- Potential for leadership
- Good listening skills
- Ability to communicate clearly and persuasively with peers; experience with public speaking is also an asset
- Self-confidence
- Respected, trusted and well liked by the peer group

- Able to work in a team
- Non-judgmental
- Motivated and committed to the programme
- Capable of respecting confidentiality
- Spontaneously developing skills
- The potential to be a role model for peers
- Dramatic ability, which can be useful if the programme uses drama as part of its techniques.

How to choose peer educators

There are several ways to recruit and select peer educators and each entails a different level of screening. Some programmes are very open about who can qualify, requiring only that the interested person abides by the rules (see the next section on setting a contract with peer educators). Others have a more rigorous selection or screening process, which aims to set a standard for participants entering the programme.

Selection process

The selection process should ideally involve other young people, particularly those who already work as peer educators. The applicant may need to complete a questionnaire, which might ask questions about experience, motivation and character. Because peer education is a complex and sensitive matter, the selection process should also involve a personal interview.

A cautionary note: The best is not always the best!

Be careful not to recruit only 'super-star' peer educators, those who stand out from their peers because of their achievements, popularity or other characteristics. In a highly competitive and rigorous selection process, there may be a tendency to select high achievers – the talented applicants that stand out the most. However, if the selection team ends up with a disproportionate number of very talented peer educators, there could be a drawback. The educators might have less in common with the target audience, who will have trouble regarding them as real peers.

Some of the best successes happen when the audience relates well to a peer educator who may be less of a 'model character' and more like them. When they can see, for example, that someone was once a 'naughty-boy type', or that a 'cool' friend is taking HIV and STIs seriously, they may be more likely to pay attention to the problem.

It is crucial to try to include primary stakeholders in the selection process. Since peer education often targets at-risk and vulnerable populations, recruiters of peer educators may need to venture out to where these populations live or hang out.

The following list of additional criteria for recruitment of peer educators was adapted from a study by Anne Calves on behalf of the IPPF Vision 2000 Funds.

Recruiting¹

Recruitment: criteria and qualities

- A successful peer educator will be acceptable to the community in which he or she will work.
- The selection of peer educators should not be the responsibility of programme managers alone. The recruitment process should involve teachers, community leaders, religious leaders and other youth organizations in identifying and recommending potential applicants.
- Clear selection criteria should be established before recruitment. The opinions of older peer educators and target groups on 'what makes a successful peer educator' must be taken into account. This makes criteria more realistic and encourages young clients to have confidence in the individual selected.
- Peer educators should show commitment to the philosophy of the programme, its objectives, goals and organizational systems. They must be available to work as required by the programme.
- Key personality attributes include the ability to:
 - communicate on sensitive issues
 - be trustworthy
 - be committed to the cause
 - be discreet and tolerant
 - be dynamic and assertive
 - act as a model for young people.
- Once trained, they must be able to facilitate a group discussion and take on responsibilities.
- The necessary socio-demographic characteristics will depend on the primary stakeholders. The age limit for peer educators is usually around 25 years, although in some cases age is less important than the skills and attributes listed above.

Setting a contract – what we all agree to do

A contract sets expectations for the peer educators, trainers and the organization hosting the training programme. Although many operate with the best of intentions, there should be agreed levels of expectation and accountability for peer education programmes to avoid misunderstandings and inconsistency.

Some may see peer education as a hobby or feel that it is acceptable to come and go as they please. An agreed contract that specifies what the expectations are for peer educators makes the programme much easier to manage. If someone is chronically breaking this agreement, then there may be grounds to consider whether or not they are a good fit and if they should continue to be part of the programme.

1 - Adapted from Recruitment of Peer Educators (p 3), in Peer Education Manual – Peer Education: Successfully Promoting Youth Sexual and Reproductive Health – Guidelines IPPF Vision 2000 Funds, 2002

For an example of a Peer Educator Training Workshop Contract that was created at an actual workshop, see Annex 1.

The sponsoring organization should also agree to some conditions regarding its role and behaviour in relation to the training. It might, for example, make sure that the training will occur in a safe place or agree to provide adequate support and supervision for the peer educators.

There may also be an agreement about incentives for the peer educators, such as providing a certification of completion of the training or of the service provided.

The contract thus becomes an indication of the seriousness of the programme and of commitments made by both parties.

How do we learn to be good peer educators?

Several types of people should have a say in the development of the training curriculum for a peer education programme. These include:

- people from the target population(s)
- people experienced in peer education training programmes
- behavioural scientists (such as psychologists, social workers and counsellors)
- programme co-ordinator(s)
- trainers
- people from relevant vulnerable populations
- medical experts
- parents
- local religious leaders
- people from the ministry of health
- social marketing experts.

The curriculum might vary in length. While some peer education programmes only give several hours of training, others provide more than 50 hours, over multiple sessions, giving a much more in-depth training experience.

Issues to cover in comprehensive peer education training

- Introductions and orientation to the programme
- Breaking the ice and getting people ready to work together
- Writing a contract
- The rationale and a comprehensive model for peer education
- Acknowledgement of participant concerns and interests
- Introduction to local needs, issues and problems to be addressed by this programme
- Introduction to the language of human sexuality
- Adolescent development in terms of anatomy, physiology and psychosocial factors
- Human reproduction
- Recognition of values and attitudes of the various stakeholders
- Sexuality in terms of gender, roles and identity
- Sexual orientation (heterosexuality, homosexuality, bisexuality)
- Discrimination and stigma
- Sexual health, especially birth control, pregnancy and parenting
- Sexual trauma, including sexual abuse, date rape
- Safer sex practices
- Sexually transmitted infections and problems
- HIV/AIDS: general information
 - statement of the problem
 - basic medical information, for example, transmission and different stages of an illness
 - primary and secondary prevention
 - counselling and testing
 - treatment
 - living with HIV/AIDS
 - care and support
- Drugs and substance use and chemical dependence
- Training the trainer with respect to presentation skills
- How to build an agenda for a workshop or intervention.

Phase 2: Implementing a programme

What makes it all work?

It has been suggested that advocates of peer education rarely refer to theories when designing peer education projects. Some researchers say that peer education is a method in search of a theory, rather than the application of theory to practice¹.

Nevertheless, the process and intervention of a peer education programme should be supported by theoretical frameworks or models which explain the rationale behind it. Potential sponsors are also likely to be more comfortable with credible theories and models.

Some peer educators may be less interested in the theory, but understanding it will help them design agendas and interventions within a more logical and comprehensive framework.

Several theories and models have been proposed as a framework for peer education programmes, and the most common ones are listed below.

Models relating to peer education

- Information, Motivation, Behavioural Skills and Resources (IMBR) Model²
- Trans-theoretical or Stages of Change Model^{3,4}
- Health Belief Model⁵

Theories used in peer education

- Social Learning Theory⁶
- Theory of Reasoned Action⁷
- Theory of Participatory Education⁸
- Diffusion of Innovations Theory⁹

To avoid exhaustive lists and explanations, this handbook explains three models that are extremely useful in the context of peer education.

Information, Motivation, Behavioural Skills and Resources (IMBR) model^{10,11} – a what, why, how, who, where and when model

This model is very useful because it is comprehensive and simple at the same time. It proposes that a programme

must be comprehensive if it is to change health-related risk behaviour; and it suggests that a comprehensive programme needs to pass on important **information**, such as health-related facts (e.g. facts about how a disease is transmitted, where it is happening, what puts people at risk and what its symptoms are).

This information on its own, however, is not always enough to bring about behaviour change. Therefore the model proposes that a good programme must also teach the **behavioural skills** needed to avoid the health problem. For example, a programme would ideally teach its participants the correct way to use a condom or how to negotiate safer sex with a partner.

People may also need the **motivation** or the 'reason' to go to the trouble to change their risk behaviour, so a strong programme will also motivate participants.

Finally, a good programme will make it clear where and when a person can get the **resources** they need in order to reduce their risk behaviours. Resources can include items such as condoms, dental dams and clinical services, such as counselling and testing for HIV and sexually transmitted infections.

How it works in peer education

With four, logical common-sense components, the IMBR model enables peer educators to easily check if their agenda includes an element of each of the four components.

Peer educators can decide which important facts to convey to their participants and which skills to demonstrate or 'model' (for example, through role plays) for their target audience. They might even encourage the participants to practice these skills themselves in the peer education training. The peer educators can decide what they think is the best way to motivate their target audience so that they take the message seriously enough to consider reducing their risks. Maybe they will bring in a guest speaker living with HIV/AIDS or show a powerful and moving video. The peer educators can also research local resources and pass this information on to the audience in the form of telephone numbers and addresses of clinics and other information.

1 - Turner G, Shepherd J. A method in search of a theory: peer education and health promotion. *Health Educ. Res.* 1999 Apr; 14(2):235-47.

2 - Zielony, R. and Lewis, T. (1995) adaptation based on the work of Fisher, J.D. and Fisher, W.A. *Changing AIDS Risk Behavior: Psychological Bulletin*, 1992; 111:455-474

3 - Prochaska, J.O. & Velicer, W.F. (1997) The Trans-theoretical Model of Health Behavior Change. *American Journal of Health Promotion*, 12 (1), 38-48.

4- Prochaska, J.O. and DiClemente, C.C. "Towards a Comprehensive Model of Change." In Miller, W.R. and Heather, N. (eds.), 3-27, *Treating Addictive Behaviors*, New York Plenum, 1986.

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10 - Zielony, R. and Lewis, T. (1994) adaptation based on the work of Fisher, J.D. and Fisher, W.A. *Changing AIDS Risk Behavior: Psychological Bulletin*, 1992; 111:455-474 (IMB was created by Fisher and Fisher; it was adapted by Zielony and Lewis to include resources (IMBR)

11 - Theories and Models of Peer Education, *Peer Education Training of Trainers Manual*, UNFPA 2003

The Health Belief model (HBM)^{1,2} – how our beliefs affect our health behaviours

Originally developed in the 1950s by Hochbaum, Kegels and Rosenstock, the HBM is commonly used to both explain and predict health-related behaviour. It focuses on people's attitudes and beliefs towards health issues and how these predict health-related behaviours.

The model suggests that taking action for health will depend on several factors. These factors include what the person thinks about the personal risk or threats. The person must therefore have a sense of what the chances are that he or she could have or get this health problem. The person may also be affected by his or her perceptions of how serious or dangerous the problem could be. He or she may also be affected by the feelings of how likely it is that the behaviour change would result in some sort of positive outcome or benefit. This model also takes into account the things that might operate as barriers to the change, such as the costs or difficulties that would result in taking the action.

In addition to this, the model suggests that there may be internal or external events, or 'cues', which prompt the person to take the action. A cue might be a physical symptom or difficulty or perhaps an external event that stimulates awareness.

Finally, it was suggested that 'self-efficacy' should be included as a factor in this model³. This means that a person's feelings or perceptions of successfully performing a particular type of behaviour may impact the health behaviour.

Peer educators must be able to understand how their target audience relates to these issues. The following factors, examples and key questions may help to link this model to peer education:

Perceived susceptibility

A person's perception of the chances or risk of contracting a health problem. Key question: *What are the chances I might get HIV/AIDS or a sexually transmitted infection?*

Perceived severity

A person's perception of how serious a condition or health problem and its consequences might be. Key question: *How bad is it to get HIV/AIDS or an STI?*

Perceived benefits

This is the person's perception of the likelihood that there will be some positive gain or benefit from the action they are taking. Key question: *How will using protection help me?*

Perceived barriers

This is the person's perception of the difficulties, namely the psychological or tangible costs, of taking the behavioural

action. Key question: *What might make it difficult for me to use protection or to say 'no'?*

Cues to action

These are the things that may prompt the action or lead to the behaviour change. These could be physical incidents that signal a need in the body, or external events or experiences, such as media reports or other experiences that stimulate action. Key question: *What kind of event might get me to start being more careful?*

Self-efficacy

An addition to the original theory, this is the confidence, feeling or belief in being able to perform the action effectively. Key question: *Will I be able to successfully protect myself?*

How it works in peer education

HBM can be very useful in peer education because it leads the peer educator to think about what might get in the way of people using protection, how much they might feel threatened by the problem and how capable they are and feel about changing their behaviour

The Trans-theoretical or Stages of Change model⁴ – what are the steps to changing behaviour?

Developed by Prochaska and DiClemente in the mid-1980s, this model suggests that behavioural change tends to occur through a series of steps or stages. According to this model, the stages begin before the person has even thought about or 'contemplated' making a change. It examines several stages that a person goes through in the process of behaviour change, from becoming aware of a need, to making a decision to change, all the way to making the change and maintaining it over a period of time. The name 'Trans-theoretical' was chosen because the model comes from several theories of behavioural change.

The actual stages are as follows:

- 1. Pre-contemplation** – the person may not have intentions to take any action and may not even be thinking about the problem or risk.
- 2. Contemplation** – the person has an intention to take action but has not yet done so.
- 3. Preparation** – the person intends to take action and has been getting ready to do so. He or she has taken some steps to prepare for changing behaviour and will take action within a month.
- 4. Action** – the person has changed the behaviour or taken the action.
- 5. Maintenance** – the person has not only changed the behaviour, but has been able to sustain the change for at least six months.

1 - The Communication Initiative-theories-Health Belief Model (Detailed) <http://www.comminit.com/ctheories/sld-2929.html>

2 - Appendix B: Selected Planning Frameworks, Social Science Theories, and Models of Change in Making Health Communications Work, A Planner's Guide <http://cancer.gov/pinkbook>, US Dept of Health and Human Services Public Health Service, National Institutes of Health, National Cancer Institute

3 - <http://www.fhi.org/en/aidscaip/aidspubs/behres/bcr4theo.html#anchor224342>>Family Health International's Webpage: Behavior Change – a Summary of four major Theories as cited in The Communication Initiative-theories-Health Belief Model (Detailed) <http://www.comminit.com/ctheories-sld-2929.html>

4 - Prochaska, J.O. and DiClemente, C.C. "Towards a Comprehensive Model of Change." In Miller, W.R. and Heather, N. (eds.), 3-27, Treating Addictive Behaviors, New York Plenum, 1986.

How it works in peer education

This theory is included in this handbook because of its value in understanding the various stages that individuals are likely to go through in order to change their behaviour. It may be of greatest use when working with an individual, especially in peer outreach education, rather than with a group.

If someone has not even thought about a problem or about making a behavioural change, or felt any sense of risk or vulnerability, it becomes clear that they may need some initial 'consciousness raising' about the nature of the problem or risk. If, on the other hand, someone has already made a decision to try to change, the peer educator might need to focus on helping the person learn the skills needed to make the change. In yet another example, a person may have already made a change, but the effects of whatever motivated the change in the first place might be wearing off. This person may need a new kind of inspiration or reminder of what it is that motivated the healthier behaviour in the first place.

It is important to note that this model may be more difficult or complicated to apply to peer education in group settings. This is because many people in a workshop or audience may be at different stages of personal change and one type of focus or intervention may not work for everyone.

In designing a programme for a group audience it is useful to try to reach all sorts of people by having a variety of activities and points of focus. Part of the programme may target those in the audience who are still in the pre-contemplation stage and have not thought much about the problem. This could be the 'raising awareness' part of the programme. Other parts of the programme might focus more on helping those already in 'contemplation' to get ready to be able to make the change(s). For example, some participants may need help in negotiating with their partners to wait for sex or use protection. Others may have already gone into the action stage, but need reinforcement or help maintaining their positive, health-related behaviour.

Skills and techniques

Skills

Certain skills and attitudes are particularly important when working with VMSE groups:

- **Patience** – you will need time to get close to people in your target population and to earn their trust and keep it.
- **Tolerance and relation without prejudices** – be honest with yourself and be aware of prejudices you may have against these people. Do not judge them by your own prejudices, but discuss them with your teachers, supervisors and team mates before contacting people from VMSE groups.
- **Understanding their needs** – it is necessary to realize that their priorities may be for food and shelter (they must be given those before information and other services). Also, people often will not wish to discontinue their unsafe behaviour just because you tell them that what they do is risky (for example, sex workers). Maybe it is enough to help them reduce their risk (for example, by using condoms). This may be more productive and helpful than trying to offer them a new life, job or the opportunity to participate in peer education.

- **Readjusting** – your meetings with them will not always go as planned, so you must think quickly and adjust your planned activities so that they are as constructive as possible.
- **Adequate communication and negotiation** – during contact with VMSE people, you must talk in a way that makes it easy for them to understand you and cooperate with you, so learning techniques that have the potential to reach them is essential (see box entitled 'Communication Techniques').

Communication Techniques: advice from the VMSE community.

Peer educators working with those of us in VMSE groups need to understand how to reach us and must be able to adapt to the rules of our settings.

Work with us must often take the form of 'one to one' interactions, for example, with some sex workers, because someone else's presence may be an obstacle to communication. (This also applies to many groups, such as young people in refugee camps or institutions.) Short contact, for no more than a few minutes may be very effective for the first communication. Do not insist on long encounters or that meetings last longer than the target participants want.

Where to meet

It is important that the place of meeting with us be more common and acceptable to us than to you, the peer educator: It may be on the street, in a park, on the periphery of the town or in refugee camps. It may be in a café or any other place where you can usually see us (so called 'ambient workshops'). It is unrealistic to expect us to come to your organization or club. After some time and when mutual trust is built, you might be able to do more constructive 'by-the-rules' work, such as traditional group workshops.

You must also modify work techniques according to our needs. As a peer educator, you must recognize these needs very well at the start. It is highly valuable to spend some time with us, in the places we live, and to learn about our abilities, needs and attitudes.

Communication

At first, you must study our communication channels and then adjust your language by taking into account the way we receive information best.

Photos or appealing and imaginative brochures that 'speak' directly to us are more effective than the most truthful and scientific information delivered exclusively through text. These things are very important for work with people who are illiterate or who do not speak the primary language/s of the country in which we live.

It is also important when working with those of us who may have weaker intellectual abilities. In these cases, you may use short films with suitable music, with or without text.

Role playing is also very effective for developing skills and giving information. Simulation (for example, how to use a male or female condom using a model such as a banana) may be more effective than any textual material. Be careful to make sure that everyone understands that in real life the condom will, for example, need to be used on the penis rather than the banana!

People living within VMSE groups best understand the needs of these groups.

To find effective channels for communication, you may look for someone to help deliver your programme (such as an informal leader of a youth group or organization, or a group of VMSE young people). This may result in more effective and closer relations and can provide important background information about the target group. It is a good idea for the person who takes on this role to receive some peer education training from your programme.

If we do not live within VMSE groups and do not experience their living conditions, we will know a lot less about their needs than those who do. We have to learn about these groups and their needs from representatives. These are the best people to teach others about their needs, motives and expectations. One very effective way to gain such insight is by organizing focus groups.

Working with focus groups

Focus groups usually consist of individuals (6–12 people) with homogenous characteristics, for example, same gender, similar age range, education, culture, profession, sexual orientation or other characteristics. For example, a focus group with female sex workers may be more successful if it does not include men because of the intimate and personal nature of some of the discussions. Focus group meetings should be held in comfortable, friendly rooms where participants can feel at ease in order to facilitate the group process.

After the educator and participants have introduced themselves and a positive atmosphere has been created, the educator explains why the group has been brought together and what will be discussed (for example, use of contraception). He or she will already have prepared questions to ask the whole group.

The educator should encourage participation without criticizing or judging participants' opinions. The aim is to learn as much as possible from group members' experiences in order to help plan future activities (for example, the best ways to teach people in this VMSE group about contraception). The rules that apply to workshops also apply to focus groups.

The focus group usually lasts for one to one-and-a-half hours. The educator must be flexible, friendly and watch that every participant has enough space and time to say what he or she wishes – no one should monopolize the time. When one question is completed, the educator moves onto the next and so on.

The focus group organizer can also ensure that there is an observer present whose job it is to carefully write the answers and thoughts of every participant, but without recording their names so as to protect their privacy. The observer also notes the atmosphere, looks for similar experiences and thoughts, language and phrases used by participants. He or she should be introduced or identify himself or herself to the participants at the beginning of the meeting.

At the end, participants should be given a chance to say anything that they did not have a chance to say earlier, or to ask questions. To get the most out of the focus group, it is advised that the educator be helped by other peer

educators, the supervisors, consultants and others experts, in the preparation, facilitation and analysis of outcome of the meeting.

Techniques

The techniques used most often in group work are:

- individual work
- working in pairs or in small groups
- brainstorming
- 'aquarium' technique
- conversation 'in a circle'
- role play
- group discussion
- games
- creative workshops
- evaluation
- video presentations.

Individual work

Each participant in the group is separately engaged in a specific task; is focused on his or her own attitudes and thinking; and is in a search for his own solution to the proposed problem.

When working in this way, it is very important that the peer educator stress the fact that there are no good or bad answers, but that every answer reflects a personal insight. The educator should also encourage hesitant participants to voice their personal opinions about the issues without forcing these participants or making them uncomfortable.

Working in pairs or in small groups

Pairs or groups of four to six participants – the optimal small group number – are involved in a certain task. The different groups should be far enough apart from each other to allow them to work without distraction.

Participants are randomly divided into pairs or small groups, which should change with each new task. Each group can elect its own leader or facilitator to write down conclusions, and also choose someone to present the results in front of the whole group. This person should bear in mind time limitations and make sure that they stick to the subject.

Brainstorming

Brainstorming is a group technique that involves the spontaneous contribution of ideas from all members of the group. It asks participants to 'free associate' about a certain subject, usually using one or a few words to express their ideas, and the peer educator writes their ideas on a flipchart or board. This is a good method for including the whole group and for thinking freely about a topic. This technique can also be used for group problem-solving.

Through brainstorming, participants can come up with all sorts of answers, and the peer educator facilitating the group must note them, but not behave in a judgmental manner regarding the value of the ideas.

At the end, the group may categorize or organize the ideas and discuss them openly. This is a good way for the educator to get an idea of the thinking and knowledge that the group has about a given topic.

'Aquarium' techniques

A small group or a pair performs a certain activity in the centre of a circle, with the remaining participants acting as observers who will make comments and suggestions afterwards. If participants will be performing in front of the larger group, they will prepare beforehand in small groups.

Conversation 'in circle'

The participants discuss certain issues in the following order: the first to start is the one who sits on the left (or right) of the educator; then the one sitting next to them and then it continues until the circle is completed.

The educator makes sure that each person in the group is heard by the participants. It is possible to use a 'pass' rule that allows participants who are uncomfortable not to speak. They can be included in the conversation later if they wish.

Role playing

Role playing is a technique where pairs or a group of people enact or 'play' life situations. Characters, situations and content are determined in advance with respect to their relationships and personal identities.

Another choice that can make role playing an entertaining and fascinating method is improvisation. Participants create dialogues or scenes throughout the game and thus take an active role in how the story unfolds.

A role play can be used to introduce a topic and explore attitudes and values. This technique helps us learn about ourselves, practice tolerance and examine our own behaviours. After the role play, the educator asks questions in order to facilitate a discussion about how the characters behaved and how their scenarios were similar or different from real life. The educator can also ask if people can think of alternative directions or strategies the characters could have taken or used.

Group discussions

Discussions are opportunities for sharing ideas and thoughts on a given topic and analysing attitudes. The role of the educator is to follow the direction of the discussion, to stimulate all participants to take part in it, to ask questions, to listen to participants and, at the end, to summarize the final conclusions that have come from the participants.

Evaluation

The evaluation is a response to what has been accomplished in the peer education. It is important for peer educators to know how to use evaluation techniques in any programme they design. The evaluation will give a clear picture of how well the participants received the information, as well as the extent to which they were satisfied with the training.

The pre- and post-test method is a good way to find out if the participants are well informed about the topic. The evaluation form is anonymous, with short, multiple-choice questions. This will help those planning the programmes to improve their methods when designing future peer education activities. Some of these ideas are described in greater detail in the phase 3 section on 'Monitoring and evaluation'.

Creating the right learning environment

It is the job of the peer educator to create and sustain the best learning environments for peer education in the training and in the field. This environment needs to be psychologically as well as physically safe and comfortable. The optimal training space will have as many of the attributes on the following checklist as possible.

Psychological work space – a checklist

- Development of an agreed set of ground rules, such as a contract created with the input of participants
- A positive learning atmosphere in which participation and ideas are encouraged and not judged
- Respect for personal confidentiality
- Protection through careful psychological supervision so that the content of the learning is not too overwhelming for the participants
- A set of referrals for psychological or medical resources in case of medical emergencies or if a participant feels the need to discuss personal issues with a professional
- The ability of the leader to dismiss any individual(s) from the programme who pose(s) a threat to the safety and well-being of the other participants
- A chance to grow and learn as a team
- Opportunities to go on field trips together
- The ability to provide conflict resolution for participants should the need arise
- An agreement that everyone is equally important and deserves respect at all times, and enforcement of this rule
- Parental consent for minors involved in the programme
- An environment that conveys to the participants that what they are doing is worthwhile

Physical work space – a checklist

- Enough space to work comfortably whether sitting or moving around
- A comfortable set of seats or sitting space
- Comfortable temperature
- Adequate and suitable lighting
- No sound interference from outside
- Good acoustics in the room so everyone can hear each other
- Nothing to visually distract participants and no way for outsiders to see into the work space
- Things to eat and drink at appropriate time intervals
- A way for all participants to see each other
- A safe way to get to and from the location

Phase 3: Monitoring and evaluation

Knowing your limits as a peer educator

In addition to the opportunities for growth and making a difference that peer education offers, there are also risks when trying to reach VMSE groups through peer education. Some of the **risks** come from trying to empower people who may not be 'experts' or professionals to deal with very sensitive and important health-related issues among those who are vulnerable. This requires that the peer educators be well-trained and supervised. Otherwise they may give inaccurate information, provide poor role modelling or worsen an existing bias. Also, if not carefully trained to understand the nature of boundaries regarding issues such as human sexuality, they might unknowingly engage in insensitive or inappropriate behaviour or condone such behaviour among their audiences. But many of these risks are also true for others working within more traditional systems if they are poorly trained and/or do not do their job well.

There can also be risks to peer educators if they are sent unsupervised into dangerous or hostile environments. Some audiences may reject the frankness of peer educators as they deliver their messages. Others might question the value of young people as educators. Yet others may be tired of hearing about the subjects raised by the peer educators, and be resistant to hearing any more about them. Tension may occur if the peer educators are from a different race or ethnicity than the target audience.

Peer educators who do not have experience interacting with certain vulnerable groups may end up being influenced to participate in risky behaviour if they are not well supervised and trained. Close supervision by well-trained and caring professionals is the best way to ensure that the education experience is appropriate and effective for both the participants and the peer educator.

Ensuring monitoring and evaluation success

It is important to monitor and evaluate any ongoing peer education programme carefully to assess how it is functioning. These programmes generally set out to accomplish certain goals and objectives, and good monitoring and evaluation will shed light on their progress.

Monitoring

The term monitoring refers to the measurement of how the programme is operating.

It looks at what is happening on a daily or monthly basis, such as the number of educational events or training sessions taking place, the numbers of people being trained or reached in the target audience, and other goals that may have been set out in a programme plan.

Evaluation

There are two major kinds of **evaluation** tools used in assessing programme success – measurement of the **process** (the series of actions directed toward the project objectives) and measurement of the **outcomes** (or **impact**) of the programme on the target populations.

Also, the two types of measurements that people use to assess the programme's functioning are **qualitative** (relating to the quality of something) and **quantitative** (relating to the quantity or frequency of something).

While these words may seem technical to people who pursue peer education for the interpersonal aspects of the work, they are well worth knowing!

Process evaluation refers to the extent that the activities that were planned to take place within the context of the programme really do occur.

The two main sub-components to process monitoring in peer education are:

- the process of training the peer educators
- the activities of the peer educators¹.

In a valuable resource book on monitoring and evaluation of HIV/AIDS programmes for young people, authors Webb and Elliott have written about some of the indicators that can be used to measure both the training and activities of educators².

Important aspects **in training educators** include

- Training process
- Information received, or what the educators have learned from the training
- Strategies learned for teaching how to negotiate condom use
- Changes in their lives as a result of being involved in the project

They also point out that the process of monitoring can focus on the production of data, which shows that educators are carrying out the specified activities and achieving a certain amount of coverage.

Measures of **educator activities** include

- Proportion of peer educators and educator groups who are active per area
- Drop-out rate of peer educators
- Number of people reached per area (by age and gender if possible)
- Number and frequency of sessions
- Number of condoms distributed at no cost to receiver, or through social marketing
- Number of requests for condoms

1 - Adapted from: Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people, Webb, D., and Elliott, L., Save the Children Fund, 2000

2 - See note 7 p22

3 - Reaching marginalized young people: the case of peer education for young drug users in Ho Chi Minh City, Vietnam, in Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people, Webb, D., and Elliott, L., Save the Children Fund, 2000

- Number of information, education and communication materials (such as posters and pamphlets) distributed
- Questions asked by participants at meetings

Successful monitoring and evaluation: an example from Vietnam

Today, there are systems in place for monitoring and evaluating programmes designed to reach VMSE groups using peer education, which is contributing to the success of these programmes and to the improvement of future efforts³.

In one example, peer education was used to reach young drug users in Ho Chi Minh City, Vietnam. As a result of this project, indicators specific to this group were identified, which can be used in the knowledge, attitudes and practices surveys (see KAP Survey in the glossary) that are a tool for monitoring a programme.

Below is an adapted version of the list of indicators. Some of them, appropriately adapted, can apply to other groups. Over time, these indicators can be used for the **impact evaluation** of many peer education projects.

Indicators

Coverage

- Number of people contacted in the target population
- Number of commodities distributed (for example, new syringes, condoms)
- Number of injecting drug users and commercial sexual workers (CSWs) receiving condoms and syringes/needles

Outcomes

- Percentage of target population who inject/smoke or have unprotected sex
- Percentage knowing where condoms and sterilized injecting equipment can be bought/accessed
- Age profile of first use of drugs or first unprotected sexual intercourse
- Percentage of child target population reporting sharing equipment or having unprotected sex
- Percentage of child target population reporting owning own syringe or not having a condom
- Percentage of children who believe they are vulnerable to HIV
- Percentage of target population who have had an HIV test

These indicators show the ways one can monitor the success of a project and its impact on a vulnerable community. With adequate monitoring and evaluation, it is possible to adapt or replicate the lessons learned from a project in other areas or with other populations.

Knowing the importance of evaluation

There is often a tendency to avoid the details of monitoring and evaluating peer education programmes. Those who may not be inclined to study the workings of a programme, preferring to simply get on with peer education in the field, might not be aware of how

important and essential the processes are to the overall success of the programme and its sustainability.

There may be a tendency to see and feel intuitively that things seem to be going very well. From several perspectives, however, this is not enough. The funders of a programme will want to know that their sponsorship is resulting in money well spent. It is necessary to attempt to measure whether the programme is really having an impact on knowledge, behavioural skills, motivation or whatever is within the quantifiable goals of the project.

Often, at the end of a peer education workshop, the educators leave with the feeling that it was very successful. But those who question the value of peer education will actually want to know whether the programme has an impact on behaviour, or simply leaves participants with a good feeling, sometimes referred to as 'the feel-good factor'. Without attending to the process of the programme, it is difficult to find out what the problem may have been when something has gone wrong or if the programme is unsuccessful in some way.

A peer education manual produced by IPPF in 2002 states:

"Monitoring and evaluation of peer educators' activities must be carefully planned, using quantitative and qualitative techniques to identify project strengths and weaknesses.

Monitoring of peer educator activities can be carried out by project staff, older peer educators and also by community members such as those represented on the project steering committee and teachers.

Monitoring procedures can include field supervision visits, activity reports, and regular meetings. Using focus group discussions and qualitative surveys with both beneficiaries and peer educators will provide greater insight into specific areas for project improvement.

Project evaluations must include process and impact indicators. Evaluation tools should be well formulated and address specific peer education outputs and outcomes. For example, process data collected may include the number of young people reached through workshops and the number of condoms distributed. Impact may be measured through pre and post-test surveys at workshops and behavioural surveys. Data collected for monitoring and evaluation purposes has little value unless it is compiled, analysed and disseminated systematically. Where this is done effectively, monitoring will make a vital contribution to programme planning and management. Referring to baseline data will also help to track the evolution of programme impact and constraints"⁴.

For a more detailed explanation of evaluation research methods which can be used in peer education programmes, refer to *Learning to Live: Monitoring and Evaluating HIV/AIDS Programmes for Young People*, Save the Children Fund, 2000. This contains a compendium of relevant ideas about programmes for young people, relationships with stakeholders, strategy options for reaching young people and all sorts of useful ideas for designing programme evaluation. ■

4 - From: Monitoring and evaluation pg.12, Peer Education Manual – Peer Education: Successfully Promoting Youth Sexual and Reproductive Health – Guidelines IPPF Vision 2000 Funds, 2002

Section 6 – Working with vulnerable, marginalized and socially excluded groups

Vulnerable groups: a definition

If you look up the word 'vulnerable' in a dictionary, you are likely to find all sorts of words which relate to it such as: lacking defence, unprotected, unsafe, susceptible, weak, young, penetrable, assailable and endangered.

The definitions of the word '**marginalized**' describe things that are on a margin or a border, outside of the mainstream and not of central importance. Marginalized things are defined as being located at the fringe of consciousness and sometimes close to the lower limit of qualification, acceptability or function.

Since the word **social** refers to society, and **exclusion** means to keep out or shut out of a place, a group or a privilege, '**social exclusion**' refers to when people are shut out of some of the privileges or prevented from inclusion in the social aspects of a society that are accessible to others. This exclusion can be from a variety of social events, community gatherings, social clubs, societies, supportive groups, events that celebrate cultures and more. While being marginalized refers to being on the edge of the culture, but still with the potential to be part of it, if not in the centre, social exclusion is a stronger term suggesting that a person, or their group, is not included at all in that society.

The impact may be similar for marginalized and socially excluded groups. For example, in a community where sexuality education is provided in the school system, there may not be culturally sensitive materials or curricula for the marginalized or socially excluded populations. The curriculum may be designed to reach only the mainstream or predominant culture.

Levels of tolerance

In some cultures, if we are homosexual we might be tolerated, but not celebrated or welcomed. Where this happens, sexuality curricula in a school system may at least acknowledge our existence and possibly provide some relevant materials to help us learn. In other cultures, intolerance may be so absolute that people who are same-sex oriented are socially excluded altogether. In such a community, there might be no reference to or acknowledgement of the existence of same-sex oriented people. If there is a reference, it may be to suggest punishment or banishment from the society. Social exclusion in this situation may lead to a complete lack of any materials to help same-sex oriented people learn about sexuality. Society's treatment of marginalized or socially excluded groups can make us vulnerable, but we can gain strength for ourselves through advocacy and self-empowerment.

Potential causes

There are lots of potential causes of vulnerability and marginalization among populations and individuals. These

causes might have their roots in biological, physical, psychological, socio-cultural, ethnic, religious, environmental, historical and political issues.

Whatever the reasons, there are often methods to provide programmes specifically designed to take vulnerability and marginalization into account. The aim is to reduce the threats to people who have these vulnerabilities and to bolster their defences.

In this handbook, the term 'vulnerable' describes groups that are more at risk or less well protected than the 'mainstream' of society. Mainstream groups may have some susceptibility to problems of health, but less so than these groups.

In the following section, the reader is invited to look into the world of vulnerability in a way that moves the experience from mere words to personal imagination and recall.

When young people learn about the darker sides of life

It may be a little difficult or uncomfortable to think and learn about vulnerability and social exclusion because these life experiences are often associated with pain, trauma, sadness and hardship. Life for some people in the most vulnerable groups in our cultures often has elements of tragedy. However, it can also have the potential for change, success and joy.

Some might think that it is not fair to expose young people to the darker sides of life. Young people, however, are sometimes not given enough credit. There is a lot of realism in our everyday lives. Many young people who have access to television, newspapers, the Internet or even the streets, are exposed on a daily basis to news stories or other evidence of discrimination, violence, war, abuse, crime and victimization.

When we as peer educators learn about such difficulties in the context of peer education, it is with a view to empowering us to make a difference in the world. We can convert the sadness to positive life energy and try to improve the lives of other young people.

Making it more personal

As peer educators trying to help people from VMSE groups, how can we understand their vulnerabilities on a personal level? It may come naturally to some of us because of our life situations. Perhaps we are, or have been, members of vulnerable, marginalized or socially excluded groups. For the rest of us, we may need to look inside ourselves and use our imagination. We must go beyond words into our hearts and experiences. Let us take a few moments to think about vulnerability. Try to imagine some of the following things, which may or may not be familiar to you.

Some days, we may feel strong, on top of things, energetic and optimistic about being able to manage the things in our lives. Other days may see us less confident, overwhelmed, in a down mood, feeling less safe and more threatened by the world. Different things can cause these various states, some coming from inside, and some from outside. The important thing to notice is that there is a difference between these sensations. Some days we feel stronger, like nothing can hurt us, and other days we feel more vulnerable. This recognition may open the door a little to better understanding or remembering what it is like to be vulnerable.

A stranger in a new or hostile place – the socio-cultural perspective

Perhaps you have travelled away from home at some point to a less familiar place, village, town or country. Have you ever felt threatened in this situation? Perhaps you did not know anyone who could help you. Perhaps physical features such as your clothing, colour of your skin or other features made you stand out as different from those around you. Maybe you felt that people could see that you were a stranger:

Ask yourself ...

- How did you feel?
- Did people look at you because you were different?
- Did you feel that some people may have felt hostile towards you, perhaps for a reason you did not even know or understand?
- Have you ever been in a place where you thought that if people knew who you were, or where you were from, that you might be in serious danger if the wrong people found out?

Imagine these scenarios for a moment. Imagine that the wrong word or look, or someone recognizing something about you, could put you in danger. You are now travelling into the world of stigma, prejudice and discrimination.

When your body is vulnerable – the biological or physical perspective

Let us now think a little about biological and/or physical vulnerability. How do the following words or situations make you feel? Have you ever experienced them?

Think about ...

- When you have been running or exercising so hard, you are completely out of breath and there is a sharp pain in your side.
- When you have been sick and sweating with a high fever or suffering from flu so that you could hardly lift your head from the pillow.
- When you have been extremely hungry, thirsty or dehydrated.
- If you have or have ever had a physical challenge of some sort
- When you have had a limb broken and perhaps needed some sort of special support or a cast.

- When you have gone to a clinic and had a medical professional examine your genitals, either for a gynaecological examination or screening for an STI or hernia.
- When you have had a test for exposure to HIV infection ... and then waited to get the results.
- If you have felt afraid of being assaulted by someone who was bigger or stronger than you and/or who was drunk or high and out of control.
- If you have been chased or threatened with a weapon?

Feeling emotionally vulnerable or the scapegoat in a group – the social or psychological perspective

Regarding psychological vulnerability:

Ask yourself ...

- Have you ever felt anxious, scared, sad or depressed?
- Have you ever lost someone you love?
- Have you ever been confused about who you are or how to behave?
- Have you ever felt lonely or lost?

To understand social vulnerability, we may think of whether we have ever found ourselves feeling not accepted in a group of people, or as if we were a 'scapegoat'. Have you ever felt that people were picking someone else in a group of young people to be made fun of as a 'scapegoat'? When you are that person it can feel pretty bad.

Imagine ...

Think of how gay people are often treated in our cultures, especially among young people. Imagine you are straight and the whole world around you is suddenly gay. Imagine that the brunt of many jokes and insults is directed at straight people. Imagine that it becomes a big insult to call someone 'straight'.

The environmental perspective

Have you ever been in a place or environment that seemed dangerous?

There could be many reasons for this danger. It might be a place where the air is highly polluted. Perhaps you have been in a place where there was a kind of smoke in the air that you felt was going to hurt your lungs, and you tried to hold your breath or cover your mouth with a cloth through which to breathe. You may have been unsure whether the drinking water was safe, but had nothing else to drink. Maybe you have been stuck in a freezing, cold and wet place, with no way to get warm or dry for a long time. People must often live in unhealthy places. This may be for various reasons, including economics. It may only be possible to change their situation through strong advocacy and public awareness. Trying to get out of dangerous living conditions might put people at risk in some other way if, for example, they do not have the resources to pay to live in a safer environment.

Opportunistic people may take advantage of a person's vulnerability by offering them a 'better' situation. By the time the person realizes it is not better; it may be too late to get out of it. People sometimes live in dangerous neighbourhoods or among a group of people engaged in risky lifestyles. Some young people may be growing up in an environment surrounded by drug use, violence or other risky life patterns.

Vulnerable, marginalized and socially excluded groups: perspectives from those who know

In this section of the handbook, we will explore various groups to help you better understand some of the issues they face. By bearing in mind the examples and visualization suggestions given above, it should become clear that there is a lot to learn and consider in reaching VMSE groups in any population. It is important to understand who they are, the barriers and obstacles we face in helping them, the best practices we know and the lessons learned when working with these populations.

In the end, it is the job of the peer educator to learn to recognize the patterns of discrimination and stigmatization in his or her culture, to become a successful educator and

to advocate against such problems. Examples of specific needs are provided in the sections that follow.

The groups that are covered in this section are:

- People living with HIV/AIDS
- Injecting drug users
- Children at special risk
- Sex workers
- Sexual minorities
- Ethnic and cultural minorities
- People with physical and mental challenges.

A group of researchers suggests the following about sub-populations of young people at high risk:

"Youth who are gay, bisexual, transgender, homeless, runaway, intravenous drug users, incarcerated, in the foster care system, mentally ill, and who have been sexually or physically abused are at increased risk of HIV infection because of greater exposure to the virus in their social networks".

They also quote sources that have found that:

"These vulnerable youth experience higher rates of health and social problems in general than other youth".

I - Shriver, M.D., Everett, C., Morin, S.F. Structural interventions to encourage primary HIV prevention among people living with HIV, AIDS 2000, 14 (suppl 1) S1-S6

People living with HIV/ AIDS

“This is the single greatest threat to humanity ever!”

A passionate quotation in 2003 from Bono, pop star from the band U2, who has raised global public awareness about HIV/AIDS.

Description of the group

People living with HIV/AIDS (PLWHAs) is a term used to describe those of us who have been infected with the human immunodeficiency virus (HIV) and/or who may already fit the diagnostic criteria for having the acquired immune deficiency syndrome (AIDS). Once we have met the criteria for AIDS, we are considered to be a person living with AIDS, even if our T-cell count (a measure of the number of white blood cells that protect us) goes back up beyond the level for the diagnosis, or if the AIDS-defining illness has disappeared.

How we continue to live our lives after finding out that we are infected with HIV depends on the culture and society in which we live, as well as our personal psychological make-up and earlier life experiences. How we will live with our illness depends not only on our own attitudes about it, but also upon the reactions of our families, partners, friends and society.

What hurts is that the quality of our social lives is often very low because of the negative reactions and stigma placed on us by some societies.

For some of us, it is as though we die two deaths. One is a physical death, but the other is a kind of ‘social death’, because of the way that we are sometimes treated by people in our society².

Barriers and obstacles to overcome

Stigma

If society stigmatizes us and treats those of us living with HIV/AIDS as ‘not wanted’, ‘different’ or ‘dangerous’, we experience alienation and isolation. It prevents us from exercising our basic human rights to work, be educated, have friends, use health and social services and other basic aspects of life. When this happens, the reaction can be to take less care of ourselves, to avoid health clinics and programmes and to live a less healthy and less responsible lifestyle. This reaction results in increased risks for the whole of society.

People usually stigmatize and discriminate for two reasons: fear and ignorance. These two feed each other and operate as a vicious cycle.

The **stigma** associated with HIV/AIDS has been widely documented. It has been shown that HIV meets four criteria for stigma-evoking illnesses. These are:

- that it is widely perceived to be the PLWHA who is responsible for having the disease or infection
- it is considered to be terminal (fatal)
- it is contagious (can be spread)
- its effects can often be seen visibly¹⁻².

Preventing stigma among people living with HIV/AIDS in our communities needs to happen through working on structures and policies. One obstacle to preventing stigma is making it a criminal act not to tell your partner in specific sexual situations about your HIV status. Other obstacles include laws that limit immigration and travel, mandatory partner notification and name-based HIV reporting³⁻⁴.

‘I feel fine’

One of the issues that HIV positive young people must deal with is the disparity between feeling fine and yet needing to take medicine. As Futterman points out, this can pose a challenge particularly as many adolescents see things as black and white issues. In light of this it is important for HIV positive young people to understand how the virus operates within the body, and how the medications can help slow it down, even in circumstances in which there are apparently no visible symptoms of illness.

Hiding HIV status

One of the obstacles to overcome with young people who are living with HIV infection relates to problems that occur as they try to maintain secrecy. Futterman points out that it is good when an HIV positive young person can reach out to an adult, such as a parent.

“However, we have numerous adolescents who chose not to disclose their status because of fear of losing the love of their parents, or being kicked out of their house, or being physically abused. And for a number of young people, disclosing their HIV status means disclosing the fact that they are gay or abusing drugs.”⁵

The result of trying to hide the infection may sometimes mean hiding medications, which in turn may affect whether or not they are taken correctly and consistently.

Psychosocial Issues

Futterman has highlighted **psychosocial issues** relating to the epidemic of HIV and young people. She points out how many young people who have HIV have histories of sexual

2 - Herek, G. AIDS and stigma. Am Behav Sci 1999, 42:1102-1112

3 - Shriver, M.D., Everett, C., Morin, S.F. Structural interventions to encourage primary HIV prevention among people living with HIV, AIDS 2000, 14 (suppl 1) S1-S6

4 - Herek, G. AIDS and stigma. Am Behav Sci 1999, 42:1102-1112

5 - Futterman, D. Youth and HIV: The Epidemic Continues, Summary by Tim Horn, March 2003
www.prn_nb_cntnt/vol8/num1/flutterman_sum.htm

and/or physical abuse. She also notes that many young people with HIV have a diagnosis of mental illness, such as depression or substance abuse problems. Some of these issues are beyond the realm of what the average peer educator can deal with, other than to know that such issues are important to refer to a professional counsellor or specialist.

'Co-morbidities' are problems that occur together. As Futterman points out, when we do not identify and address these 'co-morbidities', it can prevent young people from coping with their HIV infection, including taking their medicines properly¹.

Best practices and lessons learned

The link between prevention and support²

In countries where there is no access to medications for those who are diagnosed as living with HIV infection, it will be more difficult to convince or successfully encourage

people to get tested. Therefore, peer educators interested in successful prevention will need to see themselves in a broader perspective – in the fight against HIV/AIDS and for the rights of people living with HIV/AIDS. They will need to help with advocacy to get support and medicines for those who may be diagnosed with HIV.

Understanding discrimination and providing care and support

One of the best ways to prepare peer educators to work in the world of HIV/AIDS is to help them understand what stigma, discrimination and care and support are all about. Below are some of the topics and issues which would be included in such training for peer educators. The peer educators may, in turn, choose to bring some of these ideas to their target community.

Issues	Training areas
Education goals	<ul style="list-style-type: none"> • To accept HIV as a common disease like any other • To explore the reasons why people act in a discriminatory way • To understand types of discrimination. • To face our own fears, prejudices and misinformation about HIV • To respect the rights of people living with HIV/AIDS • To understand how we can help society change the discriminatory acts against those who are HIV positive • To learn how to provide care and support
Why do we discriminate?	<ul style="list-style-type: none"> • Because we are not informed properly about the disease and the ways it is (and is not) transmitted • Because of fear • Because HIV is considered taboo and is often connected with homosexuality, prostitution, drug use and other stigmatized behaviours and populations • To feel that we are protecting ourselves and our loved ones
Forms of discrimination	<ul style="list-style-type: none"> • Movements of HIV positive people in medical centres, shops, kindergartens, schools and so on are either limited or forbidden • They are threatened at the workplace, which results in job loss • Relations with family members and others are fragile and often broken • Their human rights and ethical principals (protected with a declaration) are constantly broken
The rights of HIV positive people	<p>The rights of HIV positive people and people living with AIDS are protected by the declaration of human rights. These are:</p> <ul style="list-style-type: none"> • Tolerance • Non-discrimination • Right to care and solidarity • Right of free movement should also include the right to travel for living, work or tourism • Right to education • Rights to health protection • Right to work • Right to privacy protection <p>With this declaration, the responsibilities of HIV positive people are also regulated, as follows:</p> <ul style="list-style-type: none"> • To be informed • To be co-operative • To be tolerant • To co-operate with health institutions and workers • To care for others

1 - Futterman, D. Youth and HIV; The Epidemic Continues, Summary by Tim Horn, March 2003
www.prn_nb_cntnt/vol8/num1/flutterman_sum.htm

2 - Levy, P. Personal communication, Nov. 2003

HIV/AIDS and human rights in the work place

In many countries throughout the world where HIV/AIDS is prevalent, every organization needs to prepare a statute or special rules to protect employees who are living with HIV/AIDS in order to comply with the International Convention on Human Rights.

These rules need to consist of the following rights:

- People with HIV/AIDS must be treated the same way as those with cancer and/or other chronic diseases
- Employers need to make it clear to other employees that people living with HIV/AIDS are not endangering other staff
- Organization and trade unions are obliged to educate employees about HIV/AIDS in order to prevent a possible panic
- Employees must not be forced to undergo HIV testing
- An HIV positive person does not have to report his or her HIV status to the company where employed. If the HIV positive person spreads the infection intentionally, he or she must be reported to the authorities.
- HIV positive people must not be blamed or discriminated against, and people who treat them in this way must be reported
- HIV positive people must not be replaced in their jobs because of their disease
- HIV positive people have the right to take leave work if they need to have medical treatment or counselling
- HIV positive people should be offered part-time work when necessary, to be able to leave work when they need to be hospitalized and go back to work when they feel they are able
- This statute must be under supervision by the company and the trade union.

It should be noted that very often in countries where laws are supposed to protect people living with HIV/AIDS, it is very difficult to follow them or prove that they are violated. It is rare that someone will 'officially' be fired from a job because he or she is a person living with HIV/AIDS¹.

Can young people help?

In some cultures, people living with HIV/AIDS, including young people, are often among the most active, driven and successful leaders and advocates for our communities and needs. Their participation in the design and implementation of programmes for this vulnerable population is essential.

"While stigma, or the threat of stigmatization itself, plays a major role in determining the acceptability of interventions to HIV-infected people, as well as the success or failure of

almost all interventions, combating stigma is an area where people with HIV/AIDS have always played a particularly active, positive role."²

In this light, one of the many valuable resources is The Global Network of People Living with HIV/AIDS (GNP+). It is a global network for and by people who are living with HIV/AIDS. The central secretariat of this network is based in Amsterdam, Netherlands.

"The overall aim of GNP+ is to work to improve the quality of life of people living with HIV/AIDS. This is achieved by helping to build the capacity of people with HIV/AIDS on the global, regional and national level."³

Those of us who are HIV+ play a vital role in prevention

In some of our communities, we are talking about our life experiences more and more in programmes for the prevention of HIV/AIDS. This is because we are putting ourselves in direct contact with people, making the information more real and credible. According to many young people, this is the most valuable kind of preventive education.

A summary

A UN report⁴ outlines 10 steps that countries, especially governments, should take as part of their prevention efforts:

- End the silence, stigma and shame
- Provide young people with knowledge and information
- Equip young people with lifeskills to turn knowledge into practice
- Provide youth-friendly services
- Promote voluntary and confidential HIV testing and counselling
- Work with young people, promote their participation
- Engage young people who are living with HIV/AIDS
- Create safe and supportive environments
- Reach out to the young most at risk
- Strengthen partnerships, monitor progress

Networking for social support

There is a large amount of resource data available on the experiences of people living with HIV/AIDS. We are finding ways to support ourselves into the future through a massive amount of information, and a huge global social network. There are countries that already have strong social and other networks, and countries that are planning them. Many organizations and coalitions of people living with HIV/AIDS publish information on the Internet. If you search on line you will find multiple examples of things we can do

1 - Levy, P. Personal communication, Nov, 2003

2 - Ibid

3 - www.gnpplus.net Website Nov. 1 2003

4 - United Nations Development Programme: State of the World's Population Report, Oct. 2003

to thrive and survive. Some of the Western and more developed countries had extensive experience in the earlier years of the pandemic (a global epidemic), and gained lots of knowledge about how to develop prevention, care and support as well as advocacy.

We can get an idea of the support by reading the writings of people who understand what it can be like to test positive for HIV. Annex 6 contains an example of the 'creed' or words written in support of people in the United States who are finding out that they are HIV positive. This was

written for an organization called 'The Body Positive'. Much of what is written should have value to many people who test positive in other parts of the world as well. It can serve as a model to be adapted to suit other regions.

It is necessary to understand that people who live with HIV/AIDS should be able to live normal and full lives: to work, learn, socialize and enjoy the beautiful aspects of life. Some of us are also infected, but not ill, and so we should not automatically be treated as if we are ill. Acting responsibly, we will protect ourselves as well as society.

Injecting drug users (IDUs)

This section is intended to give precise, dispassionate information for reducing potential harm in the use of injecting drugs. The aim is to assist peer educators in their task to improve health. We acknowledge that there are communities of people who are involved with injecting drugs, and support harm reduction programmes to help young people 'kick the habit' in their own timeframe, keeping them safe in the meantime.

The information in this section and in Annex 8 (which offers guidelines for safer injecting) is not provided or written to encourage or suggest the use or continued use of injection drugs in any way.

Description of the group

The following quotes reflect real-life stories from people who have worked in peer education.

"I remember ... something awful had just happened to me. My heart was broken into pieces. Then this older cousin (at the time I thought I could trust him), came and put his arm around me. He said, 'Don't worry; I have something that will take away your pain.' That was the first time I ever shot a drug. I was 12 years old. I never thought I would be someone who would become hooked."

"I worked in a drug clinic for a couple of years. I kept thinking I was supposed to see people like the ones I always saw in the movies, you know, like the stereotypes. I got to know them over time. So many were good people who had some bad luck, or made some choices they wished they had not. A lot of the people did not fit the stereotypes. These were people who were caring about others. They were trying so hard to do what they had to do to survive. The power of the chemical dependence was strong. They were trying to help us learn about the AIDS epidemic. Half of them were already infected."

"Those of us who inject drugs are from all types of communities. Some of us are from poorer communities, some are from the wealthiest. Some of us are early in our experience with 'using' and some are 'in recovery'. It is rare that you will hear us say we are cured, once we have become addicted. The reality is that once we have gotten addicted, we know it is always there somewhere in the background. So we say we are recovering. People do not understand that addiction is a disease, like many others."

"Some of us never make it into treatment, something else gets us first, like an overdose, or getting killed some other way."

For many young people, adolescence is often the time of first experimentation with drugs, and also the time of the onset of drug addiction.

In the last decade, some countries saw a relatively small or

insignificant problem with drugs and addiction. Today, in an increasing number of countries, there is a different picture, with a rapid rate of growth of the problems associated with drug use and addiction.

The age of first use appears in some areas to be dropping down to elementary school level. There is also a problem with violence associated with drug abuse. At the same time, there is a lack of adequate institutions to tackle this problem. The problems of drug abuse reach deep into the heart of the family. Many families do not have the strength to cope with these problems, partly because the family is itself isolated and afraid of being 'marked' as being involved with drugs.

In some countries drugs are very easy to get and are used in public places on the street, in cafés and school playgrounds. Very often families only acknowledge a drug problem after the signs become very evident.

Many drugs can diminish the ability to think critically, which often leads to risky sexual and other behaviours. Therefore it is clear that there is a crucial need to take steps to decrease risks of sexually transmitted infections, HIV/AIDS and other similar risks.

Barriers and obstacles to overcome

The following are issues to consider when thinking about young people who are involved in the world of injecting drug use.

Risks from injecting drugs

It is clear that the use of injection drugs outside a supervised medical setting carries with it various degrees of risk. Some of these risks are listed and briefly described below:

- **Impaired judgment** – the use of injection drugs alters biological and psychological functioning in a number of ways, depending on type of drug, dose and the individual's biological and psychological characteristics. The likely result is the inability to judge situations, which can put people in danger.
- **Vulnerability to sexual risk-taking** – the use of injection drugs may lead to increased sexual risk-taking in a variety of ways. Often, using injection drugs can cause 'dis-inhibition', which means that a person's normal inhibitions are reduced and he or she is likely to do things they normally would not in their 'normal' state of mind. This may include a disregard for risks of sexually transmitted infections and HIV. If one's partner is also injecting drugs then, statistically speaking, in many populations there is a greater likelihood that he or she could be exposed to HIV infection through sharing of unsterile needles.
- **Addiction or chemical dependence** – one of the major problems with the use of injection drugs is that they are highly likely to lead to addiction and

dependence, physically, psychologically or both. Although most people would probably say that they began using drugs without expecting or intending to become dependent on them, once the dependence sets in it is like a disease and is very hard to overcome.

- **Impact on mood and psychological functioning** – the use of injection drugs can have a profound impact on mood states, for example, euphoria, hyper-stimulation, sedation, anxiety reduction and depression.

Difficulties within the health care delivery system

- **Trust issues with professionals in social service or medical settings** – injecting drug users may have difficulty trusting professionals in the medical community or other services, as they may feel judged, stigmatized or under threat of being reported to parents or authorities. This may result in the user avoiding seeking services and the medical care he or she needs.
- **Discrimination in medical settings** – some of the concerns mentioned above may grow out of the real experience of discrimination and stigmatization in medical settings. When medical providers are not well educated about substance use and chemical dependence they may be more likely to treat IDUs with hostility.

Knowing and understanding the drug culture

Peer educators need to know and understand the drug culture of their target population, which involves an understanding of the following things:

- **Drugs being used** – peer educators wishing to help injecting drug users will need to understand something about the injection drugs being used, their effects, patterns of use, typical withdrawal symptoms and so on. This way they will be able to demonstrate an understanding of the issues with which users are struggling.
There are specific patterns of use and associated risks of different drugs. Cocaine, for example, has a stimulant effect, and may lead to a high frequency of injection, which increases the risks associated with injecting drugs. Heroin, which has a more sedative effect, may lead to lower sexual drive as interest in the drug begins to take precedence. Addictive potential is very high.
Engaging in sex work to get more money for drugs can become an increased risk among users of heroin, cocaine and other drugs, thus STI/HIV prevention is very important for those who inject drugs.
- **Need for access to sterilization procedures** – peer educators need to know about possibilities for sterilization of equipment for injecting drugs if they wish to help users reduce the risk of HIV/AIDS and other infections like hepatitis B and C. They should be aware of the possible use of bleach (chlorine) or other sterilization agents which are available and acceptable to the culture of injecting drug users. [Query: Did you want to mention hepatitis B and C here too?]

- **Availability of sterile syringes and cookers** – similar to the issue above, peer educators should know about how and where injecting drug users can get access to sterile injection equipment.
- **When skin-popping is part of the culture** – peer educators wishing to help injecting drug users should be aware of injecting drug practices. They should know for example about the use of 'skin-popping' techniques, or injecting just under the skin. This is when someone just injects the drug into the skin rather than directly into a vein. Some people who do this mistakenly think that since they are not using the drug intravenously, they are not at risk of HIV/AIDS. They need to be taught that this is incorrect and that they are at risk.

Social issues

There are a variety of social issues that are part of the world of being an injecting drug user in many cultures. These include:

- **Fear of criminal charges and the consequences of imprisonment** – injecting drug users are often involved in activities for which they can be imprisoned. Therefore, they may have the frequent stress of hiding and worrying about the police and possible imprisonment. For those who are parents or have other dependants, this may be particularly stressful. In some cases, being caught may also carry with it the threat of losing custody of children.
- **Culture of violence and threats** – the world of injecting drugs is also often surrounded with violence, and/or threats of violence. This can come in part from the economies of drug dealing and the desperation of some people to get drugs when severely addicted.
- **High levels of infection among peers sometimes will increase risk** – injecting drug users have become more at risk of infection with different diseases, including HIV/AIDS and various strains of hepatitis. Therefore, it has become an increasingly dangerous world in which to live and survive in a healthy way.

What is important for peer educators?

In order for peer educators to better understand the world of injection drugs, it is important for them to first understand their own relationship to the use of substances of many kinds. We often tend to 'medicate' ourselves as a way of coping with our feelings. Some of us do it with sugar-filled substances, (chocolates, cakes, candies), caffeine, alcoholic drinks, hot or cold drinks and other legal substances. We do not wish to equate these examples with injecting drugs, which is far more serious, but it is important to understand why people can end up on a road to being addicted, and to find ways to help them break their addiction.

In addition to the best practices mentioned in the previous subsection, it is important to mention that there is no substitute for training the peer educator about substance use better than meeting and learning from recovering drug users directly, or at least seeing documentary films about the subject from the local area, if they exist.

Children at special risk: street youth, orphans and children with no parental supervision

Description of the group

There are many reasons why some of us have ended up on the streets, for example some of us are orphans who have lost one or both parents, or simply do not have a parent to take care of us. Some of us have been abandoned for any number of reasons. Some of us had to run away to be safer because it was too dangerous to stay at home. When your parent is a heavy alcoholic, on other drugs or gets violent, it can get scary staying at home. Some of us found out that we were gay and decided that it would just be better to disappear. Some of us have parents who work all the time and cannot watch us at all. Some of us were in families that had to get out of town fast, and could never go back.

The examples below typify the kinds of things that go on in the minds of young people from such vulnerable groups. Although the three stories below describe imagined scenarios, they represent reality for many thousands of children. Such children end up living in high risk, abandoned situations without much parental guidance or support.

“When my dad died and my mom had to start to work to raise us, there was no time for her to pay attention to us anymore. She started to stay out all night to make money. Sometimes I know they hit her at work and she was crying a lot. I had to take care of my little brothers and sisters. That is when it all fell apart for me in school.”

“When I tried to explain to my father that I had feelings for other boys, he went crazy. I knew that if I tried to stay at home after that, it just would not be worth it. He is not ready to have a gay son. But since I can't get a good job, some nights I have to make money any way I can. I am not going to tell you what I have to do sometimes to get a warm place to sleep or enough money just to eat. But some of the other kids on the street are smart. They showed me what to do.”

“So this guy told me that he loved me and that he would marry me once we moved to a better place, in another country, to make a better life. Even my parents believed him. Now all he cares about is that I make enough money every night, or he beats me up really badly, I am just so ashamed of myself. If I ever tried to go back home, he would kill me. And, if I got away, I could never look my parents or friends in the eye again anyway. I am stuck here.”

Obstacles and barriers to overcome: perspectives from at-risk children

Some of the issues facing children at special risk include:

- Being disadvantaged – we lack the power that adults normally use to advocate for themselves

- Often we are institutionalized and therefore lack many of the rights and privileges that young people can have in a home environment
- We lack strong and consistent role models, which may leave us impressionable and vulnerable to adults or older children who may take advantage of them
- We can be influenced by poor role models as a result of a lack of guidance about whom to learn from and trust
- We suffer from a lack of information, which can disrupt our school or educational experience
- We must engage in survival behaviour
- We develop a kind of self-protective armour to deal with life's challenges in what can sometimes be unusually cruel circumstances full of loss and inconsistency
- We may suffer from post-traumatic stress syndrome or chronic stress
- We may be subject to unusually high levels of violence
- We may have physical vulnerability, such as illness or compromised immunity.

The life situations of such young people put us at risk for difficulties in our biological, environmental, psychological and social worlds.

Psychological considerations

Depression and anxiety

Some of us living in these situations feel depression and anxiety. We can be pessimistic and feel nervous. These may be our reactions to difficult life events or situations.

These situations affect how we feel about the future and our interest or motivation to take care of ourselves. It may sometimes be more severe and lead to self-destructive behaviour, 'acting out' or aggression. Some of us get into fights and into trouble, which may be a way to get attention or help from people around us who notice and may be able to help.

Trauma

The worlds of young people like us can be full of 'traumas' (profound emotional shocks) of various kinds. Some of us suffer from major loss, such as the loss of our mother or father or even both, and some of us have lost brothers and sisters. Some have been living with physical and/or sexual abuse at home, which is an ongoing 'trauma' over a long period of time.

In extreme cases we may be suffering from a kind of psychological 'syndrome', a collection of signs or symptoms that tend to happen at the same time. If the impact is very strong then we may have a problem in our functioning, or, a 'disorder'. One example is called 'post traumatic stress disorder'. This means that we suffer from problems as a result of a very difficult, highly upsetting or 'traumatic' event.

We may have repeating nightmares of the painful event, or experience 'flashbacks' as if we are going through it again. Also, some of us might have a lot of anxiety, experience a bigger than usual shock reaction when there is any loud sound nearby, and we may be very afraid of dying.

A common, lasting impact of long-term or 'chronic' trauma is that sometimes we almost seem a little 'numb', or lacking in feelings and normal reactions. We may not seem to go through the same kinds of daily up-and-down emotions as others do when faced with daily events because we have gotten accustomed to paying attention to big events and things that immediately affect us. Therefore, a peer educator may have to work harder to get our attention or reaction to something like the risks of HIV, sexually transmitted infections or drugs.

One example of an extreme trauma for young people is when we must leave our homes and, with them, perhaps, some of our rights. There is more about this in the section on cultural and ethnic minorities.

Environmental concerns

Young people at special risk may have to deal with living conditions that pose a great hardship. The places in which we live may be very uncomfortable, poorly heated, polluted, noisy and dangerous. It might be impossible to do homework or get to school on a regular basis because we have to take care of younger brothers or sisters.

Socio-cultural issues

We may experience isolation from others, have fewer chances to play with friends and less time with our families. There are often fewer adults around who care enough or have enough time to hold us, hug us and help us get through our problems. Some of the adults who are in our lives may also take advantage of us. There are fewer people around who might take us to a church, mosque or synagogue, and so there is less of a connection to a supportive spiritual world.

Biological factors

We are young and so we may be reacting to the changes in our bodies. Just like any young person, we experience hormonal changes and sometimes our moods swing. This also causes some of us to have strong sexual feelings, and we may not have anyone telling us what to do with these feelings. Some of us are not eating correctly at all because there is nobody around to tell us what to eat. Some of us get STIs and even HIV.

Since many of us are not able to get to school or cannot concentrate in school, we do not learn about our bodies the way other students do when their school teaches about this. Also, many of us do not read very well, so written information does not help at all.

Best practices and lessons learned

What follows are some examples of issues regarding orphans and best practices from a published description on the Family Health International (FHI) Website (www.fhi.org). Many of these ideas can be generalized to address the issues of

children at special risk in general, although much of it was written to address children who must deal with HIV/AIDS in their worlds as well.

State-of-the-art components of effective care and support for orphans and other vulnerable children have evolved from the lessons learned in various countries and experiences from development, child survival, children of war and HIV/AIDS-related programmes.

They point out that interventions to provide care and support for orphans and vulnerable children should be:

Emphasizing community rather than institutional care: ... resources expended to fund institutional care for a single child can assist many more children if used effectively to support a community-based initiative. The institutionalization of children separates them from families and communities and often delays healthy childhood development.

Strengthening the care and coping capacities of families and communities: ...strengthening the capacity of communities to fill the widening gaps in the safety net traditionally provided by the extended family may be the most efficient, cost-effective, and sustainable way of assisting orphans and other vulnerable children. Families and communities also play a crucial role in identifying children who are most in need, both those affected by HIV/AIDS and other vulnerable children.

Involving children and youth: Children are not simply a passive, powerless target group to be aided, but capable actors and important resources to engage in a community response to HIV/AIDS. Actively involving children in care initiatives can build their sense of self-esteem and efficacy and cultivate skills they can use in the future.

Building broad collaboration among key stakeholders in all sectors: To meet the needs of children [at special risk] ...there have to be broad networks and targeted advocacy to involve government, civil society, and nongovernmental organizations in shared initiatives of community action....

Application of long-term perspective: ...programme design requires sustainable and replicable approaches. Although material assistance is important, it is also important to ensure that community projects are not driven by material support alone but by ownership and responsibility.

Integration with other services: Since the problems experienced by orphans and other vulnerable children begin well before the death of their parents, care for children affected by HIV/AIDS should start at the earliest possible point. Services for orphans and other vulnerable children should be integrated with the elements of comprehensive care such as voluntary counselling and testing for HIV, prevention of mother-to-child-transmission of HIV, and others.

Linking care and prevention: Orphans and other vulnerable children are themselves at high risk of HIV infection due to economic hardship and loss of parental care and protection. For this reason alone, care programs should include

a strong prevention component targeting children and youth'. Another example of the useful types of resource information available on the Internet for addressing homeless young people is provided below as a case study.

Case study

What does 'Outside In' do?

'Outside In' is a social service agency dedicated to serving low-income adults and homeless youth. It began in 1968, and has continually revised services to meet changing client needs. Current programmes include a community health clinic, a homeless youth programme designed to help homeless youth obtain independent living and risk education.

Why are youth homeless?

There are an estimated 2,000 homeless youth in Portland, Oregon, USA, and there are many myths associated with their homelessness. Youth end up on the street for multiple reasons, but most run away from violent and abusive homes.

- 90% of youth report some form of violence in their homes.
- 36% of girls report a history of childhood sexual abuse, with the first incident occurring at the age of seven. These young people flee to the street in the hope of increased safety.
- Some youth find themselves abandoned by their parents. One child was left with a drug dealer for an indefinite time. Another returned home to find his parents had moved out leaving no contact

information. Other youth turned to the streets because of poverty, joblessness, alcohol/drug use and/or mental health conditions within their families. They feel hopeless about a positive future in their current environment.

- 30% of homeless youth are sexual minorities: gay, lesbian, bi- or trans-sexual or questioning. These youth and their families cannot manage the many complexities of a developing sexual/gender identity outside the norm. Most often youth believe they will better their lives when they go to the street.

How do we respond to the need?

'Outside In' has had outstanding success helping Portland's homeless youth make the transition off the streets and into stable lives.

- 80% of youth who go through the transitional housing programme never return to the streets.
- 'Outside In' has been honoured for its innovative services with its youth programme receiving the first ever award given to a programme from the Oregon Shelter Network.
- 'Outside In' also received a 'Cares' award from American Health Care Systems, which recognizes agencies for providing innovative services.

Sex workers

Description of the group

There are many reasons why a multitude of young people every year sell their own bodies, and survival is the most common motivator. People involved in sex work and the people who exploit them are often hidden from the public. Much is known, however, about the kind of life and risks that are associated with sex work, such as violence (physical and mental), discrimination, loss of basic human rights and high rates of STIs and HIV/AIDS. Clients looking for sex usually target young people because they believe that youth are still free from HIV infection. Adolescents who are sexually exploited often do not have the power to make sexual intercourse safer, for example, by using a condom or asking someone else to use one. Girls are at greater risk than boys. In general, sex workers rarely use health services and have poor access to information. Also, sex workers may offer two prices for their services: one for protected sexual activity with a condom and a higher price for it without a condom. These issues demonstrate why it is necessary to improve efforts to protect young people from sexual exploitation.

What follows is an excerpt from a paper which describes the situation of sex workers in Nepal, but can apply throughout the world:

"... most of the women and men from the different parts of the country involve[d] in sex work mostly to solve hand-to-mouth problems. Due to the lack of specific and clear legal provisions, rules and regulations, sex workers are suffering many troubles from clients, pimps (brokers), family, society and administration, especially police. In our society and culture, sex work is not accepted and recognized as a profession. Sex workers are taken as 'social slanders'. Most of the sex workers themselves feel and think that sex work is immoral. Similarly, almost all of the sex workers are not aware [of] their rights (legal, constitutional and human) and their situations'.

Another example is the profile of Roma sex workers in Europe:

Who are the Roma sex workers and how do they operate?²

- The majority of them are under 25 years of age
- They normally work very far from where they live
- Most of them are migrants
- They have a very mobile client group
- 30% of them are injecting drug users

Most of them have boyfriends or husbands as pimps/managers

Barriers and obstacles to overcome: perspectives from sex workers

Stereotyping

As sex workers, we experience a very strong degree of stereotyping in many cultures. We must often endure significant discrimination as a result of our lifestyles and are often treated as lower class citizens. In many cultures it is common to use the word 'prostitute' in a derogatory context, as a kind of accusation. We are often treated as 'dirty' individuals because sex is often treated as a 'dirty' subject. The impact of this kind of attitude on us can be psychologically damaging.

Self-esteem issues

Our self-esteem is frequently challenged because of the negative manner in which we are regarded in many cultures and even by our clients and pimps.

Some of us do this because there is no other option – we need the money to survive. Some do this work for other reasons. A lot of us got in trouble with drugs, and needed to 'turn tricks' (provide sex work services) in order to keep from getting sick (with drug withdrawal symptoms).

Some of us make good money, and even like the work sometimes, except for the crazy people out there. People usually do not care to look at who we are or why we do this. Some just look down on us ... yet still come running to us when they are feeling down at home ... or when they need our services.

Physical abuse and violence

We are vulnerable in many ways, one of which is to physical abuse from clients or pimps.

Our working lives often revolve around crime and violence.

Trafficking industry

There can be horrible effects on the lives of those of us who have ended up in the trade through the sex trafficking industry. There are many thousands of us all over the world. Sometimes we were told we were going to be married once we moved to a new location. Often, in the beginning, the whole thing seemed as though we were going to a new location for a legitimate reason, such as love, a new job or a better life. If we were already in a bad situation, it may have looked as if we would be getting ourselves out of it. Once we were far away enough from our families, we had a rude awakening. For many of us, it took some time to realize that we had been completely misled. Trafficking is a huge business. Slowly, there are programmes being set up to try to rescue us.

1 - Methodology for comprehensive model of behavior change

2 - Nikolov, N. Working with Migrant and Roma Sex Workers' Plenary Presentation from Report Seminar 'Sex, Drug Use, Mobility and HIV/AIDS in Central and Eastern Europe' June 5-8, 2003 Prague, Czech Republic

Substance use and chemical dependence

People involved in sex work often have problems relating to substance abuse. This can make us more vulnerable in a variety of ways. We may need to work under very difficult circumstances in order to obtain enough money to support our addiction. This may lead us to engage in riskier behaviour than we might otherwise.

Shame: guilt about parenting role

For those of us who have children it can be hard and we often feel ashamed. Sometimes we may move to cities where nobody will know us. If our families ever found out, it would be devastating. Sometimes it seems that other people – those who buy our services – put us to shame, just so they do not have to look too closely at who they are.

Depression

Depression is often associated with being in a job that has elements of danger, disease, violence, sexual and emotional abuse and substance abuse – such as sex work.

Health issues and infections

Sometimes we must deal with infections as a result of our work especially if we do not or do not always use condoms. Even when we do use condoms, we may, for example, get herpes from having our skin touched where there was no condom. It means going for many check-ups to the clinic and generally not feeling well. Some of us cannot have children anymore because we have become sterile from contracting infections such as Chlamydia and have not been treated in time. In the sex work industry there are physical problems that can occur with the mucous membranes (the soft tissue that lines the vagina) as a result of the impact of having multiple sexual encounters. A person can get very sore from having multiple partners, which can cause 'ulcerations', which are like open wounds in the skin. Sometimes this creates a physical situation in which it becomes easier for HIV or another virus to get into the body.

Anonymity

A sex worker who might want to help out and teach peers is likely to be concerned with keeping him or herself anonymous. If this cannot be guaranteed, it may be hard for him or her to trust the organisation enough to come for the training and to stay involved.

Best practices and lessons learned

Peer educators who can help sex workers

For a peer educator to be most successful in assisting sex workers with sexual and reproductive health and related matters, he or she must be open-minded and able to approach them with a non-judgmental attitude. It stands to reason that those who are or who have been sex workers may be the best qualified to know how, when and where to reach us with peer education.

Sex workers as peer educators

Two professionals in the area of AIDS prevention, L Brussa and H Mongard, have provided some practical advice and descriptions of steps recommended for training sex workers to be peer educators¹. Their work is based on an organization called Transnational AIDS/SIDA Prevention Among Migrant Prostitutes in Europe Project (TAMPEP). Although much of their training description and key concepts would fit a standard approach to a training course for peer educators working with any VMSE group, they do make the following points, which merit special attention:

- When devising a title for the training course for sex worker peer educators, avoid using terms referring to 'sex workers'. Brussa and Mongard point out that many sex workers see their work as a temporary condition, and not as an identity. They suggest, therefore, avoiding the use of a name, title, invitations and so on, which identify the programme as having to do with sex workers. They suggest that instead one might use the title 'Prevention and hygiene'.
- Another important recommendation is that instructors in the course should be familiar with the phenomenon of sex work.
- Similar to what should happen in all peer education courses, it is recommended that some guest speakers be invited. These could include a doctor from a local clinic, someone who works in a contraception counselling clinic, a trained peer educator or a social worker.
- Course participants should be rewarded with a small amount of money for the time and effort they put into their participation and for any possible loss of earnings incurred during their time at the workshop.
- Research
- Another important issue in designing and delivering effective peer education for sex workers is the use of good research practices².
- In order to reach sex workers with good peer education, it is always valuable to be able to gather baseline data through a 'needs assessment'. This is a way to find out what is really going on in the target population and what the needs are.

Another researcher, Pyett, said:

"It probably goes without saying that researching sex work is not easy, especially when the population is unknown and hidden because of the illegal nature of their work. Furthermore, sex workers have good reason to mistrust researchers and to resist research. How do we overcome these obstacles?"

She points out that we need to build working relationships with sex workers so that we can both train sex workers as researchers and learn from them how to do research in a sensitive and useful way.

1 - Brussa, L. and Mongard, H. Organization and carrying out of training for peer educators. In: *Research for Sex Work 1, 1998*

2 - Pyett, P. Doing it together: Sex workers and researchers. In: *Research for Sex Work 1, 1998*

The importance of maintaining confidentiality

One strategy Pyett describes is for members of a local rights organization for sex workers to ask all sex workers with whom they come into contact over a six-month period to complete a self-administered questionnaire. They placed completed questionnaires in sealed envelopes and returned them to the researchers for analysis.

This research showed that, if done carefully, it is possible to train sex workers to gather important needs assessment data, which can help in the design and delivery of peer education programmes for sex workers.

In a second study, which aimed to reach those more vulnerable sex workers missed by the first research, in-depth interviews were done to explore issues of health, risk and

safety among women who were identified as vulnerable. These women were very young and inexperienced sex workers or were drug-dependent, homeless or working illegally, particularly on the street. The interviews were carried out by sex workers trained for this purpose.

The advantages of involving sex workers as peer researchers were evident, especially in terms of sensitivity, trust and confidentiality established with the women interviewed.

Pyett concluded:

“... not only (do) sex workers make an invaluable contribution as peer researchers, but also ... if research is to make a difference to the lives of sex workers, it is to our mutual advantage that we do it together.”

Sexual minorities – gay men, men who have sex with men, lesbians, bisexuals, transgender or questioning individuals

Description of the group

It is common in many cultures to take an overly simplistic approach to the spectrum of human sexuality. Yet among people who fall into the category of 'sexual minorities', there is enormous diversity

Often, people are thought to be only heterosexual ('straight') or homosexual ('gay' in the case of men or 'lesbian' in the case of women). In some cultures, there may also be recognition that some people are attracted to people of both genders. In this case they may be called 'bi-sexual'.

There is an argument, however, that human sexuality may fall more along the lines of the research of Alfred Kinsey¹. In his research, it was discovered that the sexual preferences and attraction of people tends to fall along a continuum with many shades in between. While some people may be exclusively heterosexual or homosexual in orientation, others may be predominately one or the other; with some attraction to either the same or opposite sex as well. Thus, there may be men who are mostly attracted to women, but who also have some incidental attraction to other men. This continuum is called the Kinsey scale². As one can see from the scale, each number from 0 to 6 indicates a different level of sexual orientation:

- 0 = exclusively heterosexual
- 1 = predominately heterosexual, incidentally homosexual
- 2 = predominately heterosexual, more than incidentally homosexual
- 3 = equally heterosexual and homosexual
- 4 = predominately homosexual, more than incidentally heterosexual
- 5 = predominately homosexual, incidentally heterosexual
- 6 = exclusively homosexual

In light of the spectrum of sexual preference illustrated by the Kinsey scale, some people argue that violent reactions against homosexuals may come from people who cannot accept the part of themselves that might include some same-sex attraction.

Barriers and obstacles to overcome: perspectives from gay men, men who have sex with men, lesbians and bi-sexuals

In many cultures, it is considered taboo to have sex with people of the same sex. As gay men or men who have sex with men (MSM), we find that people do not want to talk about our situations, often refusing to admit that we exist at all. This reaction is the same for lesbians. It leads to

homophobia, which is the irrational fear and hate of men who have sex with men, lesbians and homosexuality itself. Historically, heterosexuality and assumptions of procreative sex, as opposed to homosexuality, generally set the social, cultural and moral rule. Everything that was not part of this heterosexual picture was considered to be against the rules and therefore wrong.

Same-sex relationships tend to be demonized through measures such as isolation from society, marginalization, stigmatization, discrimination and jail sentences. As gay men, MSM and lesbians, we are always treated as 'different', and often spoken about with pejorative names. Homophobia is not just a way of thinking; it is exhibited in directly aggressive behaviour towards us.

For homosexual groups, you can apply the same principles and models as for other vulnerable, marginalized and socially excluded groups. In some cultures, marginalization is so great that citizens even think that we do not exist or that there are just a few individuals who are homosexual. The reality is that we exist in significant numbers in most societies. We often live in closed unions or communities that are kept secret except among people who are sympathetic to our situations. Mostly, we are afraid of people's reactions to our sexual choice.

Discrimination and attitudes: 'What are they trying to prove?'

The discrimination towards people in sexual minorities is easy to see in some classic examples that are part of everyday life.

For example, when a man and woman are seen kissing romantically in the street, people generally take little notice. In many of our cultures, the tendency is to assume the two are intimately involved and expressing their feelings towards one another, with no further motive. If, however, the same romantic activity is happening between two people of the same sex, the experience and response of most people is quite different. Public displays of romance between same sex people may be perceived as some kind of rebellion, 'exhibitionism', or 'attempting to prove a point'. On seeing two men kiss romantically, people may ask questions such as 'Why do they have to do that in public? Are they trying to prove a point?' It is easy to see how this is a form of discrimination if you consider how much less likely people would be to make such an assumption when two people of the opposite sex kiss in public.

Homosexuality can be in contradiction with family, societal and personal expectations, which is a primary source of

1 - Kinsey, Alfred C. et al. (1948/1998). *Sexual Behavior in the Human Male*. Philadelphia: W.B. Saunders; Bloomington: Indiana U. Press.
2 - <http://www.kinseyinstitute.org/resources/images/rating-scale.jpg>

conflict surrounding these issues. Those of us in the sexual minorities who publicly state our orientation become targets for mental and physical violence. Discrimination is often outwardly expressed and we are usually marked as sick people, very often divided from our children and fired from our jobs. Because of that, many of us have dual lives, homosexual and heterosexual, private and public.

Parents of people from sexual minorities often blame themselves for their child's sexual orientation, perceiving it as an illness or defect. Typical parental emotions are:

- anger
- feelings of guilt and shame
- fear of being marked by society and of being stigmatized.

Reactions in families may be shown through:

- violent behaviours and/or attitudes
- being sent to mental institutions to be 'cured'
- being sent for 'deprogramming' in order to be 'converted' to being straight by psychologists or psychiatrists
- some parents more or less reject, 'write-off' or disown their children.

Real life experiences

The following quotes from the book 'Our Bodies, Ourselves' describe some of the thoughts and feelings that lesbians may have when it comes to accepting their sexual identity and revealing their sexual identity to others.

"I felt a strong political and personal commitment to women and a fascination for lesbians, but it scared me to think that maybe I wanted to love a woman – my parents would explode, my ex-husband would try to get custody of our kids, my friends might think I was out to seduce them. I was also afraid it would be a choice against men instead of for women. Finally one day I said to myself, "For now, I am a lesbian," and some important piece of my identity clicked into place. I'm glad I chose to be a lesbian before I had a woman lover."

*"When I went to college there were only two other black students on the entire campus, and they came from comfortable middle-class families. I felt as out of place with them as I did with the middle-class white students. I began to become aware of an attraction to women, which I kept trying to suppress. Since I was out of my element socially, I always came on as tough and aggressive to cover up, and people started accusing me of being a dyke. I was terrified that my fantasies were showing in some way, and I began dating to cover up. (...)
The women's movement gave me support because I could see other women having the courage to change their lives. Their example gave me the courage to see that I was cheating myself by pretending to be straight. (...) My life has been much fuller since [coming out] and a lot happier." (pg. 202)*

"My best friend for thirteen years broke off our friendship several months after I told her, and I haven't heard from her in ten years. No matter how well you know someone, you can never know exactly what to expect from them when you come out." (pg. 203)

In Western countries, the phrase 'coming out' is used to describe the process of public declaration of being in a sexual minority. In some countries in Central and Eastern Europe, we try to hide ourselves and our orientation, but this does not mean that the practice of sexual minorities 'coming out' will not happen in our country soon.

Preventing discrimination

To prevent discrimination, it is necessary to accept free choice in every segment of life. In this way, people from sexual minorities will be able to exercise their rights, which are the same as any other citizen. What is even more important is to accept that even though we are different because of our sexual identities, we are no less worthy as individuals.

By using peer education programmes to expose young people to positive experiences of healthy sexuality, such as people choosing to live openly as GBLTQ or "straight," working and studying together as friends, we will combat prejudice.

As previously indicated, one of the major obstacles faced by people who fall into the sexual minority categories are **stigma** and **discrimination** imposed by society. "Societal homophobia may impede implementing effective prevention programmes for gay youth and may discourage young gay men from accessing prevention services." The intensity of the stigma and discrimination often leads to a high degree of secrecy around people's sexual orientation, particularly in these communities.

It needs to be accepted that focusing sexual and reproductive health messages on young people in the sexual minorities is not condoning or promoting homosexuality, but rather acting responsibly in the face of a public health problem.³

Issues of living in a hidden situation

One of the problems about reaching those of us who are within the sexual minorities is the sometimes hidden nature of segments of our lives. Because of the discrimination that is associated with being within a sexual minority, people often live a kind of 'closeted' existence in their romantic and sexual lives. This can make it harder to reach someone who may not be open about his or her sexual orientation and lifestyle.

Trying to keep our sexual orientation hidden sometimes leads to a pattern, for example, where we hide romantic relationships from neighbours. To prevent them suspecting a homosexual relationship, someone may try to avoid being seen with the same person too often. For some, it may also lead to avoidance of going to any public venues known to

1 - Boston Women's Health Book Collective, *Our Bodies, Ourselves, For The New Century* (Touchstone, 1998). A new edition of *Our Bodies, Ourselves* is forthcoming from Touchstone in spring 2005.2 - <http://www.kinseyinstitute.org/resources/images/rating-scale.jpg>

2 - Grossman, A.H. Homophobia: a cofactor of HIV disease in gay and lesbian youth. *Journal of the Association of Nurses in AIDS Care*. 1994; 5:39-43) as cited in University of California San Francisco Fact sheet entitled "what are young gay men's HIV prevention needs?" from HIV Prevention: Looking Back, Looking Ahead, Coates, T., and Makadon, H.J., prepared by Robert Hays, Ph.D, April 1995

3 - University of California San Francisco Fact sheet entitled "what are young gay men's HIV prevention needs?", from HIV Prevention: Looking Back, Looking Ahead, Coates, T., and Makadon, H.J., prepared by Robert Hays, Ph.D, April 1995

be associated with gay or lesbian culture.

The desire or need to keep sexual orientation a secret sometimes leads to a higher level of anonymous encounters and lifestyle. This may lead to an increased possibility of knowing less about prospective sexual partner(s).

Such a lifestyle may also lead to increased feelings of loneliness and isolation or alienation.

One thing in particular that can lead to discrimination is the assumption that people in the sexual minorities are 'hedonistic', which means pleasure-seeking or self-indulgent. It may be assumed that they act on impulses that are shunned or forbidden within mainstream society. This can lead to resentment among people who may be struggling with feelings of shame or confusion regarding their own impulses, fantasies and feelings of lust.

A sexual being only ...

In many of our cultures, once a person is perceived to stand out because of some sort of difference, he or she is often automatically perceived through the lens of whatever that difference is. So, when a person is known to be homosexual, there is often a tendency for society to first and foremost perceive us through our sexuality, rather than any other role.

Shame and guilt

Because of what so many of our cultures have been teaching about what is 'right' or 'wrong', 'proper' and 'improper', and 'acceptable' or 'shameful' over the centuries, there are often major psychological issues surrounding sex and sexual orientation.

Legal

In many of our cultures the legal system has made and continues to make it difficult to be 'out' or public about one's sexual orientation and lifestyle if one is in the sexual minorities. This serves as another barrier to open communication about important health-related issues with people from the sexual minorities.

'But I'm not gay'

Many teenagers, regardless of their sexual orientation, do not see themselves as being at risk for HIV infection. Prevention messages sometimes target gay or bisexual men, however there are some young men who have sex with men but who do not relate to these messages or consider them personally relevant. This may happen when a young person identifies himself or herself as heterosexual or straight, although he or she may have experimented with same sex relationships and discontinued the practice. Also, a man may not consider himself gay if he is the inserting partner with another man rather than the receiving partner.

Best practices and lessons learned

Protecting guest speakers

Every programme organizer must find ways to ensure the safety and confidentiality of their guest speakers from vulnerable, marginalized and socially excluded groups. The organizer must ask the question: 'Can I create a safe enough learning environment for speakers who can and will share their personal experience?' and 'Can I minimize any chances of negative social repercussions after the training experience?'

Community-level programmes have been shown to reach large numbers of young men. It was revealed that:

"...one successful programme promoted a norm for safer sex among young gay men through a variety of social, outreach and small group activities designed and run by young men themselves".

The programme found that young men engaging in unsafe sex who were unlikely to attend workshops were more likely to be reached through outreach activities – such as dances, movie nights, picnics, gay rap group concerts and volleyball games. In many parts of the world, communities of sexual minorities have begun to thrive. In some regions there has been enough political activism, establishment of human rights and acknowledgement of these groups that precedents are being set for inclusion, representation and open acceptance in society.

There are now organizations active in setting such precedents. They can demonstrate successful ways in which to reach, educate and support people within the sexual minorities. With the information available on the Internet, for example, any peer educator wishing to work with people in the sexual minorities can find a multitude of resources. Some of these are listed in the resources section of this handbook.

Use of gender-neutral terms

Among the many ways to reach people in the sexual minorities in peer education, one of the most important is through the use of gender-neutral language in sexual and reproductive health education.

Many programmes were developed with the intention of reaching the 'general population', which means that they assume the participants are heterosexual. When such programmes are delivered in the field, unless carefully thought out, they tend to use examples of heterosexuality again and again and perpetuate feelings of exclusion for people within the sexual minorities. Such programmes also do not include teaching about same sex sexual encounters and the need for preventive measures that fit such circumstances.

1 - Kegeles, S.M., Hays, R.B., Coates, T.J. The Mpowerment project: a community-level HIV prevention intervention for young gay and bisexual men. *American Journal of Public Health* (accepted) as cited in University of California San Francisco Fact sheet entitled "what are young gay men's HIV prevention needs?", from HIV Prevention: Looking Back, Looking Ahead Coates, T., and Makadon, H.J., prepared by Robert Hays, Ph.D, April 1995

It is crucial to make sure that peer educators are trained in the use of gender-neutral language as often as is possible and appropriate. One example is to learn to use the word 'sex partner' rather than assuming the gender of the partner.

Understanding sexual lifestyles

There are many web resources that contain useful information to help us understand the lifestyles of young people from sexual minorities. You can also find examples of the kinds of programmes that can be developed for peers and that involve peer educators.

One useful organization which has a website is the Hetrick Martin Institute (HMI) (www.hmi.org), which is linked with the Harvey Milk School. These institutes were created for the protection of young people who are in the sexual minorities. The website provides information and statistics about lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. The following brief excerpt is from their Web page and contains statistics and facts about young people in the United States.

LGBTQ youth in school

- 41.7% of LGBTQ youth do not feel safe in their school
- 28% of gay teens drop out of school annually, three times the national average
- 69% of LGBTQ youth reported experiencing some form of harassment or violence
- 46% of LGBTQ youth reported verbal harassment, 36.4% reported sexual harassment, 12.1% reported physical harassment, 6.1% reported physical assault
- 86.7% of LGBTQ youth reported sometimes or frequently hearing homophobic remarks
- 36.6% of LGBTQ youth reported hearing homophobic remarks from faculty or school staff

Suicide

- LGBTQ youth are three times more likely to attempt suicide than other youth
- 40% of LGBTQ youth attempted suicide compared to their heterosexual peers

Student attitudes about LGBTQ issues

- 40% of high school students say that they are prejudiced against homosexuals

Another resource for young people involved in peer education is the website www.Youthresource.com. This is a project of Advocates for Youth based in Washington DC.

In its very colourful website introduction it says: *"Do you feel a bit turned InsideOUT sometimes when it comes to questions you have about your sexual orientation, gender identity, or sexual health?"*

Maybe it would help to share your concerns with someone who has been in the same situation as you ... our peer educators can give you the Inside view on being OUT".

The website has a number of links to other web pages for organizations that assist young people, including those in sexual minorities, and that include personal stories, sexual health and well-being information and other links to youth groups, advocacy issues and other topics.

In the website of an organization called Parents, Families and Friends of Lesbians and Gays (PFLAG) you can find several comprehensive fact sheets on issues about young people in the sexual minorities, including topics such as explanations of the coming-out process, discrimination and mental health issues. It also covers issues for parents of children who are in the sexual minorities, contact numbers and resources, helplines, advocacy, support and education.

For example, one fact sheet points out that: "Gay and lesbian students often feel invisible in their schools. Their invisibility is typically reinforced by heterosexism in their environment, which causes gay and lesbian young people to feel invisible, unsupported and isolated".

PFLAG provides statistics on issues such as suicide and school drop-out rates, violence, homelessness, HIV/AIDS, student and staff attitudes, depression and health issues.

The following excerpt is another example of the kind of rich information you can get from organizations like PFLAG:

Why must they flaunt it?

Developed by Parents, Families and Friends of Lesbians and Gays (PFLAG)

"Gays, lesbians and bisexuals are often accused of flaunting their sexuality when they come out as gay, when they are publicly affectionate with a same-sex partner or when they wear gay symbols or T-shirts or participate in gay pride parades.

You may be uncomfortable with your child's public displays of affection with his or her same-sex partner. Bear in mind that all couples – straight and gay – often show affection publicly because they feel love and appreciation for their partner. But stop and think: are you as uneasy about heterosexuals showing affection in public?

In some situations, what people call 'flaunting it' may only be behaving in a relaxed, natural fashion in public. In other circumstances, it may be a political decision to assert one's sexuality by wearing a T-shirt or participating in a public event. In cultures that either ignore homosexuality or deride it, expressing one's sexual orientation publicly can be an important act of self-affirmation.

If you worry about possible negative reactions to any behaviour that identifies your child as gay, keep in mind that some gays, lesbians and bisexuals will censor their own behaviour because they share those fears. But it is up to your child to make those decisions."

As with any peer education programme, for those which target sexual minorities it can help to have parental support. Organizations such as PFLAG can offer resources and ideas for how to assist parents in supporting young people who are in the sexual minorities and wish to be peer educators.

PFLAG provides some simple answers to the kinds of questions that may come up in peer education dealing with sexual minorities. Here is an excerpt from its website, which provides two answers to commonly asked questions:

What causes a person to have a particular sexual orientation?

How a particular sexual orientation develops in any individual is not well understood by scientists. Various

theories have proposed differing sources for sexual orientation, including genetic or inborn hormonal factors and life experiences during early childhood. However, many scientists share the view that sexual orientation is shaped for most people at an early age through complex interactions of biological, psychological and social factors.

Is sexual orientation a choice?

No. Sexual orientation emerges for most people in early adolescence without any prior sexual experience. And some people report trying very hard over many years to change their sexual orientation from homosexual to heterosexual with no success. For these reasons, psychologists do not consider sexual orientation for most people to be a conscious choice that can be voluntarily changed.

Ethnic and cultural minorities

Description of the group

'Majority' or 'minority' are notions that mostly relate to the allocation or partition of power. Also, the notions relate to the number of individuals that are identifiable within these groups. 'Minority groups' are usually less powerful and smaller in number. It is also possible that 'minority' refers to groups that might actually be larger in number, but are still less powerful. An example of that is the ratio between numbers of males and females, with the female proportion generally being the greater at 51%. However, from the point of view of power, females have fewer rights and are therefore still considered a 'minority' in some cultures.

Some other groups may also be regarded as minorities, such as those that have ethnically different roots from the 'majority' of citizens or a different religious affiliation. An example is the Roma community in Europe which, with an estimated population of 7–8.5 million, is considered to be Europe's largest ethnic minority¹.

Belonging to a minority group can lead to:

- being discounted
- being 'invisible' in society
- having a weaker position in social events (even those directly affecting them)
- weaker economic power
- being treated as unacceptable
- isolation
- stigmatization
- discrimination
- loss of human rights.

Very often, directly hostile attitudes are shown towards members of minority groups. Life under these conditions makes the health and rights of these groups more fragile. Furthermore, cultural circumstances and specific needs that result from the experiences of being from a minority group affect the manner in which we must deal with problems faced by these groups. These issues should be kept in mind when planning activities.

Refugees and internally displaced persons (IDPs)

Being a refugee or displaced person is one of the most shocking experiences in life and often leads to being part of an ethnic and/or cultural minority in a new location.

These experiences represent a kind of attack on human needs: from biological needs (for food and shelter), to social and psychological ones (such as control of one's own life, being part of close-knit groups, relations with others, achieving goals and ambitions).

Being a refugee is especially shocking for adolescents because they are in a specific and demanding life phase

(physically growing, completing identity formation, beginning professional careers and so on). This phase is very complex and somewhat painful. Every unexpected life event tends to delay achievement and development of tasks and increases the risk of becoming prey to negative influences. Arrival in a new society means that cultural and ethnic minorities are faced with a series of losses, and changes related to:

- the society in which they lived before
- peers
- relatives
- school
- habits
- love
- memories.

Considering the experience as a whole, it is like losing much of their identity. Idealism, a normal part of being a young person, is diminished. Very often it leads to life without choices and sometimes destructive behavior either to themselves or society. These young people live exposed to risks such as violence, STIs and other threats. Their families are usually very poor and fall into poverty suddenly. This poses an extra risk for their physical, mental and social health. Sexuality is a normal and expected part of adolescence. Living in such depriving conditions, especially in camps for refugees and IDPs, endangers young people's needs:

- to find a partner
- to have fun
- to ensure good sexual health.

At the same time, they are often deprived of the possibility of getting vital information and of the use of health services that can prevent health problems.

Planning activities with these young people must be based on understanding their specific needs in their changed life circumstances. Involving them in programmes may give them strength for:

- connecting with society
- understanding it better
- hanging out with their peers
- integrating into their communities.

This reduces the risks they might face and increases their chances of being able to have control in their lives and act responsibly and constructively in their future.

Such young people from ethnic and cultural minorities who are also refugees or displaced persons can be very reliable sources of information in all phases of programming. They best know and understand their peers, habits, needs and expectations.

¹ - Denied a Future: Volume 2: Roma/Gypsy and Traveller Education in Europe, Save the Children Fund, 2001

Barriers and obstacles to overcome

Successfully reaching ethnic and cultural minorities is of critical importance in the world of sexual and reproductive health all over the globe. There are, however, problems inherent in doing this in many countries.

The 'mainstream', predominant culture is usually different in a variety of ways from the ethnic and cultural minorities in any given country. These differences can include religious beliefs and practices, health practices, courting and marriage customs, relationship to various substances, economic situation, educational practices, human rights and representation. All of these issues can present barriers to education and best health practices within a given country. It can also lead to a lack of political power, and with it may come lack of financial resources.

The difficulties faced by the Roma population in one European country provide an example of some of the problems commonly faced by ethnic and cultural minorities in the region, which need to be addressed.¹

General situation of Roma people in Bulgaria

- High levels of unemployment
- Poor quality of life and poverty
- Lack of proper health care
- Lack of tradition in seeking medical help
- High birth rate
- Under-age pregnancy
- Lack of resources and cultural difficulties in child care issues
- High rate of illiteracy
- No access to insurance
- Very insulated and isolated community – live in their own neighbourhoods only
- A community perceived as a disintegrated minority.

In a seminar presentation on 'Sex, Drug Use, Mobility and HIV/AIDS in Central and Eastern Europe' in 2003, the presenter lists some of the common prejudices regarding Roma people and Roma sex workers in particular. It is clear that these are extremely stereotyped.

Prejudices regarding Roma, particularly sex workers

- They are dirty
- They are stupid
- All of them are thieves
- They are infectious carriers and will spread disease
- They are useless people who cannot do any worthwhile work
- They don't want any other job, and that is why they are prostitutes
- They are lazy people.

Best practices and lessons learned

Below is a checklist developed regarding the 'necessary ingredients for effective work with Roma sex workers'.² It is included as an example because it can be generalized to the principles peer educators use to work effectively with other cultural and ethnic minorities.

The necessary ingredients for effective work with Roma sex workers

- Better understanding and awareness of their way of life (cultural and social issues)
- The recruitment and involvement of Roma people in the services provided
- To steadily and slowly work towards building a safe and trusting relationship with them
- To be able to engage quickly while still aiming to offer long-term care packages
- To help them access and value a system of regular health care and check-ups
- To work towards better contact with clients on an individual face-to-face basis
- The design and publishing of culturally, linguistically and visibly appropriate resources
- The ability to communicate using clear, direct and simple language
- To encourage their efforts and successes
- To have a non-judgmental attitude towards this community.

1 - Nikolov, N. Working with Migrant and Roma Sex Workers' Plenary Presentation from Report Seminar 'Sex, Drug Use, Mobility and HIV/AIDS in Central and Eastern Europe' June 5-8, 2003 Prague, Czech Republic

2 - ibid

People living with physical challenges

Description of the group

Those of us who live with physical challenges come in all shapes and sizes, from all cultures, with different personalities, just like everyone else. Some of you might recognize us as people you used to call 'disabled' or 'handicapped'. The word 'challenged' works better for many of us. It feels less condescending, so we do not feel that it is as easy to look down on or judge us as inferior.

The fact that we are living with physical challenges means that we may have some physical detail that makes daily life more difficult than for the 'average' person. What does this mean? In some cases we may not be able to use one or more of our five senses, to see, hear, smell, taste or touch the way many people can. In other cases, we may not have the same number of arms, legs, hands, fingers or toes as most people, or perhaps they do not work the same way as others.

For some of us, it has been this way since we were born. For others, we may have had a capacity or ability before, but something happened that changed our bodies. In some cases, it happened as a result of genetics. In others, it happened as a result of some kind of drugs our mothers may have taken before we were born. Some of us lost a limb or a capacity as a result of something we did, or something someone else did. Some of us just had something happen within our body without anyone doing anything. Sometimes it happened because of a disease or infection of some kind.

Barriers and obstacles to overcome

Social exclusion – don't keep us invisible, we are right here!

To simplify things, many people tend to start with the assumption that, until proven otherwise, everyone is more or less the same – they have two hands, two arms, two working eyes, two legs and so on. This may make things a little easier for people, at least for those who are not physically challenged. But life is not like this for all of us, and it can hurt to feel that we are always the exception.

The idea of not having, or losing, a limb (an arm or leg) or a capacity such as seeing or hearing scares most of us. Therefore many people will avoid or keep a 'comfortable distance' from people who have certain physical challenges. This prevents them from having to think or feel too much about people who have a challenge and about the fear or sadness they might feel if they had to endure such a challenge.

Think for a moment about what it may be like to be on the other side of this, to be the one who is being avoided.

In the end, for many of us who are physically challenged in some way, there is not only the physical challenge to overcome but also accompanying emotional challenges, often created by our peers and our society.

Stigma and discrimination – sometimes we get treated badly and called some mean things

Most of you are probably aware of the kinds of names we can be called. We hear references to challenged people as 'cripple', 'spastic', 'gimp', 'invalid'. Sometimes these terms are used to talk about people who are not physically challenged, but as an insult. Think how this might make us feel when we live with these challenges.

Trauma

Those of us with congenital (from birth) challenges have some differences from those who have become challenged as a result of a loss of a capacity. To have had a capacity such as vision or hearing, or the ability to walk and to have lost it, through blindness or paralysis for example, can be especially upsetting. But given enough time to adapt to our new life circumstances, we can be strong and learn to get along with our challenges.

Challenged from birth or not, we also have to go through some of the same experiences because of the way we are treated by others.

Most of us do not want people to feel sorry for us, pity us or assume we cannot do anything. Many of us prefer it if you first offer to help if you think we really need it, rather than just doing something for us and assuming we can't do it ourselves. Some things might be a little more difficult and take us a little longer to do, but we might still want to do them by ourselves if we can.

You may need to understand that there can be some differences in the way you show sympathy and empathy. With sympathy, it is like saying: "Oh, you poor thing ... I feel so sorry for you". Forget it! We do not need your condolence from a higher place. Don't bother. If, on the other hand, you have a little 'empathy', that means you are trying to understand what it is like to be us, and trying to identify with us. That helps us understand each other better.

Best practices and lessons learned

Those of us who live with physical challenges need to be approached in a way that matches our age and abilities. The usual 'channels' for providing information do not always work for us. Methods and techniques of working with those of us who have visual impairment or who are hard of hearing must be adjusted to our capacities.

When you plan work with us it is necessary to understand our specific needs and to ask professionals with more experience if they can help you. Please remember that you must not look at us as 'little' or 'less valuable'. Also, how we react will depend on how you recognize our needs and capacities. Some people think that we do not have sexual desires or needs. That attitude is completely wrong and should be quickly dropped. Peers who want to help people with our challenges can help us to evolve our sexuality in a healthy, constructive way.

In peer education there are often games played and exercises done that involve physical activities. Sometimes these activities involve running, catching things, walking, jumping and so on. If we have physical challenges, we get left out of the game. One good idea is to make sure there are some games and exercises designed so that we can participate fully.

When there are physical games and exercises that we cannot play, there are some things you can do to help. Firstly, there may be a way to change or modify the game to

include us. If not there are other steps to take. For example, we may be able to play part of the game with some help. Perhaps someone can help us move. If we cannot catch something, the person next to us might be able to catch it and hand it to us if we can still throw. Sometimes we can be given a role in the game so that we can participate as a judge of some kind, if one is needed. It can be our job, for example, to see if someone crosses a line they are not supposed to. Or we can help by being the timekeeper.

It is best when we are invited to participate in the best way we can, as part of the group or in some important way in the event, exercise or game. This can also help the whole group for team- and trust-building purposes. If we can learn to trust the group, that is very important to us and to the group as a whole. Then we are really part of the team.

If we get to be peer educators it also gives an important message to our target audiences. It says that we don't all have to be perfect, super-human beings to be important to be listened to. It says that everyone counts and can make a difference. ■

Section 7 – Toolkit for planning and running a workshop

It is important for peer educators who are from and/or working with VMSE groups to be able to address the relationships between these groups, sexual and reproductive health (SRH), and related health issues. There are various forms of vulnerability that lead to or are impacted by problems related to SRH. This toolkit has been designed with a basic formula that can help

peer educators plan and run workshops dealing with SRH and various related health issues. This formula can be used for addressing things such as STIs, drug addiction, HIV/AIDS, and sexual abuse. The latter part of this toolkit is a collection of games and exercises that can be used as icebreakers and team-building for peer educators.

Organizing workshops: A basic presentation agenda¹⁻²⁻³

When a peer education group plans to present a workshop, the presenters should prepare and agree on an agenda beforehand. Ideally, the workshop should be rehearsed a week before the event, or a few days at the very least. There may be a risk of educators thinking they are better prepared than they are, but this will only become apparent when they rehearse the presentation.

Educators should receive training to run an interactive educational workshop and should become comfortable with the techniques. They must also be able to manage an audience of young people in a sensitive and appropriate fashion.

The activities in the workshop, and the time allocated to each, will change depending on the age of the audience and the length of the presentation. When they set the agenda, the peer educators can agree who will run which activities, but they should also assign understudies in case someone is unable to attend.⁴

Here is a typical agenda, using 'x' to represent a health issue (e.g. STI's, drug addiction, HIV/AIDS or sexual abuse).

Template for an agenda

- Participants Survey
- Getting started
- Ice-breaker (for example, Buzz- words for x)
- Dos and Don'ts: Creating a safe space for working together
- Brainstorming
- Personal testimony
- Get the facts: questions and answers
- Role play revolution
- Closing and discussion

Explanations of these exercises are provided on the following pages.

Setting the Agenda with a Participants Survey

In order to help peer educators understand their audience and shape the agenda of their workshop so that it is audience-appropriate, it is helpful to distribute a questionnaire, preferably a few days before the workshop. (For a sample questionnaire, see Annex 3). The survey can also be given out when participants enter the room on the day of the workshop. Allow them ten minutes to fill it out and ask that they do so without any help from their friends. After collecting the questionnaires, the peer educators can quickly scan through them to assess the knowledge and attitudes of those they are about to teach so that they know what they need to focus on and emphasize.

Getting Started⁵

Peer education workshops benefit from a 'Getting Started' exercise that explains the purpose of the workshop and the participants' different motivations for attending. This introduction will vary depending on the chosen agenda and the knowledge level and interests of the participants. Following are two examples of introductory exercises that a peer education group can use.

Introduction 1

The Reality of Living with X

All of the peer educators state their names, why they are participating in the workshop, and why they are concerned about the issue being addressed in this workshop. When the last person in line has finished the introductions, he or she says "The reality of (x) is that, in one way or another, it affects all of us who are here today in this room. We all have to deal with the fact that (this issue) exists in this world and directly or indirectly impacts our lives. **That means we are all 'people living with x'.** (When appropriate, presenters can add, "You don't have to be or have x to be affected by it".

1 - Zielony R. Adapted from Peer Education Programs for Addressing Health Issues 1999

2 - Zielony, R. & Tunick, R. Adapted from sections of Peer Education Manual, 92nd St. Y NYC, 1996

3 - Adapted from sections of the Y-Peer, 'Peer Education Training of Trainers Manual' 2003

4 - This template is an adaptation and expansion of an agenda originally developed by R. Zielony for the 92nd Street YMCA in New York City with the help of several adolescent peer educators. Rebecca Tunick, a peer educator, helped to co-ordinate the first draft.

5 - Adapted from sections of the Y-Peer, 'Peer Education Training of Trainers Manual' 2003

Introduction 2

'I am a Person Affected by (x)'

This attention-getting exercise can help peer educators quickly establish the reasons for the workshop and how x affects everyone. Caution should be used when taking this approach because it can be perceived by the audience as deceptive: some peer educators have found that audiences may not understand that the educators are not actually affected by x in a direct or personal way. Each group of peer educators must decide for themselves if this method is appropriate for their audience and for their own comfort level.

To use this approach, the peer educators stand in a line facing the audience. The first person in the line says: "Hello, my name is (name) and I am affected by x (e.g. drug addiction, STIs, sexual abuse, etc.)". This continues down the line until every educator has spoken. Each peer educator follows by making the same statement and filling in their own name. After the last educator speaks s/he should pause for a moment and then say: "For some people, this part of our presentation can be confusing. Participants may have believed that we are all experiencing x. But this is not what we are saying. What we are trying to say is that all of us – each and every one of us in this room – have to deal with the fact that x exists and directly or indirectly has an impact on our lives. So, **in a way**, we are all 'people affected by x'. (If related to HIV/AIDS they can add "You don't have to be infected to be affected").

Icebreaker – 'Buzz-words for (x)'

One peer educator leads the exercise and two others stand behind him or her and write on a big piece of paper attached to the wall. The leader of the exercise points out that: "In order to learn about x, it's important to be able to talk about it at various levels. Therefore, we do not wish to offend anyone, but we will now do an exercise designed to make us a bit more comfortable talking about x". The leader of the exercise asks the audience to call out associations, including street or slang words, for x. Peer educators present should be prepared to model for participants by calling out some suggestions themselves. However, they should be careful not to dominate the call-out or compete with participants. When the group runs out of slang words, the facilitator moves on to the next topic.

The object of this exercise is to make participants feel more comfortable discussing the topic and to let everyone know that "in this workshop, nothing is too rude or vulgar to say as long as there is a reason for saying it. We are here to learn about a very serious topic."

Because this exercise can be intimidating to some audiences, it can be helpful to first separate participants into small groups of five to eight people. Each small group will have their own easel pad and big marker and a chosen group member or peer educator can write his or her group's slang words on the pad. In a larger venue, the peer

educators may have to circulate around the room, checking in on the progress of each group. This solution means that participants are not feeling pressured to call out words in front of the whole audience, but can say them in a small group. It is ideal to have at least one peer educator working with each small group.

More information about icebreakers and other games starts on page 57.

Dos and Don'ts: Creating a safe space for working together

In order for all participants to feel comfortable and safe to participate during the workshop, it is important that the presenters and the group agree on a set of Workshop Guidelines, which might include:

- 'Right to pass' – giving participants the right not to participate in any segment of a workshop with which they are uncomfortable.
- 'Confidentiality' – respecting people's private information; this entails reaching an agreement with the audience that they will not reveal personal information about participants outside of the workshop.
- 'No put downs' – avoiding anything that might offend or humiliate someone.
- 'One person at a time' – asking that someone speaking to the group be allowed to do so, without side conversations going on.

Some peer education groups like to follow a system of ground rules based on an acronym such as 'CRABS' or 'ROPES', which have a similar set of rules. For example, a list of ground rules that follows the acronym **CRABS** stands for:

- C**onfidentiality: People will not share personal information about others outside the workshop
- R**espect: People must respect all participants in the group. This means there must be no attacks on others, and everyone must allow their fellow participants to share their points of view. Use 'I' statements, such as "I feel that," rather than "No, you're wrong, the right thing is"
- A**ttentiveness: Listen to what other people are saying. You will not only be more likely to learn something, but the people who are speaking will feel more comfortable.
- B**e open: To get the most out of the workshop, people should be encouraged to speak from their own experience. Take risks – don't be afraid to speak your mind..
- S**ensitivity: Be sensitive to others and their backgrounds. Do not make generalizations.

After the facilitator presents these ground rules, he or she asks, "Are there any other ground rules anyone would like to add?"

Brainstorming

This is one of the most important techniques for peer educators to use in order to get participants thinking openly and creatively about a topic. In this exercise, participants are broken up into small groups of six to eight people. (If the audience is small, there may be fewer groups formed and the faster groups can be given a second question to brainstorm. In a larger audience, more than one group can work on the same question, or more questions can be covered.) The peer educators intersperse themselves among these groups, ideally with two or more per group if a team of peer educators is present.

Each group is given a brainstorming question and a set amount of time to come up with answers. The facilitators can encourage the groups and help them think of more answers by giving ideas and 'clues' about how to answer the brainstorming questions.

The format for the questions can follow the following guidelines:

1. Why do some people (have/engage in/get involved with) x?
2. What are some reasons to (wait to try/abstain from/refrain from) x?
3. What are some alternatives to (being/doing) x?
4. Why do some people not protect themselves from x? (where appropriate).
5. How can you encourage someone to be safer with respect to x?

Here are lists of example answers to five brainstorming questions that peer educators might ask during a workshop on sexual health and protection:

Why do some people have sex?

- Fun
- Feels good; pleasure; enjoyment
- Friends do it
- Free
- Rebellion
- Boredom; it's something to do
- Adventure
- Curiosity; experimentation
- In love
- Following example of someone else
- Pressure by partner
- Peer pressure
- For money; survival sex
- Think they're in love
- Habit; addiction
- Because they can
- Hormones
- To escape from other problems
- Human nature; natural activity
- See it on television or the movies; pressure from the media
- Ignorant; uninformed
- Obsessed
- Fear of rejection; to stay in a relationship
- Status: it's cool; to prove manhood
- To have a baby; reproduction
- Power
- Rape
- It's for adults only
- The risk is a turn-on
- Horny; lustful
- To explore bodies
- Looking for love; to feel nurtured
- Popularity
- Intimacy
- Conquest
- Don't want to be a virgin
- Immaturity
- To escape from reality
- Stress reliever
- Emotional outlet
- To gain experience
- To hide their feelings
- Intoxication

What are reasons to wait or abstain?

- Not in the mood
- Feeling sick
- Not ready
- First time should be special
- Don't like sex
- Sex hurts
- Not in love
- Don't want to be used
- Don't want a baby
- Don't want sexually transmitted infection
- Scared
- Don't know where partner's been
- Religion
- Get caught by parents
- Sex isn't worth it
- Not the right person
- Too young
- Not comfortable with self or partner
- Consequences are too much
- People can't call you a slut
- Want to stay a virgin
- Against values

What are alternatives to sexual intercourse?

- Hold hands
- Mutual masturbation – simultaneous masturbation
- Phone sex; cybersex
- Fantasize
- Cuddle/touch/pet/fondle (hand job; etc)
- Massage
- Dry kiss
- Dry sex (humping with clothes)
- Play footsie
- Picnic
- Shower together
- Long talks
- Dance; dirty dance
- Take a long romantic walk together
- Look at sexy pictures; watch porn movies
- Use sex toys (keep sterile if sharing)
- Use food creatively
- Lick the body anywhere except on open skin or mucous membranes
- Talk dirty
- Read steamy romantic books
- Meditate
- Exercise together
- Frottage
- Herbal/holistic methods; acupuncture
- Kiss passionately
- Oral sex
- Indulge in foreplay
- Penis between the breasts
- Just sleep together (i.e. lay close to one another all night)
- Say I love you; pronounce your feelings in words versus physically
- Enjoy hobbies together

Why don't some people use protection?

- Too expensive for budget
- Ruins the mood, not romantic
- Embarrassment
- Don't know how to use
- Doesn't feel as good when using a condom
- Allergic
- Ruins spontaneity
- Not 100% effective or reliable
- Against beliefs – religious, gang rules, etc
- Don't want to look promiscuous or 'loose'
- Implies you planned to have sex
- Lack of empowerment; power struggle
- Low self-esteem
- Partner unwilling
- Fear of rejection; jeopardizing the relationship
- Selfishness, unwilling to compromise self-gratification
- Feelings of invincibility; denial
- Don't want to admit responsibility
- Excitement of risk-taking
- Don't place condoms in easily accessible location for oneself
- Pure laziness
- Blindly trust partner regarding sexual history; denial
- Ignorance, unaware of the risks involved
- Self-destruction
- Faith in other birth control methods that are not effective for protecting against disease (pulling-out, right timing)
- Intoxication
- Macho
- Marriage
- Want to get pregnant
- Anger; aggression
- Fidelity; in a monogamous relationship
- Performance anxiety
- Forgot in the heat of the moment, poor planning
- Hide sexual activity or sexuality
- Putting the responsibility on the other partner versus being responsible together

How do you encourage someone, such as a partner, to be safer?

- Condoms prevent pregnancy and transmission of sexually transmitted infections and HIV
- I care about you
- I do not want you to get sick or to die
- No glove, no love
- I do not want to get sick or to die
- If you really cared about me you would agree to protection
- If you don't use a condom, forget about me
- Don't have sex at all – abstain if there is no protection available
- Better safe than sorry
- Make it into a game; put it on for your partner
- Say: "I'll enjoy it more if we use protection"
- Sex is smoother and there is less pain with a lubricated condom
- Condoms make guys last longer
- Protect; don't infect
- If you want to be with me put a condom on. I don't want HIV, so wear it or you're gone
- Talk about safe sex ahead of time – on the phone or just in normal conversation
- Bring the partner to sexual peak and then give them the protection – at a time when they almost cannot refuse
- Better safe than sorry
- I don't know who you have been with before
- We can do it again and again if we live through the first time
- One night fling or a nine month thing?
- Condoms come in many flavours and colours
- AIDS does not discriminate

Personal testimony

In the next part of the presentation, a person who is living with x comes and talks about his or her experiences. This can often be the most powerful part of the presentation. It is good to know the speaker well and to make sure that he or she is a good public speaker and fully prepared for the presentation. Encourage the speaker to talk about things that the participants may be able to relate to, especially personal experiences such as what daily life is like for him or her. Another option is to have the participants view a documentary or video about x and its impact on the world and on peoples' lives.

Great caution should be exercised to make sure that bringing in the guest speaker will be completely safe for her/him and that it will not traumatize her/him or the workshop participants. In order to do this, peer educators can ensure that certain guidelines are observed. For example, the speaker should not be at high risk for relapse into substance use by talking about her/his personal experiences with addiction. This might happen if s/he has not been in recovery for a long enough period of time or if s/he does not have a chance to spend time with a supportive person for de-briefing after the workshop.

Get the facts

The next part of the presentation is the main 'teaching' part. While facts are given throughout the presentation, this is the time when peer educators give key facts and answer questions.

One important area to cover is reducing the risks of x. In this exercise, the educator provides clues about facts related to reducing the risk of x. An example is provided below for a discussion of HIV/AIDS. First, the following chart should be presented:

HIV/AIDS Risk Reduction:

Do not allow the following fluids:

1. _____
2. _____ 2a. _____
3. _____ or
4. _____

into your: _____

or onto your: _____

such as: _____, _____, _____, _____, _____, _____.

Next, the educator begins by prompting participants to figure out what goes in the blanks by asking, for example, "What are four bodily fluids that can transmit HIV?" Then s/he can ask "what system and types of body parts should

you avoid allowing the fluids to reach?" The following are the correct responses:

HIV/AIDS Risk Reduction

Do not allow:

1. blood
2. semen 2a. 'pre-cum' (pre-ejaculate fluid)
3. vaginal fluids or
4. breast milk¹

into your: bloodstream

or onto your: mucoous membranes

such as: vagina, anus, tip of penis, mouth, eyes, nose.

After the participants have provided answers and the educator has filled in all of the blanks, he or she will then explain the information clearly.

Role playing

Role playing exercises are simple improvisational acting scenes that enable educators to introduce facts and information about a chosen topic while also exposing participants to everyday situations related to the topic. Role playing also helps participants build or improve their skills in dealing the topic. Role playing can take a variety of forms; following are two of the most common.

Basic Role Playing

To begin, the peer educators suggest 'everyday' situations that a chosen number of participants spontaneously act out. Peer educators might also assign specific roles to each of the participants.

Here is a list of role plays that can be valuable during workshops that deal with HIV, STIs, drugs and sexuality:

1. Condom demo
2. Drug/alcohol use
3. Intoxication at a party leading to sex
4. How to clean a syringe apparatus
5. Window period: when HIV is contracted and when it shows up in tests
6. Testing: information, numbers, places to go
7. Difference between latex and lambskin condoms
8. Parent finding a condom
9. Dental dam usage
10. Should I be tested?
11. Disclosing HIV status, and being there for someone who is HIV positive
12. Homosexual and heterosexual sex issues – am I ready, are you clean, should we use a condom, what will my friends think?
13. Lubricants
14. The problem with "pulling out" (pre-ejaculate fluid)
15. New treatments or new drugs
16. Sexual harassment

1 - It should be noted, however, that in countries where clean water is not readily available the rules may be somewhat different with respect to breast feeding. Consistent, exclusive breast feeding in some areas seems to provide better health outcomes and lower risk of HIV transmission than combination of breast feeding and the use of formula.

Role Play Revolution¹

Here is another way to prepare participants for role playing. Two people begin an improvisational scene. When the scene seems to have peaked, or someone needs 'rescuing', another person taps one of the original role players and starts a new scene, or continues the one in progress. The other player improvises the response.

The scenes can be built on the same topics as explained in the paragraph on role playing.

Closing and discussion

The audience is invited to share any responses to or questions or comments they have about the workshop activities. This is an opportunity to review issues that may have arisen during the role playing, such as the choices made by characters that were portrayed by participants or educators. Ideally, the role play will serve as a 'spring-board' for discussion. Also, if there is a guest speaker, this can also be a time for participants to interact with him or her.

After the presentation, the peer educators should stay around for a few minutes so that individuals can approach them with any comments or questions. Someone may want to ask about something personal or might need a resource, and may be more comfortable approaching someone individually rather than asking during the workshop.

Icebreakers, games and exercises²

Exercises and games can be used not only in presentations, but also in preparation for presentations. There are many great exercises that can help the peer educators themselves feel more comfortable when presenting situations. These games also help to get the participants feeling more comfortable and open with each other, which in turn will lead to better presentations.

Hurricane (or 'A cold wind blows ...')

This exercise is fun and active, enabling participants to get out of their chairs and move around. The game begins with the group sitting in a circle of chairs around one person who stands in the middle. (There is one fewer chair than there are participants.) The object is for him or her to get to a seat, which will be left vacant, so someone else ends up without a seat, standing in the middle of the circle. The game works like this:

The person standing starts a sentence with: "A cold wind blows for anybody who ..." and ends it with a fact that is true about himself or herself. For example, if wearing blue jeans, he or she might say: "A cold wind blows for anybody who is wearing blue jeans". The people for whom this fact is also true must then immediately get up and run across the circle to find a seat left open by someone else (they cannot scoot over and take the seat next to them). The person in the middle also rushes to find a seat. There will be one

person left standing. That person then goes to the middle and repeats the process, and so the game continues.

The choices are not limited to physical things. They could include attitudes about things, life experiences and so on. For example, if the person believes in helping support people who wish to be abstinent, he or she could state: "A cold wind blows for anyone who believes people who wish to be abstinent should be supported in their decision". He or she might state: "A cold wind blows for anybody who thinks you should make condoms available in high school". The game ends simply whenever the facilitator (or group) chooses to end it.

Kitty wants a corner

Group members stand in a circle and one person starts as the 'kitty'. The person in the middle, the 'kitty', goes around the circle saying: "Kitty wants a corner". The people that the 'kitty' asks reply: "Ask my neighbour", and the 'kitty' moves counter clockwise to the next player. As the 'kitty' is saying that he or she wants a corner, the people who form the circle are running across the circle switching places, behind Kitty's back. The 'kitty' tries to take the place of someone who is running across the circle, and when he or she succeeds, the person left without a position in the circle is the new 'kitty'.

Body hou-ha game

This exercise is great for lifting the group's mood. Everyone stands in a circle. One person makes a noise and a body movement. The person to the left immediately imitates. The noise and body movement run around the circle like lightning and come back to the person who originated it, who then repeats it. The person to the left of the originator now creates his or her own noise and movement, and it goes around the circle.

The 'yes' name game

Here's great way for learning each others' names. It is a good game for training in and practicing good listening skills as well as for helping to teach the give-and-take necessary for good drama technique. The game involves people standing in a circle, and moving into spots where others had been standing, after calling their names, and getting a 'yes' from them. It works as follows:

First, everyone stands in a circle and introduces themselves a few times until people are familiar with other people's names. Someone begins by calling out someone else's name. That person responds 'yes' and the person who called out his/her name moves to replace him/her bearing in mind that it is forbidden to move until hearing the answer "yes". The person whose name was called follows the same procedure.

1 - Adapted from a technique taught by Stacy Block, Peer Education Program "Reflections", Brunswick, New Jersey.

2 - Adapted from sections of Zielony, R. & Tunick, R., Peer Education Manual, 92nd St. Y NYC, 1996. This section includes a description of games and exercises created and/or submitted by a number of peer educators and instructors, including Shira Piven, drama expert. The original source for many of them is unknown.

Ball toss name game¹⁻²

This exercise is great for teaching peer educators about the value and elements of good communication. Everyone stands in a circle and introduces themselves once or twice. Someone gets an object to toss (for example, a crumpled-up ball of paper). That person makes eye contact with someone, calls out his or her name, and tosses the ball. If they forget someone's name, they can ask him or her to repeat it. After a couple of minutes, a second and then a third ball can be introduced, which increases the chaos and laughter.

You can then give the group the assignment of trying to make, for example, 10 or 15 completions, without a drop, or you have to start counting again. The instruction, however, is that all three balls are to be involved in this exercise.

When this has been done, a discussion can be facilitated. The discussion can first be about how the players felt playing the game. Then, it can move to the idea of how throwing the ball (from one person to another) can be considered as a metaphor for how we communicate as peer educators. The facilitator should ask the group to consider what the necessary ingredients were for the completions to occur. Things such as: making eye contact, calling someone by name, making sure they are ready to receive the ball (or message), throwing it directly to the person, not throwing it when there is another ball coming in, and so on, are all important elements to include.

Associative name game

This is another fun exercise that helps participants learn names. Each player chooses an action that begins with the first letter of his or her name.

Jason: "I am jumping Jason" (he jumps).

Rebecca: "He is jumping Jason" (she jumps). "And I am running Rebecca" (she runs).

Kate: "He is jumping Jason" (she jumps). "She is running Rebecca" (she runs). "And I am kicking Kate" (she kicks).

Pass a clap³

Everyone stands in a circle. To pass a clap, you must make eye contact with the person next to you and clap at the same time as him or her. That person makes eye contact with the person on their other side and claps. That person claps with them and then turns, makes eye contact, and claps with the next person. A rhythm builds and the leader can call out 'faster' or 'slower' to increase the speed of the beat being passed.

What are you doing?

This exercise can help prepare participants for role playing. Everyone stands in a circle. One person begins to mime an

action, for example, bouncing an imaginary basketball. The person to his or her left asks: "What are you doing?"

The person who appears to be bouncing a basketball responds, but actually states that he or she is doing some other activity, for example: "I'm reeling in a shark". This response can be the first thing that pops into his or her head. The person who posed the question must then mime the stated activity, in this case, reeling in a shark, as creatively as possible. The person next to him or her then asks: "What are you doing?" The person already miming responds with the first thing he or she thinks of, and the person who asked then mimes that action, and so on. Each person must continue miming the activity, until the second person after them has begun his or her miming.

Building a machine

This can help participants learn the value of teamwork. One player starts with a repetitive, rhythmic motion and sound. Another player leaps in and joins the building of the machine by making a different sound and motion in rhythm with the first person. This continues until everyone except the facilitator is contributing to the machine's ability to work. The facilitator can tell them to slow down, speed up and even to freeze. The job of the machine is to stay 'in sync' with each part.

Rope (or pretzel)³

Everyone stands in a close circle, puts out his or her right hand and grabs the right hand of someone else. Then each puts out his or her left hand and takes the left hand of a different person. Without letting go, they must get out of the pretzel (or untangle the 'rope') and get back into a circle. If the group gets very good at this, variations can be made such as: no talking, only whispering, and so on.

Caution: People participating in this game should be seriously warned before starting that they need to be very careful not to hurt anyone by twisting their arm, stepping on them, etc.

Mirror

In pairs, each participant mirrors exactly what his or her partner's hands are doing. The person in the pair who is leading can switch. Sometimes it is unclear who is doing the controlling; ideally they work together, taking turns to lead and follow.

To tell the truth

This exercise can help show participants how easy it is to make assumptions about people. All players are instructed to write down something about themselves that is true but that nobody else in the room knows. They should be forewarned that what they write down will eventually be

1 - Adapted from an exercise taught by Robert Eckert, NDRI (Narcotic and Drug Research Incorporated).

2 - Revised in Peer Education TOT Manual, 2003 Y-Peer UNFPA, UNICEF, UNESCO, WHO

3 - Eckert, Bob, The LIFE Institute (Learning Institute for Functional Education), Peer Education Programme "Reflections". Bergen, New Jersey, USA.

4 - Adapted from the exercise "Knots/Giant Knot," New Games for the Whole Family, Dale N. LeFevre, Perigree Books, 1988.

revealed to the entire group, so it should be something they are comfortable sharing with everyone! Each person writes his or her name on the piece of paper and gives it to the facilitator. The facilitator chooses one of the secrets and then chooses three panellists, including the person whose secret it is, to “tell the truth,” without revealing whose secret he or she has chosen. The facilitator then chooses three judges. The facilitator reads the secret and each panellist tries to convince the judges and the audience that they are the person whose secret was just read. The person whose secret it really is cannot lie!

Each judge asks each panellist one question to help them determine who the secret belongs to. After the questions are asked and the responses are given, the judges vote and then the person whose secret it was reveals him or herself.

The other half

The facilitator writes word pairs on index cards or squares of paper. Each card will have one word, such as ‘hair’, and will have a corresponding card with its word pair, such as ‘brush’. Other examples of word pairs are: book-mark, grand-mother, door-knob, hot-dog, light-bulb, brief-case, sling-shot, snow-ball, knee-cap, lip-stick, skin-cream, jump-rope, toe-nail. Each participant is given a card with a word written on it. People then have to find the match to their card.

Get up together

This is another team-building exercise. Participants divide up into pairs. Each pair sits on the ground with their backs to each other and links arms. They must stand up together, keeping their arms linked at all times. After successfully doing this, the group divides into threes and then fours, and so on. Then the entire group attempts to stand up together.

Honey, I love you

This exercise is a good way to inject some fun and laughter into a workshop. The group sits in a circle with one person standing in the middle. The person in the middle approaches someone in the circle and says: “Honey, I love you, won’t you please, please smile?” That person has to respond without smiling or laughing. The person being asked says: “Honey, I

love you too, but I just can’t smile”. If he or she can respond in this way without laughing, then the person in the middle must move to the next person in the circle. The goal is to get out of the centre by saying the words: “Honey, I love you, won’t you please, please smile?” in the funniest way possible so that the person he or she is saying it to will smile.

Condom relay race

Here is a great way to test participants’ knowledge of how to use condoms. After being taught how to put on a condom, the group breaks up into two teams. Each person is given a condom. The teams race each other to finish getting their condoms onto a cucumber before the other team does without making any mistakes or skipping any steps. If someone messes up, he or she is given a new condom and has to start all over again.

Safer sex password¹⁻²⁻³

This is a good way to help participants remember key words related to safer sex and HIV/AIDS prevention. The group splits into two groups that sit facing each other. One group is shown a password, a word related to safer sex that is chosen by the facilitator. The goal for the group that is shown the password is to try to get the other line to figure out the password by giving them one- or two-word clues without giving the password away. One person gives a clue, and the person directly across from that person guesses the password. If he or she is wrong, the next person on the line gives a clue, and the person across from him or her guesses. This continues until someone guesses the password. Sample passwords might include: mucous membranes, clitoris, pre-cum, penis, condom, AIDS, etc.

Train

Participants form two or more lines. All of them need to close their eyes except the last participant who gives directions to everybody. If he or she squeezes the shoulders of the person in front, it means they should carry on straight forward, a vibration on the left shoulder means a left turn for the train and a vibration on the right shoulder means a right turn. Every participant does this to the person ahead. They need to watch out and not hit the trains. ■

1 - Adapted from a concept used in the High Risk Adolescent Project “H-RAP” Curriculum of Westover Consultants in Washington DC, USA.

2 - Peer Education TOT Manual, 2003 Y-Peer UNFPA, UNICEF, UNESCO, WHO

3 - Adapted from Zielony, R. & Tunick, R., Peer Education Manual, 92nd St. Y NYC, 1996

Glossary

A

Abortion: Induced abortion, or the voluntary termination of pregnancy, is used to end an already established pregnancy. Most abortions – nearly 90% – take place in the first three months of pregnancy. Abortion can be done in one of three ways: with medicine; by vacuum aspiration or through surgery. Spontaneous abortion is when the body terminates the pregnancy by expulsion of the embryo/fetus before 22 weeks of pregnancy or below 500g of weight.

Abstinence: Sexual abstinence means voluntarily not having sex. Sex has different personal meanings for people. To some it may only mean intercourse with the penis in the vagina; to others, it may include anal sex, oral sex and other forms of sexual activity like kissing, caressing or 'petting'.

Acquired immune deficiency syndrome (AIDS): A facilitated invasion of disease that is often fatal, caused by the **Human Immunodeficiency Virus (HIV)**. It is believed that almost everyone infected with HIV will eventually develop AIDS because the body's immune system is progressively weakened by HIV.

Adolescence: The period of transition from childhood to adulthood, describing both the development to sexual maturity and to psychological and often relative economic independence. The World Health Organization uses the 10-19 year age range to define adolescence, with further divisions for early adolescence: 10-14 years, and late adolescence: 15-19 years.

Advocacy: A campaign or strategy to build support for a cause or issue. Advocacy is directed towards creating a favourable environment by trying to gain people's support and influence or change legislation. See also **Information, Education and Communication**.

Anal sex: Sexual intercourse when the penis penetrates the anus. While some sexual activity may involve anal penetration with other things, usually the term 'anal sex' is limited to penile/anal penetration.

Asymptomatic: A state in which there are no signs or symptoms of certain diseases, for example, when an HIV positive person does not show symptoms of AIDS.

B

Barrier methods: Barrier methods of contraception prevent pregnancy by physically or chemically blocking the entrance of sperm into the uterine cavity. Some, particularly condoms, help to provide some protection against sexually transmitted infections, including HIV. Barrier methods include cervical caps, condoms, diaphragms, female condoms, spermicides and sponges.

Bisexual: A sexual orientation in which the person is attracted to and may have sex with both sexes (male and female).

C

Cervical secretion: A body fluid produced by the cervix, the neck-like opening to the uterus.

Condom: A barrier method of contraception that not only prevents pregnancies but can also help to add some protection against sexually transmitted infections, including HIV/AIDS. There are two types of condom. The male condom is a thin rubber or latex (rubber) or polyurethane sheath fitted over the penis before sexual intercourse. The female condom is made from polyurethane (like a thin plastic film) and is placed in the vagina.

Confidentiality: Information at one's disposal, unavailable to others unless permission is given by the person directly concerned with the information.

Contraception: The prevention of unwanted pregnancy, which can be achieved by various methods.

Counselling: A two-way process of communication in which one person helps another to identify her or his sexual and reproductive health needs and make the most appropriate decisions about how to meet them. Counselling is characterized by an exchange of information and views, discussion and deliberation.

D

Dental dam: Dental dams are square pieces of latex, which is a material similar to that of condoms. They were originally designed for dental patients to keep fragments of materials from falling into the throat during certain procedures. They have also been used to cover the vulva during oral sex to reduce the risk of sexually transmitted infections.

Dual protection: Dual protection is protection against both unintended pregnancy and sexually transmitted infections, including HIV. For sexually active individuals, a condom is the only device that is effective for dual protection. Dual protection can also be achieved by using condoms with another method of contraception, referred to as dual method or double protection. Dual protection is of particular relevance when interventions are focused on groups in vulnerable situations such as young people, sex workers etc..

Dis-inhibition: This is the psychological impact which is caused by some types of drugs that result in people feeling less inhibited when using them.

Drug resistance: When a virus or disease is not affected by a particular type of medicine. This can develop naturally over time, even after a drug may have been effective, and when someone discontinues use of a medicine temporarily and the virus replicates into a form which cannot be damaged by the drug. A person can be infected with a drug-resistant strain from the outset (if that is the nature of the source of infection).

E

Emergency contraception: Method of contraception used to avoid pregnancy after a single unprotected act of sexual intercourse that results from lack of use or failure of a contraceptive. Two types are available: hormonal treatment (known also as the morning-after pill, which has to be taken within 72 hours) and the insertion of an intrauterine device (which has to be carried out within five days). Emergency contraception pills are thought to prevent ovulation, fertilization, and/or implantation. They are not effective once the process of implantation has begun, and will not cause abortion.

Epidemic: When an infectious disease spreads quickly among many individuals in a city, country or region..

Evaluation: A study in which any number of different techniques may be used to gather and analyse information to determine whether a programme is carrying out the activities it had planned, and the extent to which the programme is achieving its stated objectives through these activities.

F

Family planning: The conscious effort of couples or individuals to decide and attain their desired number of children and to regulate the spacing and timing of their births. Family planning is achieved through abstinence, timing methods, contraception and through the treatment of involuntary infertility.

Fecundity: The physiological capacity of a woman or man to produce or beget a live child. See also **Fertility**, which is the actual reproductive performance.

Female genital mutilation (FGM): A traditional practice that involves cutting away parts of the female external genitalia, or other injury to the female genitals, for cultural or other non-therapeutic reasons. FGM is usually carried out by untrained traditional practitioners under unhygienic conditions.

Fertility: The actual reproductive performance of an individual, group or society.

Fertility regulation: The process by which individuals and couples regulate their fertility. Methods include, among others, delaying childbearing, using contraception, seeking treatment for infertility, interrupting unwanted pregnancies and, in the case of mothers with an infant or a small child, breast feeding.

Focus group discussion (FGD): A qualitative research method used to establish why and how people behave in a particular way. The technique usually involves in-depth discussions with small groups of people (8–10). A moderator prompts the group to discuss particular topics that are of importance to a forthcoming project or activity, and then encourages a free and open exchange of ideas and feelings.

G

Gay: A man whose sexual orientation is homosexual (primarily same sex attraction).

Gender: The word 'gender' is used to classify a person's sex, either as male or female. Beyond this, there are other definitions that lead to a deeper understanding. 'Gender identity' is how people identify themselves, and is part of their personal feelings and judgment about who they are.

Gender roles

Within cultures, there are 'gender roles' which are considered to be either more typically male or more typically female.

Attributes considered typical to the male or female role may be clear within many cultures, or shared by both in others.

Gender equality: Equal representation of women and men. Gender equality does not imply that women and men are the same, but that they have equal value and should be accorded equal treatment and rights.

Gender equity: The application of fairness or justice in all gender issues. This applies both to the composition of power structures and to social divisions of labour. Insisting on absolute equality of numbers may not always be equitable. In the area of reproductive health, where women bear the largest share of the costs, dangers and burdens (physical, mental, social, economic), it is usually thought equitable and fair that women should control a greater proportion of the decision-making. Equal opportunities for women and men require that women and men start with equal status and access to knowledge and resources, so when this is not the case, women may initially need special treatment.

H

Heterosexuality: A person with a sexual orientation in which he or she is sexually attracted to partners of the opposite sex.

Highly active anti-retroviral therapy (HAART): The name given to treatment regimens recommended by leading HIV experts to aggressively suppress viral replication and progress of HIV disease.

Homosexuality: A person with a sexual orientation in which he or she is sexually attracted to people from the same sex (man–man; woman–woman).

Hormonal contraception: Systemic methods of contraception based on either a progestogen combined with an oestrogen or a progestogen alone. The methods of delivery include pills, injectables, implants and the intrauterine system. All are reversible.

Human immunodeficiency virus (HIV): The virus that causes AIDS. Two types of HIV are currently known: HIV-1 and HIV-2. Worldwide, the predominant virus is HIV-1. HIV-2 has initially shown greater prevalence in Central and Western Africa.

Both types of virus are transmitted by sexual contact, through infected blood (including infection from unsterilized drug injecting equipment) and from mother to child (either before or during birth, or through breast feeding), and they appear to cause clinically indistinguishable AIDS. However, HIV-2 is less easily transmitted, and the period between initial infection and illness is longer in the case of HIV-2.

While some people experience mild HIV-related disease soon after initial infection, nearly all then remain well for years. Then, as the virus gradually damages their immune system, they begin to develop illnesses of increasing severity, including diarrhoea, fever, tuberculosis, pneumonia, lymphoma and Kaposi's sarcoma.

HIV negative (HIV-): Proven absence of antibodies for HIV in someone's blood with specific blood tests.

HIV positive (HIV+): Proven presence of antibodies for HIV virus in someone's blood with specific blood tests.

I

Immune deficiency: A breakdown or inability of certain parts of the immune system to function, thus making a person susceptible to certain diseases that they would not ordinarily develop.

Indicator: A measure which can be recorded, collected and analyzed in order to allow a complex concept to be measured so that the researcher (or manager) can compare actual results with expected results.

Infertility: Strictly, infertility means not fertile – that is, childless. However, infertility is often defined and usually understood as the inability of couples of reproductive age, who are having sexual intercourse without contraception, to establish pregnancy within a specified period of time. This can be due to disorders of either the male or female reproductive systems.

Information, education and communication (IEC):

A programme to ensure that clients or potential clients of sexual and reproductive health services are given the means to make responsible decisions about childbearing and about their sexual and reproductive health. **Information** involves generating and disseminating general and technical information, facts and issues, in order to create awareness and knowledge. **Communication** is a planned process aimed at motivating people to adopt or maintain healthy attitudes or behaviour; while **education**, whether formal or informal, is a process of facilitated learning to enable those learning to make rational and informed decisions.

Informed choice: Voluntary decision by a client to use, or not to use, a contraceptive method (or accept a sexual and reproductive health service) after receiving adequate information regarding options, risks and benefits of all available methods. The exercise of both the right of access to family planning and the right to make informed and responsible decisions about childbearing require full knowledge of the benefits, purposes and practice of family planning, and the personal, familial and societal consequences of individual reproductive behaviour.

Intrauterine (contraceptive) device (IUD or IUCD): A long-term, reversible method of contraception, involving the insertion into the uterus of a small flexible device made of metal and/or plastic. IUDs are effective for at least four years or longer.

K

Knowledge, attitudes and practice (KAP) survey: Survey undertaken with a target group to establish the level of knowledge (for example, information about sexual and reproductive health), the prevailing attitudes (for example, towards use of protection, sexual activity), and the current situation with regard to actual behaviour (such as contraceptive use).

L

Lesbian: A woman whose sexual orientation is homosexual (primarily same sex attraction).

Lymphadenopathy: Inflamed (swollen) lymph nodes (often in the neck, behind the ears, groin or armpits), which is a common symptom indicating that the immune system is fighting an infection or illness.

M

Menstrual regulation (MR): Evacuation of the uterus of a woman who has missed her menstrual period by 14 days or fewer, who previously had regular periods and who has been at risk of conception. It may be performed before proof of pregnancy. In some countries menstrual regulation is legal, even though therapeutic abortion is not.

Microbicide: The word 'microbicides' refers to a range of different products that share one common characteristic: the ability to prevent the sexual transmission of HIV and other sexually transmitted infections (STIs) when applied topically. A microbicide could be produced in many forms, including gels, creams, suppositories, films, or as a sponge or ring that releases the active ingredient over time. Some of the microbicides being investigated prevent pregnancy and some do not. It is important to have both non-contraceptive microbicides as well as 'dual-action' microbicides that prevent pregnancy, so that women and couples can protect their health and still have children. This is not possible with condoms.

Monitoring: The continuous follow-up of activities to ensure that they are proceeding according to plan and are on schedule and/or to signal the need for adjustment. It keeps track of and registers achievements, personnel utilisation, use of supplies and equipment, and the money spent in relation to the resources available, so that if anything goes wrong immediate corrective measures can be taken.

Monogamy: A relationship with only one partner.

Mother-to-child transmission (MTCT): Transmission from a woman who is HIV-infected to her infants during pregnancy, delivery and/or breast-feeding.

Men who have sex with men (MSM): This refers to any men, whether they self-identify as gay, bisexual or heterosexual, who engage for whatever reason in sex at some time with another man.

Mucous membranes: These are the pink wet tissues which are found in the lining of six body openings: the eyes, nose, mouth, tip of the penis (urinary meatus), the vagina and anus.

N

Negotiation skills: The essential skills needed for someone to be able to communicate and assert their needs with respect to someone else, for example, the ability to negotiate with a partner to insist on the use of protection.

Nonoxynol 9: A spermicide that helps to protect against pregnancy when used with a female barrier method, but does NOT necessarily protect against sexually transmitted infections such as HIV, chlamydia or gonorrhoea. In fact, frequent use of nonoxynol-9 can irritate the lining of the vagina (and the anus if used rectally) and subsequently increase the risk of acquiring a sexually transmitted infection, including HIV.

O

Oral contraception (OC): See **Hormonal Contraception**.

Oral sex: A sexual practice during which there is a contact between the mouth and the genitalia, e.g. fellatio (mouth on a penis), cunnilingus (mouth on vulva or vagina).

Oral testing: A form of testing for HIV and other viruses. This is a form of testing using a swab to lightly scrape on the inside of the mouth or cheek for a sample.

P

Pandemic: An epidemic so widely spread that vast numbers of people across countries are affected.

Periodic abstinence: A method of contraception in which couples avoid sexual intercourse during the fertile phase of the menstrual cycle. This method depends on the ability of the couple to identify the fertile phase (sometimes called fertility awareness) and the couple's motivation and discipline to practise abstinence when required. It is also known as natural family planning.

Pre-ejaculate fluid: This fluid, also known as pre-cum (slang), is the small amount of clear or whitish sticky fluid which emerges from the penis during sexual arousal before full ejaculation occurs. It cleanses the tube in the penis, and is usually not noticed when it is emerging, but can contain live sperm and cause pregnancy.

Promiscuity: Having frequent, especially casual, changes of sexual partners or relationships for a short period of time. This term is based to some extent on personal judgment, therefore the use of the non-judgmental, purely descriptive term 'multiple sexual partners' is preferable in peer education.

Prostitute: An individual who engages in direct sexual activity with another person in exchange for money, goods and/or drugs. The term includes those who earn money through sexual labour on a regular basis, as well as those who do it casually, informally or intermittently. Prostitutes can be male, female or cross-gender (for example transsexuals, transvestites); they can be adults, adolescents or, sometimes, children. The word 'prostitute' is considered derogatory in some cultures, so sex worker or commercial sex worker may be preferred.

Q

Questioning: A term used in the field of human sexuality to describe someone who may be unsure of her or his sexual orientation.

R

Rapid testing: There are various forms of rapid testing for HIV that enable a person to get the test's results in a shorter time than common testing. Some involve drawing blood, taking a sample of oral mucous or taking a sample of urine. However, the results of rapid tests, if positive, are preliminary and must be followed up with an acceptable confirmatory test.

Refusal skills: The skills required to be able to say 'no' when someone tries to encourage a person to do something s/he does not want to do.

Risk reduction: Describes techniques or strategies which can be used in order to lower the risk of transmission of an infectious disease. Using a condom is a risk reduction technique for sexual transmission of various sexually transmitted infections.

Reproductive age: The span of ages at which individuals are capable of becoming parents. The phrase can be applied to men and women but most frequently refers to women. 'Couples in reproductive ages' nearly always means couples where the woman is of childbearing age. The age range 15-49 years is most often taken, but occasionally 15-44 is used, including in the United States.

Resistance: Some viruses have either developed, or will develop, a resistance to certain medications, so that the medicines will have no impact on them. If for example someone has an 'AZT-resistant' strain of HIV, he or she will need to try a different drug to help combat the effect of HIV.

S

Safer sex: Any sexual practice that aims to reduce the risk of passing HIV (and other sexually transmitted infections) from one person to another. Examples are non-penetrative sex or vaginal intercourse with a condom. During unsafe sex, fluids that can transmit HIV (semen, vaginal fluid or blood) may be introduced into the body of the sex partner. The five elements of safer sex include: consistent condom use; reducing the number of partners; practising mutual fidelity; engaging in safer sexual acts, including delaying the age at first intercourse; or abstaining from sex.

Semen (sperm): The whitish liquid containing sperm (male reproductive cells) produced by the testicles and secreted from the male genital organ just before and during ejaculation (the male sexual climax).

Sero-positive: A positive reaction to a test on blood serum for a disease: for instance, the term applied to a blood test where HIV antibodies have been found. If someone tests sero-positive it suggests he or she is infected.

Sex education: Basic education about reproductive processes, puberty and sexual behaviour. Sex education may include other information, for example about contraception, protection from sexually transmitted infections, and parenthood.

Sexuality education: Education about all matters to do with sexuality and its expression. Sexuality education covers the same topics as **Sex education** but will also include issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active. It will provide information about sexual and reproductive health services. It may also include training in communication and decision-making skills.

Spermicide: A chemical contraceptive inserted into the vagina shortly before intercourse. Spermicides are more effective when used in conjunction with other contraceptives such as condoms or diaphragms. Used sparingly they may offer some limited protection against

sexually transmitted infections. However, they can also be a source of irritation and increased vulnerability to infections. Spermicides are available in various forms: creams and jellies, foams, suppositories, foaming tablets and plastic films. Some condoms contain a small amount of spermicide. See also **Nonoxynol 9**.

Sterility: The inability to produce a live birth.

Syndrome: Combination of symptoms of certain diseases which together tend to demonstrate a particular disease entity. AIDS is a syndrome rather than a single disease because, once a person has AIDS, he or she can get a variety of different illnesses due to his/her weakened immune system.

T

Thelper cell: This is a major type of cell essential for the immune system, which is attacked by HIV infection. It is also referred to as a CD-4 cell.

Transgender: A person who does something to change from her or his gender to be of the opposite gender, either through dress or clothes (transvestite) and/or other changes, such as taking hormones and perhaps having surgery (transsexual) to become completely identifiable as being of the other sex.

U

Universal precautions: The use of standard precautions (such as the use of protective gloves) – by health care professionals, in schools and other settings – against blood borne infections by treating everyone's body fluids as though they might potentially be carrying infection.

Unsafe sex: Sex practices without protection from sexually transmitted infections including HIV, including; oral, vaginal or anal intercourse without condom or dental dam; vaginal or anal sex without condom where partner withdraws before ejaculation; fisting (the act of shoving a fist up someone's anus or vagina) without using latex gloves; rimming (applying tongue to anus) without using an oral barrier or dam; and shared sex toys that have not been sterilized or not covered with a condom.

V

Vagina: Female genital organ that links the womb with the labia.

Vaginal sex: Sexual intercourse during which the penis penetrates the vagina.

Viral load: A measure of the quantity of virus in someone's system at a given time. This test is sometimes used to get an idea of what is happening in someone's immune system if they have HIV infection.

Voluntary counselling and testing (VCT): VCT is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. VCT has a vital role to play within a comprehensive range of measures for HIV prevention and care, and should be promoted. The potential benefits of VCT for the individual include improved health status through good nutritional advice and earlier access to care and treatment/prevention for HIV-related illness; emotional support; better ability to cope with HIV-related anxiety; awareness of options for prevention of MTCT feeding; and motivation to initiate or maintain safer sexual and drug-related behaviours. Other benefits include safer blood donation.

W

Window period: A period between the moment of infection and the moment when antibodies can be detected through a blood test. The window period for HIV can last up to three months, however, the virus can usually be detected sooner.

Withdrawal: One of the oldest methods of family planning relying on the man withdrawing his penis before ejaculation. It remains a commonly used method in a number of European countries. It is also sometimes referred to as coitus interruptus. Because of pre-ejaculate fluid, it poses a greater risk for pregnancy than many people understand. ■

Resources

Websites

www.advocatesforyouth.org
www.youthresource.com
www.youthshakers.org
www.fhi.org/en/youth/youthnet/index.htm
www.ambientejuven.org
www.mobileaids.org
www.youthHIV.org
www.thebody.com
www.unfpa.org
www.unicef.org
www.cdc.gov/hiv/pubs
www.aegjs.com
www.europpeer.org
www.youthaids.org
www.youthpeer.org
www.siecus.org
www.youthpeer.com/resources.htm#guidelines

Books and Publications

- International Planned Parenthood Federation (IPPF), *Peer Education: Successfully Promoting Youth Sexual and Reproductive Health. Guidelines* (London: IPPF Vision 2000 Funds, 2002)
- A Brodala and J Mulligan, *The PeerAid Book. Approaches to Setting Up and Running Young People's Peer Education Projects* (London: SV Education for Citizenship, 1999)
- Bundeszentrale für gesundheitliche Aufklärung (BZgA), *Peer Education. A Manual for Practitioners* (Cologne: BZgA, 2001)
- D Flanagan and H Mahler, *How to create an effective peer education project: guidelines for prevention projects* (Durham, NC:FHI, 1996)
- International Planned Parenthood Federation (IPPF), *The Peer Education Approach in Promoting Youth Sexual and Reproductive Health: Lessons Learned* (London: IPPF Vision 2000 Funds, 2001)
- United Nations Educational, Scientific and Cultural Organization (UNESCO), *Peer Approach in Adolescent Reproductive Health Education: Some Lessons Learned* (Bangkok: UNESCO Asia and Pacific Regional Bureau for Education, 2003)

IPPF European Network Member Associations

ALBANIA

Albanian Center for Population and Development
E-mail afpa@albaniaonline.net

ARMENIA

'For Family and Health' Family Planning Association of Armenia
Web <http://www.armfha.com> • E-mail armfha@netsys.am

AUSTRIA

Österreichische Gesellschaft für Familienplanung (ÖGF)

Ignaz Semmelweis Frauenklinik
Web <http://www.oegf.at> • E-mail office@oegf.at

BELGIUM

Fédération Laïque de Centres de Planning Familial (FLCPF)

Web <http://www.planningfamilial.net>
E-mail flcpf@planningfamilial.net

Sensoa

Web <http://www.sensoa.be> • E-mail info@sensoa.be

BOSNIA AND HERZEGOVINA

APP-XY - Family Planning Association of Bosnia and Herzegovina

E-mail bhfpaxy@bih.net.ba

BULGARIA

Bulgarian Family Planning and Sexual Health Association (BFPA)

Web <http://www.bfpa-bg.org> • E-mail bfpa@online.bg

CYPRUS

Family Planning Association of Cyprus (FPAC)

E-mail famplan@spidernet.com.cy

CZECH REPUBLIC

Společnost pro plánování rodiny a sexuální výchovu (SPRSV)

E-mail planrod@centrobox.cz

DENMARK

Foreningen Sex & Samfund

Web <http://www.sexogsamfund.dk>
E-mail danish-fpa@sexogsamfund.dk

ESTONIA

Eesti Pereplaneerimise Liit (EPPL)

Web <http://www.amoree> • E-mail eppl@amoree

FINLAND

Väestöliitto

Web <http://www.vaestoliitto.fi>
E-mail central.office@vaestoliitto.fi

FRANCE

Mouvement Français pour le Planning Familial (MFPF)

Web <http://www.planning-familial.org>
Email mfpf@planning-familial.org

GEORGIA

HERA XXI

E-mail ntsul@access.sanet.ge

GERMANY

PRO FAMILIA Bundesverband

Web <http://www.profamilia.de>

E-mail international@profamilia.de

GREECE

Family Planning Association of Greece (FPAG)

E-mail HellenicFPA@hotmail.gr

HUNGARY

Magyar Család- és Nővédelmi Tudományos Társaság

Web <http://www.szexinfo.hu/>

E-mail arpad.meszáros@office.ksh.hu

ICELAND

Fræðslusamtök um kynlíf og barneignir (FKB)

Web <http://www.mmedia.is/fkb> • E-mail fkf@mmedia.is

IRELAND

Irish Family Planning Association (IFPA)

Web <http://www.ifpa.ie/> • E-mail post@ifpa.ie

ISRAEL

Israel Family Planning Association (IFPA)

Web <http://www.opendoor.org.il>

E-mail ippf@post.com

ITALY

Unione Italiana dei Centri di Educazione Matrimoniale e Prematrimoniale (UICEMP)

Web <http://www.uicemp.org>

E-mail uicemp@tin.it

KAZAKHSTAN

Kazakhstan Association on Sexual and Reproductive Health (KMPA)

E-mail center:kmpa@alnet.kz

KYRGYZSTAN

Reproductive Health Alliance of Kyrgyzstan (RHAK)

E-mail rhak@infotel.kg

LATVIA

Latvijas Ģimenes Planosanas un Seksualas Veselības Asociācija "Papardes Zieds" (LAFPSH)

Web <http://www.papardeszieds.lv>

E-mail lfpa@mailbox.riga.lv

LITHUANIA

Seimos Planavimo ir Seksualines Sveikatos Asociacija (FPSHA)

Web <http://www.spa.lt> • E-mail lithfpa@takas.lt

LUXEMBOURG

Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle (MLPFES)

E-mail plannlux@pt.lu

MOLDOVA

Societatea de Planificare a Familiei din Moldova

Web <http://www.iubire.md> • E-mail fpa@moldova.md

THE NETHERLANDS

Rutgers Nisso Groep

Web <http://www.rutgersnissogroep.nl>

E-mail a.dubbeldam@rng.nl

NORWAY

Norsk forening for seksualitet, samliv og reproduktiv helse (NSSR)

Web <http://www.seksuellopplysning.no>

E-mail ksexo@online.no

POLAND

Towarzystwo Rozwoju Rodziny (TRR)

Web <http://www.trr.org.pl> • E-mail trr@trr.org.pl

PORTUGAL

Associação Para o Planeamento da Família (APF)

Web <http://www.apf.pt>

E-mail apfportugal@mail.telepac.pt

ROMANIA

Societatea de Educatie Contraceptiva si Sexuala (SECS)

Web <http://www.sexdex.ro/sd/index.jsp>

E-mail sediu@secs.ro

RUSSIA

Russian Family Planning Association (RFPA)

Web <http://www.family-planning.ru> • E-mail rfpa@dol.ru

SLOVAK REPUBLIC

Slovenská spoločnosť pre plánované rodičovstvo a výchovu k rodičovstvu (SSPRVR)

Web <http://www.rodicovstvo.sk> • E-mail ssprvr@nextra.sk

SPAIN

Federación de Planificación Familiar de España (FPFE)

Web <http://www.fpfe.org> • E-mail info@fpfe.org

SWEDEN

Riksförbundet för Sexuell Upplysning (RFSU)

Web <http://www.rfsu.se> • E-mail info@rfsu.se

SWITZERLAND

PLANes - Fondation Suisse pour la Santé Sexuelle et Reproductive

Web <http://www.plan-s.ch> • E-mail info@plan-s.ch

TURKEY

Türkiye Aile Planlamasi Dernegi (TAPD)

Web <http://www.tapd.org.tr> • E-mail tapd@tapd.org.tr

UNITED KINGDOM

fpa

Web <http://www.fpa.org.uk>

E-mail Library&Information@fpa.org.uk

UZBEKISTAN

Uzbek Association on Reproductive Health (UARH)

E-mail uarh@mail.eanetways.com

Annex I

Peer educator training workshop contract¹

The following basic ground rules were set by a group of participants at an IPPF EN workshop.

As a member of this training workshop, I agree to do my best to stick to the following rules:

- Respect my fellow participants.
- Use 'I' statements.
- Be on time.
- NOT smoke during work time (even if we are working outside).
- Listen to others.
- Remember that there are no 'right' or 'wrong' questions.
- Be part of the group.
- No mobile phones.
- Respect confidentiality.
- Not express or act upon prejudices.
- No put downs.
- Respect and take advantage of the right to pass when appropriate.
- No 'killer looks' showing judgement or disapproval to what someone says or does.
- Respect everyone's right to be different.
- Follow my feelings.
- Rule of 'oops' (if you feel you have hurt or offended someone) and 'ouch' (if you feel hurt or offended by someone).
- Speak a language spoken and understood by all participants.
- One person talks at a time.

In addition:

- I agree to take this peer education seriously.
- I agree to be aware of my responsibility in this work.
- I agree to participate actively.
- I agree that I will try not to offend anyone, and will apologize if appropriate.
- I agree that I will try not to express any personal prejudice.
- I agree that I will try to overcome any personally held prejudices.
- I agree that I will suggest rather than dictate.
- I agree that I will try to be tolerant of others.
- I understand that attendance is required at all training, work and performance activities, and that excessive absences are likely to bring into question my ability to continue being part of this programme.
- I will try to be a good team player as part of this programme. ■

.....

Date

(Please print name above)

Signature above)

Witnessed Date

¹ - Zielony, R., Sanna, L., and workshop participants of IPPFEN Peer Education TOT Workshop in Herzegovna, Montenegro, March 2003. Part of the idea was based on an idea from a draft of the Mount Sinai Peer Education Training Manual

Annex 2

Sample evaluation ¹

This particular type of form is an example of an evaluation of specific activities and their perceived value by participants.

Date Location

Workshop location How many days did you attend?

How useful did you find the following training exercises?

	Not at all useful	A little useful	Somewhat useful	Very useful	Excellent
1. Getting started					
2. Icebreaker – Slang words for sex					
3. Dos & Don'ts: Workshop Guidelines					
4. Brainstorming					
5. Personal testimony – Guest speaker or film					
6. HIV/AIDS 101					
7. Role playing or drama					

¹ - Zielony, R. Draft developed in the context of an International Workshop Development for UNFPA and other organizations - 2003.

Annex 3

Pre-Workshop Questionnaire (sample)

This is an adapted example of a questionnaire used with a community of Bucharian teenagers in New York City.

Anonymous questionnaire on HIV/AIDS and sexuality

Date:

A. Are you male or female? Male Female

B. How old are you? (circle your age) 12 13 14 15 16 17 18 19 20 older than 20

1. The average time between infection with HIV and the onset of (AIDS) illness is over eight years.

True False Don't know

2. Vaseline petroleum jelly and oil damage latex (condoms).

True False Don't know

3. Please put an X next to all of the body fluids which transmit HIV/AIDS:

Blood Breast milk Saliva Semen
 Sweat Tears Urine Vaginal fluid

For this questionnaire, sexual intercourse means vaginal intercourse (the penis is put into the vagina) or anal intercourse (the penis is put into the anus).

4. I think it's OK for unmarried boys/men my age to have sexual intercourse.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

5. I think it's OK for unmarried girls/women my age to have sexual intercourse.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

6. My friends think it's OK for unmarried boys my age to have sexual intercourse.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

7. My friends think it's OK for unmarried girls my age to have sexual intercourse.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

8. I think it's OK for unmarried people my age to have oral sex.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

9. Regarding risk behaviour, Bucharian [Jewish] teens behave the same as average non-Bucharian teens in New York City.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

10. Getting high on alcohol or drugs can increase a person's risk of contracting HIV/AIDS or sexually transmitted infections.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

11. If Chlamydia goes untreated what disease can it lead to in a woman?

12. If a high school has 2,000 students, how many high schools would be needed to fit all the teenagers who get a sexually transmitted infection in this country in a year?

1 5 10-20 21-30 31-40 50 or more

Examples of recommended games and exercises for peer educators

Organizing group work

1. A discussion on the following subject:

What are the obstacles to ensuring the rights of people who are HIV+ and/or living with AIDS? (If the group seems stuck, the facilitator can stimulate discussion by posing questions about what rights currently exist/should exist regarding marriage, jobs, parenting, confidentiality, access to medicines, etc.)

2. A workshop with the theme 'Create your own slogan'.

Aim: to notice prejudice and discrimination towards HIV+ people and towards AIDS as a disease in general.

Materials needed: flipcharts, coloured pens and blank badges or labels (for participants to wear on their shirts)

Time needed: about 30–40 minutes depending on the size of the group

What does the educator do?

1. Divide the participants into small groups and ask each group to do a brainstorming exercise on the theme "What people need to know about HIV and AIDS in order to protect themselves and other people from the infection". Also, ask "In what ways are people discriminated against regarding HIV/AIDS?"
2. Ask each group to write down any slogans they can think of or create relating to discrimination.
3. When plenty of ideas have been written on the flipcharts, ask each participant to choose one of the slogans and write it on their badge.
4. Ask the participants which slogan seems to be the most effective and why they think so, and what they think will happen if they wear the slogan in public for several days.
5. Ask for volunteers to wear the badges in public and then discuss the reactions of the people they encounter at the next meeting.

3. Role play

Aim: To discover and discuss 'Why do some people discriminate?'

Situation 1 – The principal of a kindergarten decides whether or not to let a child into school

A mother who is sitting in front of you wants her child to attend this kindergarten. You have heard that the woman is a drug user and has AIDS and that her deceased husband was also a drug addict and had AIDS.

You are determined not to let this child be accepted into the kindergarten because you assume the child is infected, too.

Situation 2 – Goran, a pupil in the eighth grade, finds out his friend is HIV+

In our class, there is a new student. His name is Marko. He is HIV+. Nobody in the school knows about it. Goran

becomes a very good friend of Marko. Eventually Goran learns about his friend's HIV status.

He doesn't know what it means so he asks his parents. Goran does not get an explanation about what it means to be HIV+; but he is no longer allowed to be Marko's friend. He decides to talk to Marko about it and still be his friend.

4. Game: 'values and feelings'

Aim: an opportunity for open and honest expression of feelings and thoughts

Number of participants: All

Time needed: about 15 minutes

Materials needed: a large classroom with three big signs on which the following are written: 'I agree', 'I disagree' and 'I'm not sure'.

Method used: the peer educator reads one of the 'Values and feelings' statements listed below aloud. Then, based on their feelings about the statement, the participants stand next to the sign that has the response they agree with most (either 'I agree', 'I disagree' or 'I'm not sure'). The educator then asks a few participants in each group to explain why they moved under that particular sign.

This same process is used for the remaining 'Values and feelings' statements. Later, the educator will encourage a discussion about the ways group members responded to all of the statements and how they felt when doing the exercise.

Important: there are no right or wrong answers; only attitudes and feelings. Also, the educator should stay neutral when participants are expressing their views and values.

Values and feelings

1. We need to treat HIV+ people with respect, dignity and sympathy.
2. Homosexuality is a valid and accepted sexual alternative.
3. AIDS is transmitted by foreigners.
4. An HIV+ person should be registered with the local government.
5. HIV+ people must inform their sexual partners.
6. An HIV+ woman who is pregnant must have an abortion.
7. An HIV+ person should not be permitted to work as a health worker.
8. People living with AIDS must be isolated if they do not adhere to medical advice.
9. Nobody should be concerned about someone's HIV status except the infected person.
10. Children of HIV+ parents should not be allowed to attend school.
11. Children of HIV infected people must be taken away from their parents.
12. Institutions and people who discriminate against those infected with HIV should be punished. ■

Annex 5

Sample report format for a peer education workshop

Peer educators can use this sample report to provide information to their organizations about the workshops they have facilitated.

Date:

Location of workshop:

Sponsoring organization:

Number of participants: Age range of participants:

Demographic data: number of females number of males

Racial/ethnic groups participating (for example, 50% Muslim, 50% Christian, etc.):

Pre-test survey administered? yes no

Post-test survey administered? yes no

Evaluation of workshop questionnaire administered? yes no

There can also be a separate or integrated checklist of topics covered:

HIV/AIDS

STIs

Contraception

Gender violence

Substance abuse

The form might have more specific subsections, such as:

HIV/AIDS basic information

HIV testing

Prevention techniques

Spectrum of disease

Treatment

Guest speaker living with HIV

Video

Workshop summary (including successes and challenges):

Analysis of pre and post test:

Important issues that came up that should be noted:

Results on the evaluation of workshop:

Follow-up plans:

Peer educators presenting:

Creed - You are not alone

There are more than one million of us in the United States.
Don't isolate yourselves.

By Jim Lewis and Michael Slocum, former editors of *Body Positive*

Maybe you have tested HIV-positive very recently; maybe you've known it for some time, but this is the first time you've reached out for information or support. You need to know that you are not alone. There are over one million HIV-positive people in the United States.

Testing positive for HIV does not mean that you have AIDS, but HIV is probably the greatest threat to your life you have ever faced. This virus may remain inactive in your body for a long time, but it may not. If you are healthy now, you may still go on to develop some sort of health problems related to HIV. You may develop AIDS. There remain many uncertainties surrounding HIV, and though there is currently no "cure" for HIV infection, there are treatments. You need to learn what information is available and make informed choices about your health.

Many HIV-positive people now live fulfilling and happy lives. Many are healthy and show no symptoms of disease. Many choose to take treatments and drugs that promise to lengthen their lives. So, as serious as this is, there is hope. You do not have to look at testing HIV-positive as if you've been given a death sentence.

It's a good thing you found this out. As upsetting as testing positive may have been for you, you are better off knowing, so you can learn about HIV and decide what you want to do about it. The fact that you cared enough about yourself to get the HIV test and the fact that you are reading this magazine show that you are concerned about your health. So give yourself some credit. You have taken important first steps to take care of yourself, and you should be glad about it.

Years ago, those who tested HIV-positive had few places to turn for support. These people felt like they were hanging in limbo. Fortunately, much has changed. We know more about HIV now, and many organizations have formed around the world to offer support and information to people living with this virus. Many have already faced the questions inherent in living with HIV, and many will follow. You don't have to face this by yourself. There are lots of hands reaching out to assist you.

Your Emotional Health

Finding out that you are infected is usually overwhelming. Even if you had suspected it for some time, learning that you are can be a traumatic experience. Testing HIV-positive has led some people to quit their jobs, quickly write out

their wills, and say goodbye to their friends and family, only to discover that they aren't sick and will probably live for many years to come. It's common to perceive these results as an immediate death sentence, but this is simply not true.

What you are feeling now is perfectly normal. Anger, fear, confusion, numbness, depression -- all are completely natural reactions to the kind of news you've heard. If you've known for even several weeks, you may find yourself having a normal day, then suddenly remember that you are HIV-positive. It's common for this kind of realization to just "hit you in the face" out of nowhere over and over again. You are not going crazy if this happens to you. Your moods may swing from profound sadness one moment to extreme anger the next. That's normal, too.

The first step to getting through this emotional turmoil is to acknowledge what you are feeling. Don't be surprised to find yourself going through the day in a state of shock. Allow yourself to feel nothing. Your emotions will come rushing back soon enough. This is merely a way that your mind "turns off" to allow you to cope with a problem.

If you are feeling angry, that's fine. You have every right to be angry, and a lot to be angry about. This virus is threatening your very existence. It's okay to express this anger. If you're frightened, acknowledge your fears. You are thinking about things that would make anyone fearful. You are allowed to feel the way you do. Don't be hard on yourself or think you have to be strong. You don't have to be anything.

Fear Of Sickness and Death

Almost everyone is afraid of getting sick and dying. If you're young, you may never have had to face the death of someone close to you. We often think of dying as something that happens only when we're old. You may never have really considered the reality of your own death before. Now, suddenly, you are HIV-positive and your mortality becomes very real. You may be afraid of pain, of hospitals, or of becoming unattractive to others through an illness.

Your reaction to the idea of getting sick or dying could go one of two ways. You may decide that you are definitely going to live and that there is no way that this virus is ever going to "get" you. This is a form of what's called "denial" - refusing to face some of the possibilities of living with HIV. If you find yourself feeling this way, try to keep in mind that having hope to go on with your life is good. However, it can become dangerous if it keeps you from taking care of yourself.

The other way you might choose to deal with the subject is by deciding that you are absolutely going to die of this and there is nothing you can do about it. If you go this way, you may find yourself fantasizing about your own sickness and death. You have to keep in mind that there are many people who are HIV-positive who are living productive, happy lives, and you can be among them if you choose. It's good to face up to the possible consequences of this infection, but not to the point that living today becomes less important than your fear of the future. It helps to remind yourself that everyone will die, but that doesn't prevent most people from living today.

Starting Over

One of the truths of testing HIV-positive is that once you know, you can **never not know again**. For better or worse, your life will always be different now. You may be experiencing great feelings of loss about this. You may feel that certain areas of your life are now in the hands of doctors, insurance companies, or symptoms. This can make you feel as though you have less control over your own life and may cause you incredible anxiety.

Know this -- you do not have to give up control of your life. By arming yourself with information and deciding what is right for you, you will soon realize that you are still the same person you were. It is your life, your body, your health, and no matter how well-meaning your family, your friends, or your doctor may be, they have no right to take control of your life. Allow yourself to take time to decide what you want to do. Then go do it.

You may find that many of the priorities in your life change rapidly. If you are considering making major changes in your life, just make sure that you think them through carefully. Many HIV-positive people have made huge changes in the way they live. Many have broken bad habits, such as drinking too much or smoking. Some have gotten out of bad relationships or quit jobs they really hated. Facing the possibility of getting sick or dying has made many of our lives much better because it has made us take action in areas we have previously ignored or repeatedly put off. Mortality can be a great motivator.

Some people blame themselves for being HIV-positive. This kind of guilt and self-hate is very destructive. Regardless of how you were infected, you did not go somewhere or do something with the intention of infecting yourself -- so why beat yourself up about it? You are facing enough right now; you don't need to punish yourself for testing HIV-positive also. Grief, or extreme sadness, is one of the emotions that most HIV-positive people face at some point. You may be grieving for yourself, facing the possibility of your own death. For many of us, the virus is not only affecting our lives, but the lives of those we love. Many have lost friends and loved ones to HIV, or have many people in their lives who are also HIV-positive. Allow yourself to express grief and fear in some way. Permit yourself to cry. These feelings are valuable and normal; ignoring them will not make them go away.

You may also feel that you are now damaged in some way -- that no one will want to touch you or love you or that you are less desirable because you are HIV-positive. You may feel that you will never be able to love again, that no one would want to be with you if they knew that you were HIV-positive. These feelings will pass. You are not "damaged goods." You are still a valuable person, as capable of giving and receiving love as ever. You can make your own decisions, relax, and enjoy each day. This may be a struggle and you may have to find new ways of coping with daily life, but it's worth it.

Getting Support

Many of us have been raised with the idea of "rugged individualism," that we must face things on our own, that this is what "strength" is all about. Asking for help or reaching out for support are often considered weaknesses. Consequently, a very common response to testing HIV-positive is withdrawal. We isolate ourselves, hiding the news of our status. This can be very painful.

Your life does not have to be doom and gloom. It is possible to have a very positive attitude as a person living with HIV -- millions are doing it right now -- but it is much more difficult to get on with your life and live happily if you're trying to do it alone.

There's no need for you to handle this by yourself, and it's probably a mistake even to try to do it. You are not the only person facing this. Learn who the others are and what they have to offer: just hearing how someone else has adjusted to living with the virus can be enough to help you realize that life is still good, that you can still have love and laughter. And you may also be surprised to learn that your own sharing can help others. In sharing the issues that concern us, each of our voices lends strength to the others. Support groups, like those at Body Positive, are a powerful means of learning to cope with this new beginning. There are support groups offered by HIV/AIDS organizations across the country. If you don't know of an HIV/AIDS organization in your area, call us at (212) 566-7333. If there's no support group in your area, you may be just the person to get one started. Just remember: those millions of people living successfully with HIV are people who've reached out to get the help they needed. Wherever you are, you can find support, or the means to create it. It just doesn't make sense for us to face the same issues without helping each other out. We are not alone. And neither are you. ■

Michael Slocum and Jim Lewis were editors of Body Positive. HIV/AIDS organizations around the world have reprinted "You Are Not Alone" in their own languages.

This article was provided by **Body Positive**, Inc. There is a host of articles written for The Body Positive available at: <http://www.thebody.com>
Sexual Health Exchange, 1998 - no. 4

Annex 7

The following excerpt is from the Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe Project (TAMPEP), reprinted with permission from the Royal Tropical Institute (KIT), Amsterdam, Netherlands.

Europe: TAMPEP supports sex workers as peer educators

Sexual Health Exchange, 1998 - no. 4

The Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe Project (TAMPEP) is active in Austria, Germany, Italy and The Netherlands. Its interventions reach 23 groups of female and transgender sex workers who have migrated from Africa, Eastern Europe, Latin America and Southeast Asia. TAMPEP's methodology is based on work through cultural mediators and peer educators/supporters. The mediators are professional fieldworkers of the same ethnic and/or cultural background as their target group members. The peer educators/supporters are sex workers who help facilitate healthy behaviours and participate in developing prevention materials adapted to the target groups' specific needs. They also assist in evaluating and analysing the interventions.

TAMPEP's experience shows that the establishment of a peer educator group should not be an intervention's main and/or only goal. Rather, it should form part of a broader approach that also includes seminars, workshops and other field activities aiming to empower sex workers and provide them with a supportive environment for safer behaviours. This is because sex workers cannot always effectively influence clients or owners of sex work establishments. Their cultural mediators, on the other hand, may intervene, e.g., in addressing unsafe working conditions or repressive police measures.

Migration of sex workers - between and within countries - may limit the impact of projects that base their effectiveness on repeated contacts with the target group. It is necessary to maintain a continuous cycle of peer educator activities in order to train new workers. Mediators may attempt to maintain contacts with peer educators who have moved - this would contribute to further spread of health promotion messages to a broader audience.

It must also be recognized that the nature of sex work itself could make peer educator interventions difficult. Feelings of competitiveness and jealousy are not uncommon and some sex workers could find it hard to accept that their colleagues are gaining more knowledge and power as peer educators. Moreover, the peer educators must balance a new dual role: they may be considered "insiders" as sex workers and "outsiders" as educators.

TAMPEP has found that successful sex work peer educators are leading members of their target group (i.e., of the same ethnic/cultural background). They have some basic knowledge of health, educational talents and excellent communication skills. They further are characterized by high levels of ambition and motivation.

In the interventions carried out by TAMPEP, 2-3 months are spent to complete all activities related to selecting, training and following up peer educators. The educators are trained in courses with 10-12 persons; they receive a small attendance fee to cover possible loss of earnings during the course and to acknowledge the time and energy they invest in the training. Trainees also participate in organizing the course itself, which usually has a neutral title such as "Prevention and hygiene". This is because many sex workers do not see sex work as an identity - they rather consider it a temporary occupation. Each session includes guest speakers such as physicians, staff of contraception counselling centres, social workers and already trained peer educators. A certificate is awarded upon completion of the course. This provides the peer educators with a symbol of recognition, both for their peers and members of public service agencies with whom they liaise.

Follow-up activities monitored by TAMPEP cultural mediators include: supporting the peer educators in their role of mobile health messengers; providing additional and updated knowledge as well as educational materials not included in the basic course; and facilitating contacts between the peer educators and public health personnel and official agencies.

Based on more than 5 years' work, TAMPEP notes that the following principles are important for sex work-oriented peer education projects:

- peer education programmes should be placed in a broader context of promoting self-esteem, health, safety and civil rights, including protection of the rights of migrant sex workers
- peer education programmes should be carried out using autonomous community-based organizations as a base
- the sex work scene changes continuously (market "demand", sex workers' nationalities, governmental policies, etc.), so peer education models and programmes should be continuously adapted to these changes.

Continuous cycles of data collection, implementation and evaluation of work dynamics and the results of trans-national peer education programmes are the basic conditions needed to gain positive results in achieving changes in sex workers' health behaviour.

From the time this article was written the programme has been considerably expanded. More information can be found at www.tampep.com. ■

Annex 8

This section is intended to give precise, dispassionate information for reducing potential harm in the use of injecting drugs. The aim is to assist peer educators in improving health. We acknowledge that there are communities of people who are involved with injecting drugs and support harm reduction programmes to help young people 'kick the habit' in their own timeframe, keeping them safe in the meantime.

The information in this section, which offers guidelines for safer injecting, is not provided or written to encourage or suggest the use or continued use of injection drugs in any way.

Information about injecting drug use

Caution: This annex contains some descriptions related to injection drug use. Anyone who is recovering from addiction may choose not to read these descriptions unless they are ready to revisit some of the emotions and feelings associated with using drugs. Much of this information came from the experiences of drug users themselves.

Drug Craving and Addiction

People who are drug addicted experience a time that is characterized by intense craving, namely the time from the moment of obtaining the drug to getting it into the bloodstream. Injecting drug users often describe an extraordinary sense of urgency to find a way to get a needle to inject the drug. A recovering drug user who was interviewed said that once he gets his hands on the drugs he is driven, and describes his feelings by referring to a needle as a 'spike', a term normally used for a sharp pointed object. He recalls thinking and feeling: "Give me a spike, give me a spike, where can I get a spike?"¹

Many people do not understand the difference between use of a drug for recreational purposes and the extreme urgency during withdrawal once occasional use has evolved into addiction and illness. Often in an attempt to understand substance use and chemical addiction people try to use their own life experience to guess what it may be like. The pain and discomfort of withdrawal symptoms are often overlooked when non-drug users or addicts think about drug addiction.

"I would have done anything, and I mean anything ..."

Behavioural changes can be extreme among drug users. Interviews with recovering addicts often reveal that, upon reflection, there is guilt about their past behaviour when they were most severely addicted. People will describe what it was like to be severely addicted. They report that they "would have done **anything**" to get drugs or the money they needed to get drugs.

Things to know about injecting drug use

The person who works with injecting drug users needs to know: patterns of drug use, the techniques of injection drug use and related practices. Only in knowing these details can the educator properly teach the injecting drug user how to reduce the harm and risks of unsterile injection practice.

Safer injection²

Although injecting drugs is not supported or recommended, for those who do inject, it is very important to do whatever can be done to reduce the harm by learning how to inject more safely. This practice is referred to as harm reduction. It means that although injecting drugs is harmful and may kill, there are ways to reduce the amount of harm done or to prevent the worst from happening.

This text consists of a summary of medical facts, techniques of injection of drugs, 'junkie' (a street term) wisdoms and other information. The process of preparation and planning of the injection of drugs is one of the most important things that a person can do to prevent potential harm. Before the injection of the substance, a person must evaluate the security of the situation being sure to have sterile materials and to prepare the drug on a clean surface, using clean equipment.

Choosing the safest place for taking drugs

Some places are safer for drug use than others and a person should always use the safest place possible. They should be considerate towards others – nobody wants to see used needles and syringes in their building or bloody tissues in public toilets.

Who do people use drugs with?

It is important for drug users to have the support of people who know that they take drugs, especially in cases of emergency such as an overdose. Sometimes other trusted drug users can provide mutual support. If a person is concerned about a friend using a large quantity of drugs, he or she might choose to make sure there is someone trustworthy to be there with the friend every time he or she uses drugs in order to prevent overdosing.

Equipment and materials used for injection drug practices

Syringe for injecting the drug: usually includes a plastic plunger, a plastic syringe shaft and a hollow, sharp needle. Keeping drug injection as safe as possible

It is very important for someone who is using injection drugs to use good needles and syringes and to use them properly. There are certain steps to ensure a safer injection. A rule that should be obligatory for drug users is: 'Use new needles and syringes for every injection'. This rule should be

1 - Personal communication with an IDU in a methadone treatment programme, 1987

2 - Handbook draft Yugoslav Youth Information Center? 2003

practised at all times and become the injecting drug users' motto, just like in hospitals. Needles become blunt fast; they are blunt even after a few uses. The use of a blunt needle causes unnecessary trauma to the veins and surrounding tissue and creates a larger injecting wound and more severe bleeding. The process of 'sharpening' a needle (with a match box, for example) is dangerous since it can damage the top of the needle and cause potential harm to the veins; it is possible to make the top of the needle too thin, causing a fraction of the needle to stay in the veins.

The needle and the syringe are sterile for their first use, immediately after they are opened, but used ones are not. To reiterate, the safest practice is to use clean and sterile needles and syringes for each injection and dispose of the used materials properly. Avoid sharing needles and syringes or equipment for drug use with other users. The blood and some other material that remain in the needle and the syringe can be transmitted to other users of the same equipment. The same thing goes for the 'cookers', the cotton and the cooking spoon. Viruses such as HIV and hepatitis can be transmitted in this way. The only secure way to avoid the spread of infections is never to share injecting equipment with another person. In many countries there are syringe and needle exchange programmes that aim to increase the availability of sterile injecting equipment and to remove contaminated syringes from circulation. Some of these schemes may also provide information on safer sex, refer to appropriate services and distribute condoms.

If someone has to share a needle and a syringe, they need to clean these items thoroughly before each use. If someone is in a situation in which they have decided to use another person's equipment or to share their own, they need to follow the instructions for cleaning in order to lessen the possibility of transmission of blood-borne diseases. The process of cleaning needles and syringes is not 100% safe; blood-borne diseases can be transmitted even if a person uses the safest method possible. However, some methods have proven reasonably effective.

Cleaning equipment

These are the steps to take:

- Whenever possible, clean the needle and the syringe separately.
- Then throw away the water used for cleaning.
- Rinse the needle and the syringe with (household) bleach. In order to do this, fill the syringe to the top with bleach, and shake it for two minutes.
- Then throw away the bleach.
- Next, rinse the needle and the syringe with cold water to remove the remaining bleach.
- Again, throw away the water.

If bleach is not available, use hydrogen peroxide, a detergent or a synthetic alcohol. Some people use drinking alcohol such as vodka or rum, if that is all they have.

IMPORTANT: the bleach needs two minutes in order to kill the hepatitis B virus. It is not certain whether it kills hepatitis C. Apparently it kills HIV in 30 seconds.

Some people also clean the cooker with bleach if it has been used by others. They sometimes divide the cotton into smaller pieces so everybody has his or her own piece. Always remember to throw away the water. Using the same water can facilitate the transmission of infection.

Preparing a dose

Clean and hygienic preparation of the drug will lower the risk of transmission of infections that can seriously damage health. Every time a person uses injection drugs, he or she creates conditions for bacteria and other micro-organisms to enter the body or the bloodstream intravenously. The equipment that people recommend using for injection of drugs is clean needles and syringes, clean 'cookers', cotton (not cigarette filters), clean water, a good lighter and citric acid.

There are several things that injecting drug users need to do before preparing their dose.

First, they must wash their hands thoroughly with soap in order to eliminate viruses and bacteria on the hands. If not, they should at least wipe their hands with a wet tissue to keep them as clean as possible. They should use a flat surface to prepare the dose. Injecting drug users always need to make sure that their needle and syringe are clean. They must be careful because some people reseal used needle packages to sell them as if they are new. It is safer to wait to unpack sterile needles and syringes until ready to use them.

Cooking the dose

Drug in powder form needs to be liquefied before being injected. This process is called 'cooking the drug'. Different drugs have a different process of turning into liquid. Morphine (in liquid form) does not need cooking. Some drugs dissolve in water without cooking, such as cocaine. Heroin gets diluted without adding acid but apparently people accomplish better dilution by using powdered vitamin C. Using lemon juice can provoke fungal infection that can damage the eyes. When people inject pills, they must make sure that the pills are diced well before they get diluted. Today, manufacturers produce pills that cannot be dissolved in water and when heated they dilute in a small portion. Therefore some drug users check to see whether their pill will dissolve in water. Overall, injecting pills is usually avoided because of this difficulty. Injecting undiluted pills can cause abscesses. If there are particles of the drug that do not get diluted, some drug users try filtering them through cotton. It is not recommended to cook the

dose again if there is blood in it as it can lead to coagulation of the blood. Always use the syringe to draw the drug into it through a cotton filter. Making sure there is no air in the syringe is also very important because air in the needle can be extremely dangerous and possibly fatal.

Choosing a spot for injection

Most drug users know that they need to change the injection site on their body in order to lower the possibility of infection and to keep the veins in good shape. If an injecting drug user does not change the injection site randomly, the veins get weaker and injecting becomes more difficult. Consequently, infections can attack the site and cause serious damage. Therefore, it is recommended to use both sides of the body and the hands for injections.

Cleaning and preparing the injection site

It is recommended to use alcohol to clean the injection site. Users wipe the spot once (not rubbing it hard), put a rubber band on the bicep of the arm, lower the hand and make a fist with the palm. They often loosen the band shortly after injecting in order to allow the blood to circulate normally.

Insertion of the needle

Injecting drug users tend to use an angle of 13–35 degrees to insert the needle, always heading towards the heart. If the top of the needle is thick the chances of rupturing the vein are greater.

Final preparation

If the needle is in the vein, the injecting drug user will pull the plunger of the syringe upwards. If dark blood gets in it, they are in a vein. If there is no blood or only a very small quantity, the needle is not in the vein. If this is the case, they will usually try the whole process again. The injection site might get swollen and the effect of the drug is lowered. This might result in abscess or other problems.

Pulling the needle out

After a successful injection, the IDU will pull the needle out carefully using the same injecting angle. In order to prevent haematoma, they will release the band before injecting. They will press the injection site firmly in order to help the coagulation (clotting). They will not put alcohol on the spot as this might increase bleeding.

Proper disposal of equipment

An injecting drug user should take the rubbish (the leftover material) to a needle exchange centre. If there isn't such a centre, the he/she should pack the used needles up well and throw them in garbage bins. Improperly disposing of used needles can jeopardize the health of other people, including the health of people who collect and process the garbage. Therefore drug users should find a metal can (such as for tinned food). The IDU should put the needle in the syringe and crush it with the clip, then put all of the equipment in the can and throw the can in the garbage bin. ■