ESTICOM Training Programme

Overview & initial findings of the Training Programme

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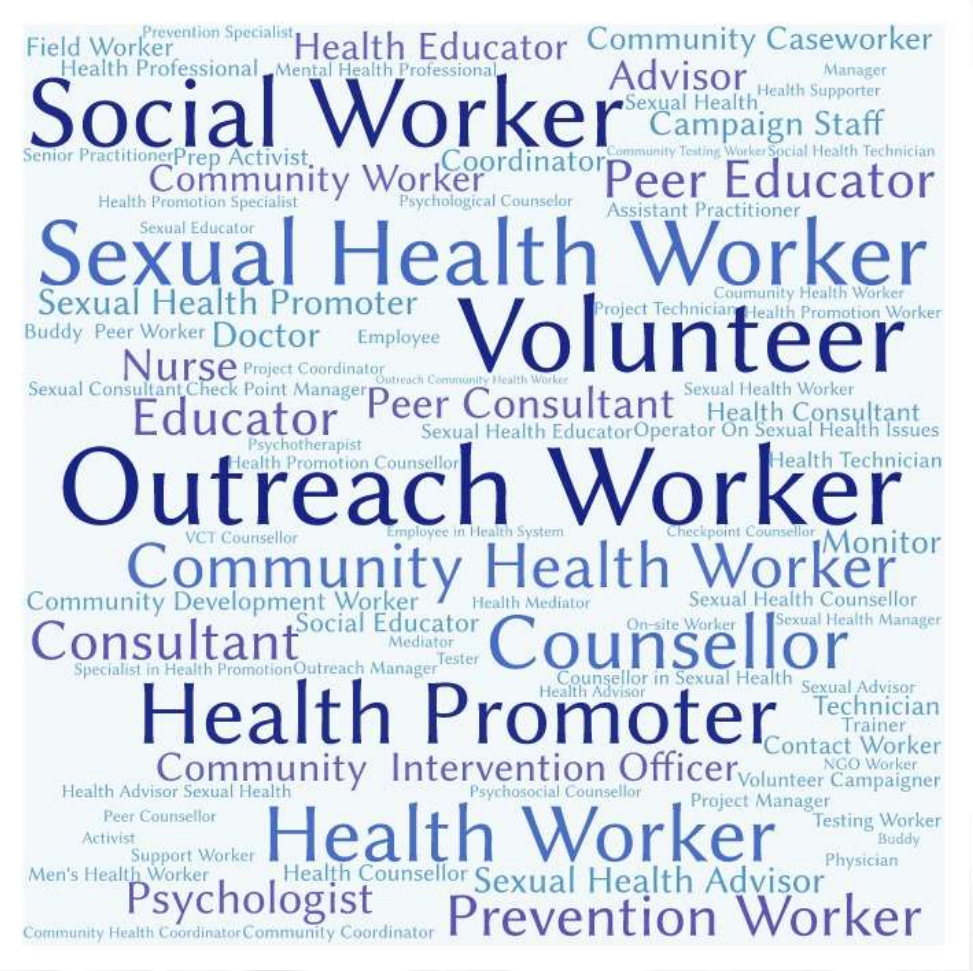
Community Health Worker

„A CHW is someone who currently provides sexual health services directly to gay, bisexual and other MSM which includes HIV/STI and/or viral hepatitis (Hep B&C).

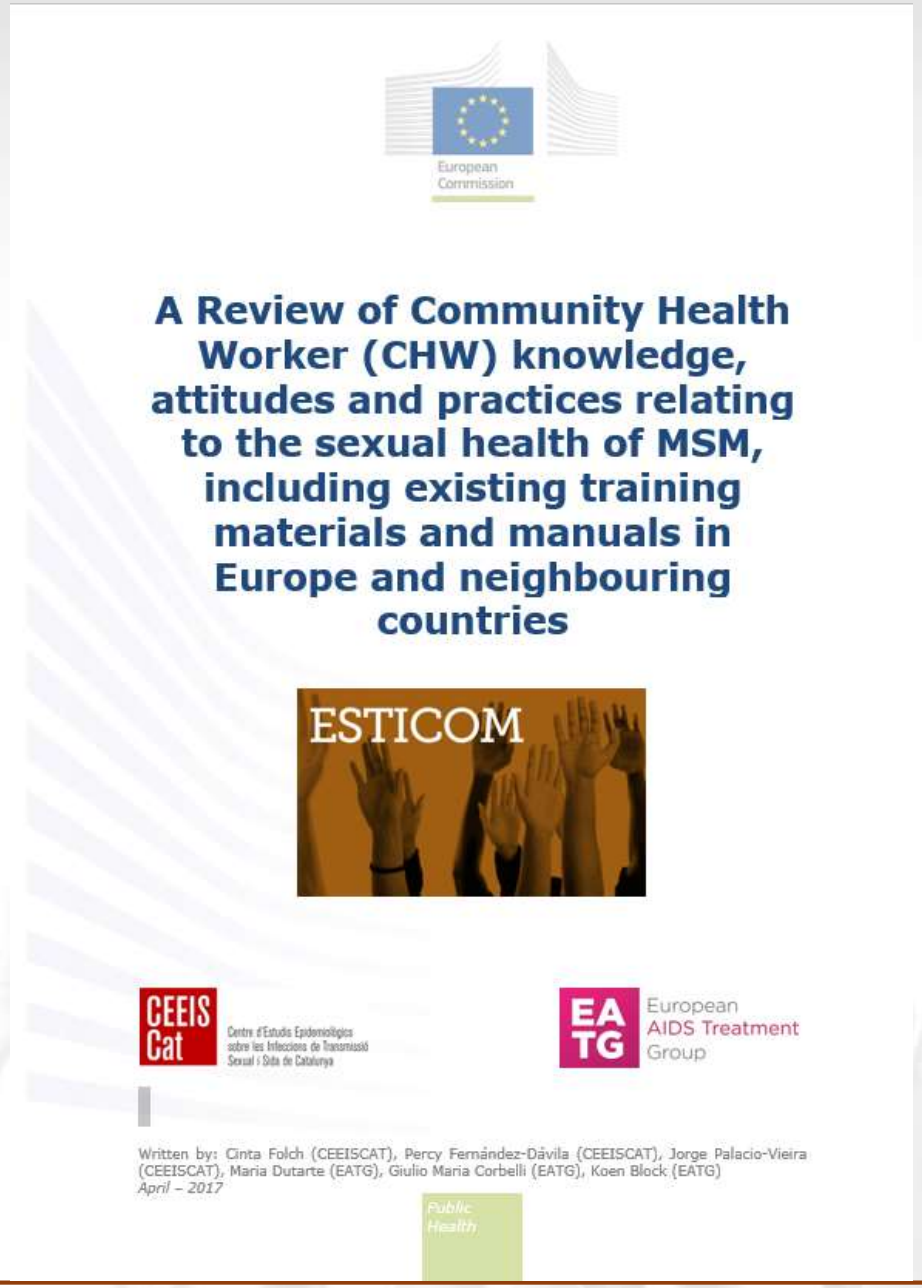
A CHW delivers health promotion and or public health services directly to gay, bisexual and other MSM in a community (i.e. non-clinical) setting.“

Preliminary CHW definition by ECHOES

Community Health Worker



Training Needs of Community Health Worker


European Commission
A Review of Community Health Worker (CHW) knowledge, attitudes and practices relating to the sexual health of MSM, including existing training materials and manuals in Europe and neighbouring countries
ESTICOM
CEEIS Cat
Centre d'Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya
EATG
European AIDS Treatment Group
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April – 2017
Public Health


ECHOES


Training Programme

Training Needs

- Limited or no access to trainings (10%, up to 22,5% East-EU)
- No standardized training curriculum
- Theoretical framework missing in half of the trainings
- Most trainings without certification
- Mostly not monitored or evaluated
- Most trainings only cover knowledgebased topics
- CHW miss collaboration / exchange with CHW from other European countries

Training Needs

- Important topics underrepresented, i.e.
  - Mental health
  - ChemSex
  - New prevention technologies, i.e.PReP
  - Discrimination / stigmatisation

- Trainings for CHW mostly cover only topics
    - CHW already know (knowledge)
    - National NGOs & governments are interested in

Training Needs

- Gaps all over Europe in regards of
    - Attitudes
    - Skills, i.e.
        - Communication
        - Interpersonal
        - Service coordination
        - Capacity building
    - Cultural competencies in regards of gay/MSM life, sexuality, (sub-) communities
    - Management (monitoring & evaluation)

Training Recommendations

- Emphasis on competency-based rather than knowledge- based trainings
- Integrated conceptual and pedagocial approach strongly recommended
- Include innovative approaches (E-Learning)
- Core common (European) training protocols -> adapted to local context and enriched by local, national material
- Incentives, recognition and certification as crucial motivation component to be considered
- Focus on Eastern Europe (most training gaps)

Training Needs & Recommendations

Overview Training Material &Programme

Overview

- Piloting of the first Europe wide provision of training for Community Health Workers covering a wide curriculum.
- Contains three ‘arms’
    - Development of the ‘toolbox’ Training Materials in module form (40 to 50 hours of training)
    - Development and provision of the Training of Trainers sessions
    - Support and provision for National Pilot Trainings
- Linked to the two surveys just presented
    - EMIS 2017
    - ECHOES – review of CHW training provision and survey of CHW training needs

Overview

- The materials also contain a Needs Assessment Tool and Evaluation Tool and suggested Curriculums to guide the choice of materials
- All materials for both the Training of Trainer Workshops and the Training Modules were developed using both the pedagogical approach (choosing identified subjects for module development) and an andragogical approach (using the experiences of the participants and facilitators present)

Training Material Development

The training materials were developed under four modules, each with their own aim.

Aim One: To increase the access to prevention, including testing services for HIV, STI's and Viral Hepatitis among MSM and priority sub-groups.

Aim Two: To improve the linkage and retention in care, as well as quality of care, including treatment for HIV/AIDS, STI's and Viral Hepatitis.

Aim Three: To improve the integration of services to ensure patient centred care, including in-patient and out-patient facilities, including Community & Prison Health Services.

Aim Four: To reduce stigma and discrimination due to sexual orientation and of people living with HIV/AIDS in healthcare settings, including prison health services and in the community.

Training Materials

Training modules developed to meet these aims include:

- Cultural Competency strategies to remove barriers to access; improve quality of services and retention into care; Patient Involvement; Peer Mentoring; Capacity Building and Community Engagement.
- Vulnerable MSM subgroups and subsequent sexual health needs: MSM Youth; MSM Migrants; Non Gay/Bi identified MSM; MSM from ethnic or cultural minority groups; Trans* MSM; MSM with drug (Chemsex) and alcohol needs; MSM in prison settings.
- The epidemiological dynamics of HIV infection among MSM in Europe.
- Syndemic Production Model on intertwining factors for poor sexual health for MSM.
- New Prevention Technologies: TasP; PEP; PrEP; Self Sampling/Self Testing

Facilitator Manual & Participant Workbook

Prevention Theory

Exercise: Evidenced based components of a basic response to HIV, STI's and Viral Hepatitis.

Overarching aim of this section: To increase the access to prevention, including testing services, for HIV, STI's and Viral Hepatitis among MSM and priority sub-groups.

Learning Objective of this exercise: To have a good knowledge of the epidemiology of the MSM HIV epidemic in Europe.

Purpose: This exercise allows participants to examine the evidenced based responses to HIV, STI's and Viral Hepatitis.

Methodology: (c.a. 20 mins)

- Tell the group we are going to examine the evidenced based responses to HIV, STI's and Viral Hepatitis.
- Split the people into groups of 3-5. Ask these groups to discuss what they believe are the evidenced based responses to each area, taking notes on separate sheets of paper for HIV, STI's and Viral Hepatitis.
- Tell the groups they have 15 minutes for this task, 5 minutes for each area

Facilitated feedback: (c.a. 40 mins)

- Ask groups in turn to feedback one point on each of the areas, capturing these as bullet points on 3 separate flipchart sheets headed HIV, STI's and Viral Hepatitis.
- Take this feedback from each of the groups in turn until there are no more points to be made.
- Now share with the group they information on PowerPoint around each area (HIV – Condoms & Lube, etc; STI's – Condom use, treatments etc; Viral Hepatitis – Vaccination, treatment etc.)
- Point out any differences between the list the groups have generated and what is contained on the PowerPoint and the probable reasons why there is a difference. The groups may have included responses such as sero-sorting which does not pass the evidence threshold, an explanation is included in their workbooks.
- Inform the group that more information is contained in their workbooks.

Expected Learning Outcome: Participants will have a better understanding of what the evidence based responses to HIV, STI's and Viral Hepatitis are.

Prevention Theory

Evidence Based Responses

Participant Workbook

What constitutes the Evidence Base?
Systematic reviews of peer-reviewed literature that addressed efficacy of HIV and STI interventions among MSM were performed on the interventions listed. The process involved exhaustive search strategies to search multiple scientific databases as well as the World Health Organization and UNAIDS databases. The final step was grading the evidence by applying the Highest Attainable Standard of Evidence (HASTE) grading system.

The evidence retrieved from the included studies was evaluated by way of the grading instrument HASTE, i.e. the Highest Attainable Standard of Evidence [41]. The HASTE grading builds upon the GRADE system, and takes into account three categories that are given equal weight: efficacy data; implementation science data; and biological and public health plausibility, which makes it specifically useful for analysing public health evidence [42]. A quality assessment was done on all included studies, and taken into account in the HASTE grading. Levels of evidence are described in Table 1.

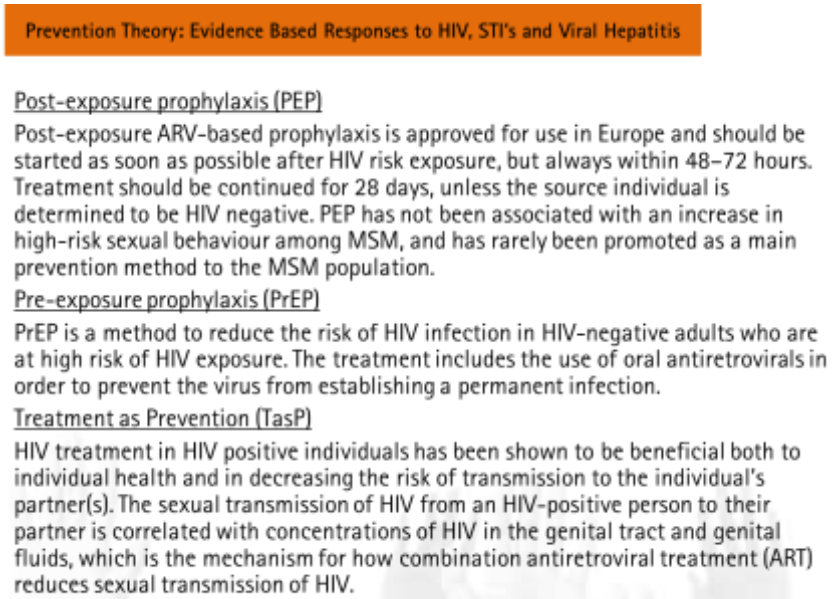
Table 1: HASTE Grading criteria used to assess the strength of evidence

Grade Level		Strength of Evidence	Explanation
Grade 1		Strong	High plausibility
			Efficacy is consistent
			Large body of consistent implementation data
Grade 2	Grade 2a	Conditional - Probable	Plausibility
			Limited efficacy data
			Consistently effective from implementation data
	Grade 2b	Conditional - Possible	Plausibility
			Limited or inconsistent efficacy data
			Limited or paucity of implementation data*
	Grade 2c	Conditional - Pending	Plausibility
			Ongoing efficacy trials
Grade 3		Insufficient	Undefined plausibility
			Inconsistent data
			Inconsistent or paucity of implementation data
Grade 4		Inappropriate	Consistent data demonstrating lack of efficacy
			Consensus from implementation data of inappropriate intervention

*Adapted with permission from Baral et al [41]. Modified to add paucity of implementation data to Grade 2b.

All information taken from:
ECDC Guidance: HIV & STI Prevention Among Men Who Have Sex With Men 2015

Powerpoint Slides & E-learning tool



E- Learning: Outlines/Scripts/Questions: Module One: Core

Prevention Theory: Evidenced based responses to HIV, STI's, Viral Hepatitis

HIV

"Which of the following are responses to HIV are based in the available evidence as being effective for MSM?"

- Testing at the clinic
- Testing in a community setting
- Taking a sample of spit or blood and sending it off to be tested (self sampling)
- Taking a sample of spit or blood and testing it yourself (self testing)
- Condom use
- Using any lubricant you have to hand like Vaseline or baby oil
- Using water based lubricants
- Using silicon based lubricants
- Only sleeping with men you know are the same HIV status as you are. (Sero-Sorting)
- Circumcision
- Avoiding sex
- Treatment with anti HIV drugs (TasP)
- Taking HIV medications to stop becoming positive if you are negative (PrEP)
- Taking HIV medications to stop becoming positive if you've had condomless sex (PEP
- Getting drunk and forgetting all about it when sexually active

The following are the recommended responses from the ECDC 2015 Guidance on HIV and MSM

Condoms and condom-compatible lubricant use

Condom use when having anal sex with a partner of unknown viral burden or infection status is a core component of HIV and STI prevention. Condoms prevent contact between semen and rectal mucosa, as well as between rectal fluid and the penile mucosa, thereby preventing the transmission of HIV.

Operational research also emphasises the importance of condom-compatible lubricant use (water- or silicon-based) during anal sex. Lubricant use facilitates entry and prevents micro-tears in the rectum during anal sex as well as decreasing rates of condom breakage. Oil-based lubricants increase the risk of latex condom breakage and are not recommended in combination with condoms for anal sex. The importance of condom-compatible lubricant use needs to be taken into account as a part of condom promotion interventions for MSM, and preferably distributed through the same programmes. Sub-optimal lubricant use is common among MSM, and correct use of lubricant should be included in prevention messages.

HIV testing

Provide voluntary and confidential HIV counselling and testing through a variety of ways that are easy to access for the target group, including outreach to the community, and routine offering of tests in clinics and community-based settings.

It is suggested that individual counselling and mapping of risk behaviour should be used for individual recommendations around frequency of testing for HIV (and other STIs), but that annual testing for sexually active MSM would be a minimum suggested interval for testing.

Community-based testing

Rapid HIV testing and counselling in community settings delivered by trained staff or peers can increase the uptake of HIV testing among MSM and can reach populations of men that have previously not accessed HIV testing [74, 75]. MSM have also expressed preference for rapid testing over conventional testing in some European settings [76, 77]. Testing done in community settings such as testing centres located in easily accessible areas and at easily accessible times of day, or through outreach or mobile services, can allow easier access to and uptake of HIV testing services. Community-based testing services provide testing that is free or

Curriculum

- Four curricular formats devised:
  - Curriculum A: Skills
  - Curriculum B: Basics
  - Curriculum C: Good Practice
  - Curriculum D: Development
- Used the 7 point procedure to help build
- Diagnosis of needs/formation of objectives/selection of content/organisation of content/selection of learning experiences/organisation of learning experiences/determination of what to evaluate and the ways and means of doing it
- Incorporates the Pedagogical and Andragogical approaches

Evaluation

- Pre and post evaluation, both learner and programmer evaluation.
- Evaluate skills and knowledge acquired
- Use of variety of assessment methods such as self, peer and ipsative.
- Ongoing evaluation of theory and knowledge into practice – what are we trying to affect and have we done so?
- Encourage self reflective practice e.g. Gibbs, Rolfe etc.

Needs Assessment

- Follows closely the outlines suggested within the ECHOES survey
- Assessment of skills, knowledge and comfort levels of CHW's across the range of issues contained within the training package
- Needs assessment will indicate issues to cover within local trainings

Output

- Training of Trainers guide plus supporting process documentation
- Toolbox training modules for both face to face and e-learning translated into 10 languages
- Evaluation, Needs Assessment and Curricular tools
- Finalised version: end of August 2019

Overview Pilot Training Programme

January – October 2018

Training of Trainers Workshops

January - April 2018

Training of Trainer Workshops (ToT)

- 4 ToT Workshops: Berlin, Warsaw, Vilnius, Athens
- 61 participants from 27 countries
- All EU member countries except Luxembourg, Malta, Slovakia
- 2 weekends each
  - Selected ESTICOM material & excercises
  - Needs Assessment
  - Preparation for National Pilot Trainings
  - Training facilitation

ToT evaluation

- Perceived as useful for working as CHW and as trainer - would recommend the ESTICOM trainings to colleagues
- Training material found useful, some participants already use ESTICOM material
    - In the work as CHW with their clients
    - In their trainings
- Better understand the challenges to work as CHW, broader scope
- Changes in mind and skill-set (gay men identities, sexual attitudes & needs, non-judgemental services etc.)
- Exchange / learning from each other / building a CHW network

National Pilot Trainings

May - October 2018

National Pilot Trainings (NPT)

- 17 NPT incorporating 21 countries will be conducted
- 3 already implemented
- 5 on hold

NPT implemented

- Russia (18.-20.05.)
- Romania / Moldova (15.-17.06.)
- Poland (22.-24.06.)

NPT planned

- England (15.-17.08.)
- Germany (17.-19.08.)
- Austria (27.-28.08.)
- Spain (14.-16.09.)
- Greece / Cyprus (17.-19.09.)
- Portugal Porto (20.-21.09.)
- Croatia (21.-23.09.)

NPT planned

- Switzerland (26.-28.09.)
- Italy (28.-30.09.)
- Czech Republic (04.-05.10.)
- Baltic Countries (LT, LV, ES) (05.-07.10.)
- Finland (12.-14.10.)
- Sweden (12.-14.10.)
- Denmark (26.-28.10.)

NPT on hold

- The Netherlands
- Ireland
- Bulgaria
- Slovenia
- Portugal Lisboa

Initial general learnings

- ESTICOM approach successful – enriches the common trainings
    - Focus on attitudes and skills
    - Cultural competencies
- Synergy / collaboration with national training programmes crucial to success of the programme
- Implementation strategy and constant coordination needed
- Facilitator‘s role (safe space, friendly environment, flexibility, facilitator – not teacher) crucial
- Access to the material has to be made as simple as possible

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