

# Review: Together We Can [TWC] Peer Education Programme



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## ACRONYMS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ARC</b>	American Red Cross
<b>BFLA</b>	Belize Family Life Association
<b>BRC</b>	Belize Red Cross Society
<b>CBO</b>	Community-based organisation
<b>CC</b>	Community Council
<b>CRRO</b>	Caribbean Regional Representation Office
<b>CRSF</b>	Caribbean Strategic Framework
<b>CSW</b>	Commercial Sex Worker
<b>FBO</b>	Faith-based organisation
<b>FM</b>	Field Manager
<b>GA</b>	Global Alliance
<b>GIPA</b>	Greater Involvement of People Living with HIV
<b>GRC</b>	Guyana Red Cross Society
<b>Haiti</b>	Haitian Red Cross Society
<b>HIV</b>	Human Immunodeficiency Virus
<b>IEC</b>	Information, Education and Communication
<b>IFRC</b>	International Federation of the Red Cross and Red Crescent
<b>ILO</b>	International Labour Organisation
<b>IPPF</b>	International Planned Parenthood Federation
<b>IT</b>	Instructor Trainer
<b>JRC</b>	Jamaican Red Cross Society
<b>LGBT</b>	Lesbian, gay, bisexual and transgender people
<b>M &amp; E</b>	Monitoring and Evaluation
<b>MoE</b>	Ministry of Education
<b>MoH</b>	Ministry of Health
<b>MSM</b>	Men who have sex with men
<b>NAC</b>	National AIDS Committee
<b>NGO</b>	Non-governmental organisation
<b>NS</b>	National Society
<b>NT</b>	National Trainer
<b>OPEC</b>	Organization of the Petroleum Exporting Countries
<b>PANCAP</b>	Pan Caribbean Partnership against HIV and AIDS
<b>PE</b>	Peer Educator
<b>PEPFAR</b>	President's Emergency Plan for Aids Relief
<b>PLHIV</b>	People living with HIV
<b>PSI</b>	Population Services International
<b>PTA</b>	Parent Teacher Association
<b>SLRC</b>	St. Lucia Red Cross Society
<b>SRH</b>	Sexual and Reproductive Health
<b>STIs</b>	Sexually Transmitted Infections
<b>ToR</b>	Terms of Reference
<b>TWC</b>	Together We Can peer education programme
<b>UNGASS</b>	UN General Assembly Special Session on HIV/AIDS
<b>UNAIDS</b>	Joint UN Programme on HIV/AIDS
<b>VCT</b>	Voluntary Counselling and Testing

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## EXECUTIVE SUMMARY

### 1. Introduction

Overall, this report attempts to provide a picture of the background and the current status of the Together We Can (TWC) programme using both quantitative and qualitative data. It should be recognised that it is challenging to provide an equitable evaluation for the countries involved in the TWC evaluation. Different evaluation methods were used in the six evaluation sites. Only three out of the six countries involved in the review were visited. National Societies receive different levels of funding and technical support from the Caribbean Regional Representation Office (CRRO). The American Red Cross supports TWC programmes in Guyana and Haiti both of which receive funding from PEPFAR. Since 2009, CRRO support has focused on the three National Society members of the International Federation's Global Alliance, Belize, Guyana and Jamaica. The Latin Caribbean Regional Representation covers Haiti though there is no programmatic support provided by this office. Each National Society employs different numbers of full-time Red Cross staff to work as part of the TWC programme. For example, the Haiti and Guyana National Societies employ salaried field managers, while their equivalents in Belize, Jamaica, St. Lucia and Trinidad and Tobago are volunteers.

### 2. Background

According to UNAIDS most recent report,

*“although it [HIV] accounts for a relatively small share of the global epidemic, the Caribbean has been more heavily affected by HIV than any region outside sub-Saharan Africa,..... with the second highest level of adult HIV prevalence. .... Although sharp declines in HIV incidence were reported in some Caribbean countries earlier this decade, the latest evidence suggests that the regional rate of new HIV infections has stabilized.”*

The Caribbean has a mixture of generalized epidemics (HIV prevalence is consistently over 1 per cent in pregnant women) and concentrated epidemics (HIV prevalence is consistently over 5 per cent in at least one defined sub-population and below 1 per cent in pregnant women in urban areas). Women account for approximately half of all infections in the Caribbean. HIV prevalence is especially elevated among adolescent and young women, who tend to have infection rates significantly higher than males their own age (United States Agency for International Development, 2008).

### 3. Purpose of the review

The purpose of this evaluation was to work with a range of stakeholders to

- i. Assess the effectiveness of the current TWC programme against its objectives, with a view to determining whether the intervention is making an impact on the targeted groups.
- ii. Assess the relevance of TWC i.e. whether the methodology is responding to local epidemic situations, whether we are targeting the right people in the right way and at a scale to reduce HIV transmission.
- iii. Assess the efficacy of the programme, and whether internationally recognised peer education standards outlined in the International Federation's document are being met, and make recommendations for improvement.
- iv. Determine the most appropriate regional level monitoring mechanism to ensure that internationally recognised peer education standards are adhered to and maintained.
- v. Make recommendations as to the way forward for HIV peer education programming in the Caribbean region.

### 4. Methodology

The evaluation involved reviewing key documents and visits to Haiti, Jamaica and Trinidad to interview staff, volunteers and beneficiaries. In addition to this, in-depth telephone conversations took place with senior Red Cross staff or volunteers from Belize, Guyana and St. Lucia. Interviews also took place with the Director Generals of St. Lucia and Antigua and Barbuda and with a

member of the Health and Care Advisory Board of the IFRC. All National Societies that fall under the Caribbean Regional Representation were contacted by e-mail.

There were a number of constraints to the evaluation (see Section 4.3: Constraints).

## **5. Effectiveness of the current TWC programme against its objectives**

Peer education programmes need to set realistic behaviour change goals that take into account challenges faced by the intended audience, including where peers reached are on the behavior change continuum. Overall, the TWC programme curriculum takes into account the needs of those who are sexually active and those who are not yet in a sexual relationship, through the promotion of both condom use and abstinence. However, it does not fully address some of the challenges of modern day life facing young people in the Caribbean, for example sexual relationships with an older person in return for money, goods, favours or protection.

Overall, the effectiveness and impact of the TWC programme has been challenging to evaluate, with only Haiti and Guyana, currently supported by the American Red Cross, producing quantitative data to measure the overall effectiveness of the programme in relation to peers reached.

In relation to peer educators, quantitative information from pre and post-tests of peer educator training in Haiti and Guyana, indicates that within those settings the programme has been effective, particularly in relation to knowledge and attitudes, although less effective in relation to self-efficacy. Additional time in the curriculum needs to be allocated to issues associated with negotiation, including “saying no”, delaying sexual activity, mutual fidelity, and condom use.

Qualitative data gained from peer educators in Haiti emphasizes the positive impact that the programme has on peer educators. Although, not statistically significant, quantitative data related to peer educators in Belize would indicate that the programme is effective. No quantitative data is available from Jamaica, St. Lucia, or Trinidad and Tobago.

In order to ascertain overall effectiveness of a peer education programme, it is important that the quality and scope of activities delivered by peer educators are routinely and robustly monitored and that a checklist is provided to assist with this. In some sites, it was ascertained that peer educators were not routinely monitored.

The way in which some peer educators manage the implementation of the TWC curriculum, i.e. adopting a “pick and mix” approach to sessions implemented with peers reached will affect its overall effectiveness as it is a curriculum which is designed to be delivered in total.

## **6. Integration with other Red Cross programmes and building capacity in National Societies**

Within the time allowed, it was challenging to comprehensively address the extent to which TWC was integrated into other National Society programmes. However, the evaluation revealed that TWC peer educators did play a valuable role in the broader NS HIV programme and in some cases in other health programmes, such as the Club 25 youth blood donor recruitment strategy. A review of the curriculum did, however, show that the TWC peer educator training does not include any orientation to the Red Cross Red Crescent and its guiding principles, nor to the role that volunteering plays within the Red Cross Red Crescent movement.

Although not entirely attributable to TWC but to HIV programmes overall of which TWC is the major component, the way in which the capacity of Global Alliance National Societies had been built was evidenced by the different activities being undertaken in relation “strengthening National RCRC Society capacities to deliver and sustain scaled-up HIV programme”. St. Lucia reported that organisational capacity had been built as the National Society now had National and Regional HIV Trainers. No information was forthcoming from Trinidad and Tobago.

## **7. Relevance of TWC**

**a. Relevance: Working with vulnerable populations:** The impartial image of the Red Cross in the Caribbean allows valuable work with vulnerable and marginalized groups to be undertaken by National Societies.



It needs to be recognised that not all youth are equally vulnerable to HIV. Some young people are more at-risk of HIV or are in situations of greater vulnerability, for example in Haiti HIV prevalence is nearly double for women aged 15-24 years who have a partner ten or more years older. In order to be more relevant in the prevention of HIV, it is, therefore, increasingly important that National Societies prioritize their target groups and focus interventions and resources where they are likely to have the greatest impact.

The current thrust with TWC is in-school youth in a range of schools. However, it would appear that no analysis is undertaken on which school populations may face heightened vulnerability and within a school, what segments of the school population are most vulnerable to HIV infection. It is important for National Societies to recognise that individual youth may live in significantly different peer cultures and that broadly focused interventions may have limited success when youth in reality divide themselves into discrete subgroups with different norms and leaders. It is, therefore, important to take a decision on what segments of the youth population need to be targeted by an HIV prevention programme.

It is vital to work directly with most-at-risk populations to try to prevent further infections. For example, surveys throughout the Caribbean have identified extremely high infection rates among sex workers, with the sex work scene changing continuously, peer education models and programmes should be continuously adapted to these changes. In addition to sex workers, emerging evidence from the Caribbean indicates that substantial transmission is also occurring among MSM, with the stigma associated with homosexuality impeding HIV prevention initiatives with this target group.

In addition to HIV prevention activities and of equal importance is the need to address vulnerability by advocating on behalf of the most vulnerable communities confronted with the threat of HIV, improving access to services and reducing stigma and discrimination.

If National Societies are to increase their work with vulnerable populations, it is important to understand the local specificities of the HIV pandemic and to work with the most at-risk populations to develop appropriate interventions.

**b. Relevance: Training of peer educators:** Over the years, each National Society has developed its own way of implementing peer educator training. No individual curricula were available for review, other than the one used in Jamaica, the *Guide to Training Peer Educators* and National Societies' agendas for peer educator training. However, what was ascertained is that the *Peer Educator Handbook* and *Activity Kit*, supplemented by PowerPoint presentations are the main methodology used. This may have its limitations as there are areas of the *Peer Educator Handbook* and *Activity Kit* that need strengthening.

The *Guide to Training Peer Educators* recommends that the Peer Educators' workshop is held over two weekends totalling 24 hours. The newly released Federations' Standards for HIV peer education programmes recommends that peer educators receive a minimum of four to five days, initial training (Standard 7.7: Initial training). Three National Societies conduct their training in less than four days. Whilst it is recognised that this may be due to financial constraints, it is an area that needs consideration if peer educators are to have the necessary knowledge, attitudes and skills relevant to their responsibilities.

**c. Relevance: TWC curriculum (all countries except Haiti):** It is recognised that TWC is a generic peer education HIV programme and that there has been a recent review of the curriculum, with modifications suggested in relation to the use of appropriate language, deleting some activities that have not worked and moving exercises to blocks that are more appropriate. However, the curriculum as written needs strengthening to make it more relevant. The following need to be included: antiretroviral (ARV) treatment including compliance, gender, HIV and AIDS and STI information, positive living, prevention of mother to child transmission, risk, (including, forced sex, intergenerational sex, multiple and concurrent partners and transactional sex), sexual and reproductive health and VCT. In addition, the curriculum does not provide guidance on how to work with 10 -14 year olds.

**d. Relevance: TWC curriculum: Haiti:** The TWC curriculum has undergone substantial adaptation, including the addition of sidebars for amending sessions for 10-14 year olds to make them more appropriate; the inclusion of a case study related to transactional sex and the inclusion of an activity related to “My body”. This latter activity explains changes that occur during puberty, how male and female reproductive systems function and how pregnancy occurs from conception until birth.

However, case studies are still, with the exception of one case study related to transactional and intergenerational sex, related to boyfriend/girlfriend rather than to some of the more challenging situations which youth face.

**e. Relevance: National Responses to HIV prevention education for in-school young people:** When TWC was first introduced into the Caribbean, it was a ground breaking and innovative programme that received international acclaim. However, since TWC was first introduced, there has been a considerable shift in addressing HIV within the school curriculum, with many countries implementing Health and Family Life Education in school. This challenges the relevancy of Red Cross implemented TWC programmes in school settings in those countries.

Currently, TWC is not implemented on a sufficient scale to reach enough in-school youth through the use of the four blocks *in the Peer Educator Handbook* to curb the epidemic. Reaching a critical mass of youth may be better achieved by integrating HIV education into the school curriculum and system. Through their extensive experience of working with youth, National Societies could liaise with the Ministries of Education or Youth and Support re the feasibility of the Red Cross taking on an advisory or training support role. This approach may ensure that the added value brought by TWC through its use of dynamic interactive educational techniques such as: role-playing, group discussions, quizzes, coupled with a non-judgmental approach could be introduced into the school system.

## **8. Efficacy of the programme and the extent to which the Standards for HIV peer education programmes have been implemented**

Whilst there has been compliance with a number of standards, there are standards that need strengthening. Three key HIV peer education standards that underpin HIV prevention work need strengthening in the following ways:

- **Standard 1:** That individual National Societies strengthen links with organisations of PLHIV and work towards their involvement in programme development.
- **Standard 1:** That individual National Societies segment their in-school and out-of-school target population according to who is most vulnerable to HIV infection and actively target new vulnerable populations. This may require developing new intervention models with most at-risk youth populations
- **Standard 1:** That the Federation conduct through e-mail a learning needs assessment of staff and appropriate volunteers in relation to working with vulnerable populations and that this assessment informs the agenda for a workshop on work with key vulnerable populations.
- **Standard 2:** That National Societies conduct a gender analysis.
- **Standard 2:** That individual National Societies discuss the comparative advantages and disadvantages of conducting some elements of the programme in single-sex and mixed sex groups.
- **Standard 3:** That advocacy work is undertaken in relation to creating an enabling environment to ensure that friendly, accessible, affordable and appropriate sexual health services and resources to support peer education activities are available.

In addition to these three standards, if the National Societies are to continue using peer education as a prevention strategy (see Section 12: Recommendations for the way forward for HIV peer education programming in the Caribbean region), the following need to be addressed:

- **Standard 5:** That the Health Network discuss generating financial resources to ensure the sustainability of their HIV peer education programmes. Despite being considered by some as an inexpensive intervention (due to reliance on volunteers), good quality peer education can be

costly because of the need for financial resources for training, support, supervision, supplies and allowances.

- **Standard 7:** That prior to its re-print and funding permitting, the Federation commission an amendment of the *Peer Educator Handbook* and *Activity Handbook*, in countries other than Haiti, to ensure that the new curriculum incorporates issues relevant to societal gaps and missing information. See comments made in Section 7.2: Training: Peer Educators: Findings.
- **Standard 7:** That individual National Societies give strong consideration to extending the length of peer educator training to four to five days and that at the same time consideration is given as to how refresher training can be incorporated into the programme by those National Societies that no longer do this.
- **Standard 8:** That individual National Societies emphasise during all trainings, the need for peer educators to have repeated contacts with their peers in schools and formal youth settings and conduct the full curriculum, in addition to one-off discussions with family, friends and neighbours. Furthermore, adult leaders or teachers who support peer educators in the field should be informed about this.
- **Standard 9:** That individual National Societies discuss the minimum requirement for meeting and field-based supervision, and where this involves adult leaders or teachers that guidelines are created related to their involvement.
- **Standard 10:** That the Federation work with National Societies to strengthen the policy environment, particularly in relation to HIV Workplace and Gender Policy development.
- **Standard 11:** That in any HIV prevention programme, that a greater emphasis be placed on data collection in relation to the knowledge, attitudes and self-efficacy of the target group and that staff receive training in data collection, analysis and dissemination.

## 9. Federation-wide Network

From limited information obtained during the evaluation, it would seem that a network would be valuable. However, there would not appear to be agreement on whether this should be for HIV alone or for a broader range of issues as will be covered by the Health Network.

As far as could be ascertained, discussions related to the Health Network focussed on using the Disaster Management Network as a model rather than looking at other Regional HIV Networks.

## 10. HIV Reference Centre

The review revealed that there is a need for an HIV reference centre as there is currently no repository of information related to Red Cross HIV programmes within the Caribbean. For example, as far as TWC is concerned, information lies with individuals and there is little institutional memory through which the progression of tools and methodology can be traced. Nor are all documents dated.

However, whether there should be a wider reference centre needs further consideration. A reference centre may duplicate what is available through existing websites and may also have considerable cost implications. In addition to acting as a repository of local Red Cross information, a reference centre could play a role in:

- Capturing regional lessons learned
- Sharing relevant experiences from other regions
- Identifying RCRC and other tools that can be adapted to the Caribbean context
- Supporting the adaptation and/or development of tools and methodologies
- Promoting the development, piloting and revision of materials through exchanges and internships for Red Cross Society staff and volunteers
- Supporting the development of Regional Trainers

These and other ideas for a reference centre need to be researched in greater depth by the Federation and the Health Network, with outside support, funding permitting.

## **11. Lessons Learned**

### **a. Greater involvement of people living with HIV and key vulnerable populations**

- The participation of PLHIV in any HIV prevention programme is imperative. This is a programme area that needs strengthening.
- Although examples were given of how TWC had been used with a small number of vulnerable groups, in the main, National Societies do not target their TWC programmes according to vulnerability. In order to be more relevant National Societies need to address the HIV prevention needs of the most vulnerable and at-risk populations.
- TWC would appear to be less suited to some vulnerable populations. For example, members of vulnerable populations who have limited literacy skills (TWC relies on flipcharts and written materials) and those who are transient or have less structured lifestyles and are, therefore, unable to commit to a curriculum-based activity that requires attendance at all activities.
- The TWC curriculum would need to be adapted with specific population groups such as MSM, prisoners and sex workers to be relevant to their actual situations of risk and vulnerability.

### **b. Gender**

- Males and females are given equal responsibility. As far as representation is concerned, overall it is a predominantly female programme with male peer educators under represented.
- During the training of peer educators and activities with peers reached, the majority of the curriculum is conducted in mixed sex groups. Whilst effective teaching and learning involves open discussion and it is recognized that girls and boys need to learn to communicate with each other, they also need to be allowed the space to discuss gender issues and power dynamics in relationships in single sex groups.
- Peer educators were able to describe ways in which males and females can protect themselves and others from HIV but were unable to give examples of how gender roles impact on the spread of HIV.
- Overall, there is little in the curriculum, which would suggest a gender analysis has been implemented to ascertain how gender inequalities expose women and girls to the risk of HIV and how gender inequalities reinforce the subordination of women and girls.

### **c. Creating an enabling environment**

- An area that needs strengthening is advocacy work in relation to creating an enabling environment to ensure that friendly, accessible, affordable and appropriate sexual health services and resources to support peer education activities are available. This can include training of service providers.

### **d. Model of peer education**

- TWC is the model of peer education used by National Societies in the Caribbean. Other than Jamaica, who has a peer education project with young MSM using a peer outreach education/support approach, no National Societies have given consideration to an alternative model of peer education.
- TWC is a comprehensive model of peer education, which identifies the roles and responsibilities at different levels within the programme. Internationally the programme has received several awards and has been acknowledged as an example of best practice.
- TWC is a curriculum-based intervention with between 14 and 22 activities according to site, which works well with in-school youth and youth in formal groups when delivered in its entirety.
- High quality TWC is resource intensive, in terms of both monetary and human resources
- An informal model of peer education, which is less resource intensive, may be more practical in some settings, for example with sex workers and street youth, and may provide more depth on areas important to a particular beneficiary, for example condom promotion with sex workers.

### **e. Training of peer educators**

- Whilst TWC is a Caribbean-wide intervention, National Societies have adopted an individual approach to training.

- National Societies have training agendas but there is no actual written up-to-date peer educator training curriculum used by all National Societies and peer educator training varies in length from two to five days.
- Due to financial constraints, some National Societies are unable to offer follow-up or refresher training.

#### **f. Peer educators**

- Many peer educators were “near peers” and were, in some instances, more than five years older than their peers.
- .Studies have shown that youth peer education programmes have a positive impact on the peer educators themselves.<sup>1</sup> TWC peer educators demonstrated that they were the beneficiaries of the peer education process, with quantitative and qualitative data demonstrating that peer educators had made positive changes in their own knowledge, attitudes and behaviour.
- The skills learnt through the initial training and through the implementation process has provided youth with real life skills that they have been able to use. For example, it was reported that a young woman in Grenada, who is now teaching, had said that the programme had enabled her to make better life decisions, and a young woman in Jamaica, who had been a peer educator, reported that TWC had shaped her future career and that she is now an HIV consultant.
- In the main, peer educators clearly understood their roles and responsibilities.
- In some National Societies the follow up and support of peer educators after training needs to be strengthened to ensure the accuracy of peer educator information, that the programme is delivered in its entirety and to ensure peer educator retention.
- In some National Societies, due to financial constraints, there has been a lack of incentives and motivation strategies, which may contribute to peer educator retention.

#### **g. Target group activities**

- Attractive materials in the form of the *Peer Educator Handbook* and *Activity Kit* guide the implementation of activities with the target group. However, peer educators reported that these are not available in sufficient quantities to enable them to be used appropriately during activities. This may compromise the quality of activities, which are strongly based on the use of the *Activity Kit*.
- Although, it is recognised that peer educators can add to the information provided in the *Peer Educator Handbook* and the *Activity Kit*, the information in these materials needs strengthening. The following need to be included: antiretroviral (ARV) treatment, including compliance, gender, HIV and AIDS and STI information, positive living, prevention of mother to child transmission, risk, (including, forced sex, intergenerational sex, multiple and concurrent partners and transactional sex), sexual and reproductive health and VCT. In addition, the curriculum does not provide guidance on how to work with 10 -14 year olds.

#### **h. Support to National Societies**

- Currently only the three Global Alliance member National Societies receive technical and financial support from the Caribbean Regional Representation Office for their HIV programmes. This may lead to the implementation of less robust peer education programmes in those National Societies that do not receive such support. Indeed, one National Society requested more support. Other regions do not adopt this approach but have elected to continue supporting those National Societies preparing to join the Global Alliance on HIV.

#### **i. Monitoring and Evaluation**

- Some National Societies have robust monitoring and evaluation systems in place, whilst in others it is less robust and needs considerable strengthening.

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<sup>1</sup> Philliber S. In search of peer power: a review of research on peer-based interventions for teens. In *Peer Potential: Making the Most of How Teens Influence Each Other*. Washington, DC: The National Campaign to Prevent Teen Pregnancy, 1999.

- The suite of Monitoring and Evaluation Toolkits, at peer, peer educator and instructor training level, do not appear to have been utilized.

## **12: Recommendations for the way forward for HIV peer education programming in the Caribbean region.**

Whilst there are a number of recommendations made throughout this report, the following are key recommendations for the way forward.

### **1. Peer education as an HIV prevention strategy**

In the International Federation's Global Alliance on HIV, peer education is a key approach for HIV prevention. A literature review of community-based peer education programmes targeting youth in lower income countries found that peer-led interventions are effective in connecting youth to services, distributing HIV prevention resources and increasing knowledge.

More importantly, several peer education projects also resulted in behaviour change to reduce the risk behaviours associated with sexual activity. Specifically, they led to an increase in condoms or contraceptives and a decrease in the number of sexual partners.

Although there has been limited rigorous evaluation of HIV prevention programmes, studies and national experiences over the past 20 years strongly suggest that strategies are likely to be most effective and cost-effective when **they are carefully tailored to the nature and stage of the epidemic in a specific country or community.**

In order to maximise the impact of peer education programmes, it is important that National Societies ensure that programmes:

- Are well targeted for vulnerability
- Provide consistent follow-up and support to peer educators
- Are implemented at a scale to have impact on the targeted population
- Utilize a life skills approach to HIV prevention.

### **2. The way forward**

As far as the way forward is concerned for HIV peer education programming in the Caribbean region, it is recommended that the focus of the programme remain with youth as this is an area in which National Societies have developed expertise and links. However, it would seem that TWC is at a juncture and is faced with a number of options:

#### **Option 1: Develop a new peer education programme responding to most-at-risk populations:**

Following an analysis of local epidemic patterns and the current response/gaps in each country, develop a new model which is shorter, more flexible, less intensive and less expensive, has multiple contacts to build trust and is more appropriate to most-at-risk and vulnerable populations. For example, peer outreach support, with one-to-one or small group peer led interventions. The model could, for example, be based on the model with young men who have sex with men that is currently being implemented by the Jamaica Red Cross. Other models utilised by National Societies in the Americas and in other regions could be explored and adapted, such as some of those highlighted in the International Federation's new HIV Prevention Guidelines.

#### **Option 2: Continue using TWC**

In the long-term, the continued use of the current model with existing target groups, i.e. working in the main with non-targeted and non-segmented in-school youth, youth in formal groups, including a small number of youth from vulnerable populations would not appear to be an option. It cannot be implemented at a scale to have impact on the targeted population, health and family life education either has been or is in the process of being introduced into schools and more importantly there is a need to work with key vulnerable populations in line with

- **The Global Alliance on HIV:** *"Interventions must seek out **the most vulnerable** and build resilience i.e. in line with the fundamental principles of the Red Cross Red Crescent, they must prioritise reaching and empowering the people that are most in need."*

- **The Standards for HIV Peer Education:** Standard 1.2: Targeting according to HIV vulnerability: *“Key populations that **are particularly vulnerable to HIV infection** are targeted by the peer education programme, based on local and international information on HIV vulnerability. Key populations include sex workers and their clients, injecting drug users, men who have sex with men and people in prisons, but may include other populations such as especially vulnerable youth, transgender people, migrants and mobile workers.”*
- **UNAIDS:** *“No single prevention measure or approach will effectively serve the varied populations in need in any country. As resources are limited, it is essential that strategic information [i.e. information on the epidemic and its drivers which can inform and support sound programmatic and policy decision-making to achieve programme goals] be used to guide assistance **towards populations and settings where HIV transmission occurs and which contribute most to the epidemic.**”<sup>2</sup>*

However, if National Societies want to continue using TWC as a peer education model, there would appear to be two alternatives, which could be phased in to the work of the National Society

1. **Use TWC to work with key vulnerable populations:** Following an analysis of local epidemic patterns and the current response and gaps in a country, use TWC to work with relevant key appropriate vulnerable populations. That is, those who are not transient or do not lead less regular lifestyles, which mean that they are unable to commit themselves to attendance at all activities. Such an approach could capitalize on the experience that National Societies have already developed in working with key vulnerable populations and could include working with:
  - Young prisoners
  - Youth in reform schools
  - Street children living in institutions
  - An MSM organisation
  - NGOs whose focus is working with non-traditional TWC groups

This option should include a more in-depth assessment of the suitability of the current TWC model and curriculum for specific vulnerable populations, who should be involved during the assessment and adaptation processes. This option would require the adaptation of the curriculum with the target population to address their specific risk and vulnerability situation, in addition to training of youth peer educators from the target populations.

2. **Segmenting the target population:** Use the current model with an emphasis on
  - Shifting the focus from generic in-school youth and youth in formal groups by segmenting the target populations according to which in-school youth or youth in formal groups are most vulnerable to acquiring HIV.
  - Targeting youth in vulnerable locations, i.e. youth who live in locations that are violent, poor and in which sex for offers and sex work is common, or where there are high levels of youth migration. This approach would require research into youth sexual practices.

### **Option 3: Another option not listed above**

Whichever option is chosen, National Societies would need to take into account recommendations made in this report, including the need for:

- Significant changes in the curriculum content to reflect the realities of the lives of youth in the targeted populations, by addressing issues such as, forced sex, intergenerational sex, multiple and concurrent partners and transactional sex where these are not already included.
- An improvement in programme quality, including the provision of follow-up training and adequate supervision and the establishment of a routine monitoring system where these are not already included.
- Compliance with standards for HIV peer education programmes, in particular those standards that should underpin any peer education programme (see 3 below: Addressing standards and Section 8.3 and 8.4).

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<sup>2</sup> Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access, UNAIDS, Geneva, 2007

### 3. Addressing standards

Implementing an effective youth peer education project such as TWC requires rigorous standards. Overall, National Societies need to address the three key standards that underpin HIV prevention peer education programmes related to the involvement of people living with HIV and key vulnerable populations, gender equality and advocacy as follows:

- **Standard 1:** That individual National Societies strengthen links with organisations of PLHIV and work towards their involvement in programme development and that partnership agreements with such organisations are drawn up and signed.
- **Standard 1:** That individual National Societies segment their in-school and out-of-school target population according to who is most vulnerable to HIV infection and at the same time actively target new vulnerable populations.
- **Standard 1:** That the Federation conduct through e-mail a learning needs assessment of staff and appropriate volunteers in relation to working with vulnerable populations and that this assessment informs the agenda for a workshop.
- **Standard 2:** That National Societies conduct a gender analysis (See *Standards for HIV peer education programmes*: Appendix 2: General analysis for an HIV peer education programme).
- **Standard 2:** That individual National Societies discuss the comparative advantages and disadvantages of conducting some elements of the programme in single-sex and mixed sex groups.
- **Standard 3:** That advocacy work is undertaken in relation to creating an enabling environment to ensure that friendly, accessible, affordable and appropriate sexual health services and resources to support peer education activities are available.

In addition to these three standards, if the TWC programme is to continue, a number of other standards need to be addressed (see Section 8.3 and 8.4).

### 4. Roadmap of the way forward

Presented below is an ideal roadmap of the way forward. It is recognised that due to financial constraints and existing plans for 2010, this roadmap may not be possible in its entirety. Discussions need to take place between the CRRO and the Zonal Office re funding for the process.

3. That at its next meeting, the Health Network appointed an HIV sub-committee, which is comprised of members who have experience in HIV programming.
4. That the CRRO conduct through e-mail a learning needs assessment of staff and appropriate volunteers in relation to working with vulnerable populations.
5. That HIV programme managers of all appropriate National Societies and the HIV sub-committee receive training (a maximum of five days) on the IFRC Standards for HIV peer education programmes and relevant sections of the HIV prevention principles and guidelines for programming facilitated by a person with experience in the Standards.
6. That following the needs assessment related to vulnerable populations, HIV programme managers of all appropriate National Societies and the HIV-sub committee receive training in working with vulnerable populations. Starting points for involvement in such a workshop could be the Jamaican Red Cross, with its young men who have sex with young men project, Caribbean Vulnerable Communities (CVC) Coalition (<http://www.cvccoalition.org>), International HIV/AIDS Alliance Caribbean Office and Jamaica AIDS Support for Life (JASL) (<http://www.jamaicaaidssupport.com/>).
7. That HIV programme managers of all appropriate National Societies and the HIV-sub committee together identify any further options and then take part in a facilitated SWOT analysis of **each option** in order to agree a Caribbean way forward for peer education work in the region.
8. That the HIV sub-committee agree an overall peer education strategy to guide future peer education work in the Caribbean.



9. That National Societies undertake an individual analysis of local epidemic patterns and the current response and gaps in a country.
10. That individual programme managers replicate the SWOT analysis within their National Societies to agree a way forward for their National Society within the newly developed peer education strategy.

## SECTION 1: INTRODUCTION

Overall, this report attempts to provide a picture of the background and the current status of the Together We Can (TWC) programme using both quantitative and qualitative data. It should be recognised that it is challenging to provide an equitable evaluation for the countries involved in the TWC evaluation. Different evaluation methods were used in the six evaluation sites. Only three out of the six countries involved in the review were visited. National Societies receive different levels of funding and technical support from the Caribbean Regional Representation Office (CRRO), and in the case of Haiti and Guyana from the American Red Cross. Each National Society employs different numbers of full-time Red Cross staff to work as part of the TWC programme.

Different methods were used in the six evaluation sites. Three countries, Haiti, Jamaica and Trinidad and Tobago were visited, with a total of three days allocated to each country. During this time semi-structured interviews or focus group discussions were undertaken with programme staff and volunteers. In addition to this, there were extensive e-mails with those who manage the programmes in country. For Belize, Guyana and St. Lucia, the evaluation took the form of a 2-hour telephone call, plus extensive e-mails with programme staff or senior volunteers.

As the Terms of Reference (ToR) contained a large number of objectives and activities, individual sections address key findings, conclusion and recommendations, rather than separate sections being devoted to these.

In addition to reviewing the programme, the evaluator was asked that, where possible, she provide suggestions and documents, which may lead to the strengthening of HIV prevention programming.

## SECTION 2: BACKGROUND

This section details the background to HIV and the Together We Can (TWC) Peer Education Programme in the Caribbean

### 1. HIV in the Caribbean

**1.1. Overview:** According to UNAIDS most recent report<sup>3</sup>, “although it [HIV] accounts for a relatively small share of the global epidemic, the Caribbean has been more heavily affected by HIV than any region outside sub-Saharan Africa,..... with the second highest level of adult HIV prevalence. .... Although sharp declines in HIV incidence were reported in some Caribbean countries earlier this decade, the latest evidence suggests that the regional rate of new HIV infections has stabilized. As behavioural data in the region are sparse, it is difficult to determine whether earlier declines in new infections reflected the natural course of the epidemic or the impact of HIV prevention efforts.

The Caribbean epidemic is fuelled by a culture in which men are encouraged to have multiple sexual partners, by a thriving sex industry, and by men having sex with men.

A considerable share (17%) of AIDS cases reported in the Caribbean have no assigned risk category; since many cases are only officially reported long after the diagnosed individual has died, it is often difficult or impossible to carry out epidemiological investigations. National HIV burden varies considerably within the region, ranging from an extremely low HIV prevalence in Cuba to a 3% [1.9–4.2%] adult HIV prevalence in the Bahamas.”

A recent IFRC report related to Latin America and the Caribbean<sup>4</sup> says that the pandemic is “fuelled by a range of social and economic inequalities exacerbated by high level of stigma, discrimination of highly vulnerable groups, and persistent gender inequality and homophobia”.

**1.2: Gender:** The Caribbean has a mixture of generalized (HIV prevalence is consistently over 1 per cent in pregnant women) and concentrated (HIV prevalence is consistently over 5 per cent in at least one defined sub-population and below 1 per cent in pregnant women in urban areas) epidemics. Women account for approximately half of all infections in the Caribbean. HIV

<sup>3</sup> Information for this section is taken from UNAIDS. Report on the global AIDS epidemic. Geneva, UNAIDS, 2009

<sup>4</sup> IFRC, Inequalities fuelling HIV pandemic: Focus on Red Cross societies' response in Latin America and the Caribbean, 2009

prevalence is especially elevated among adolescent and young women, who tend to have infection rates significantly higher than males their own age.

**1.3: HIV treatment:** In part due to collaborative efforts to reduce the price of medications, the Caribbean region has made important strides towards increasing access to HIV treatment. Whereas only 1 in 10 Caribbean residents in need of treatment were receiving antiretroviral drugs in July 2004, treatment coverage of 51% had been achieved as of December 2008, a level higher than the global average for low- and middle-income countries (42%). Paediatric antiretroviral coverage in the Caribbean (55%) was also higher in December 2008 than the global treatment coverage level for children (38%).

**1.4: Heterosexual transmission:** Heterosexual transmission, often tied to sex work, is the primary source of HIV transmission. For example, In Barbados and the Eastern Caribbean the annual reported incidence of HIV is three to six times higher in women aged 15–24 than in men. Surveys throughout the Caribbean have identified extremely high infection rates among sex workers; 27% in Guyana in 2005 (Presidential Commission on HIV and AIDS, 2008) and 9% in Jamaica in 2008. This compares with 1.5% in the general population. Statistics show that females between the ages of 10 to 19 years in Jamaica are three times more likely to be HIV positive than males of the same age group.

Civil society monitoring indicates that a relatively small share of external HIV financing in the Caribbean has focused on programmes delivered by sex worker organizations.

**1.5: Men who have sex with men:** Emerging evidence indicates that substantial transmission is also occurring among MSM. The epidemiological studies involving MSM are relatively rare in the Caribbean. However, the few that exist suggest a high burden of HIV infection in this population. A 2006 study in Trinidad and Tobago found that 20.4% of MSM surveyed were HIV-infected, while a subsequent study in Jamaica found HIV prevalence of 31.8%. As in many other parts of the world, the stigma associated with homosexuality impedes HIV prevention initiatives in the Caribbean focused on MSM. Although women are believed to account for the vast majority of sex workers in the Caribbean, emerging evidence suggests that male sex workers who sell their services to tourists in the region may also face considerable risks of acquiring HIV.

At least nine Caribbean countries criminalize sexual conduct involving members of the same sex.

**1.6: Injecting drug use:** Transmission during injecting drug use plays a relatively modest role in the epidemic in the Caribbean.

**1.7. Prevention of mother-to-child transmission:** As of December 2008, 52% of HIV-infected pregnant women in the Caribbean were receiving antiretroviral drugs for the prevention of mother-to-child transmission. Regional prevention coverage in Caribbean antenatal settings exceeds the global average (45%) and is an improvement over the regional coverage in 2003 (22%). In response to the remaining coverage gaps, United Nations stakeholders joined with regional partners to launch the Caribbean Initiative for the Elimination of the Vertical Transmission of HIV and Syphilis.

**1.8: Prisons:** Relatively little data exists on HIV prevalence in the general prison populations in the Caribbean. From information available in three countries (Cuba, Jamaica and Trinidad and Tobago), regional patterns are consistent with those seen internationally, with HIV prevalence among prisoners (ranging from 4.9% in Trinidad and Tobago to 25.8% in Cuba) substantially higher than in the general population.

## **2. Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012**

The Caribbean Strategic Framework (CRFS) 2008-2012, of which the Federation is an international collaborating agency, provides the strategic direction and programmatic orientation for the members of the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) in their pursuit of achieving universal access to HIV and AIDS prevention, treatment, care and support services by 2010. The six priority areas of the framework are:

- An enabling environment that fosters universal access to HIV prevention, treatment, care, and support services

- An expanded and coordinated multisectoral response to the HIV epidemic
- Prevention of HIV transmission
- Treatment, care, and support
- Capacity development for HIV and AIDS services
- Monitoring, evaluation, and research

### **3. Background: International Federation of Red Cross and Red Crescent Societies (IFRC) response to HIV and AIDS**

The IFRC response to HIV and AIDS is outlined in its HIV and AIDS Policy (2002), the Global Health and Care Strategy (2006-2010), Strategy 2010, the HIV in the Workplace Directive (2006) and in its Global Alliance on HIV. The latter was launched in the Americas in 2008.

The purpose of the Global Alliance is to “*to do more and to do better*” to reduce vulnerability to HIV and its impact, by strengthening and making better use of the combined capabilities of Red Cross Red Crescent National Societies and the International Federation Secretariat and by tapping into regional networks and other funding and operating partners. The Global Alliance on HIV functions within the framework of government-led national HIV and AIDS strategies, and encourages close coordination with other national and international partners. The Global Alliance has three programmatic outputs:

1. Preventing further HIV infection
2. Expanding HIV care, treatment and support
3. Reducing HIV stigma and discrimination

These three programmatic outputs are bolstered by a fourth enabling output

4. Strengthening National Red Cross Red Crescent Society capacities to deliver and sustain scaled-up HIV programmes

Belize, Haiti, Guyana and Jamaica are Global Alliance countries involved in the current TWC evaluation. Trinidad and Tobago has been identified as a potential member, based on National Society capacity, and prevalence rate in country. Work is in progress to orientate Trinidad and Tobago to the requirements of the Global Alliance.

One of the Global Alliance’s key prevention approaches is peer education. Recognizing that peer education is a cornerstone of Red Cross Red Crescent HIV programmes around the world, the IFRC, in close collaboration with the British Red Cross, developed in 2009 *Standards for HIV peer education programmes*. The IFRC hoped that these standards would provide a useful tool for establishing quality benchmarks for improved and more effective Red Cross Red Crescent HIV peer education programming worldwide.

### **4. Peer education**

A peer is a member of a group of people sharing the same or similar characteristics. For example, a peer can be a person of the same age and background; a person who does the same kind of work; a person who shares a similar lifestyle or values. A near peer is a person that shares many characteristics of a true peer but differs in some way, such as being slightly older or no longer belonging to the same social group. HIV peer education involves selecting, training and supporting members of a specific group to educate members of their peer or near peer group about HIV and related topics. The more peer educators have in common with the people with whom they interact, the more likely those people are to receive the messages and be influenced.

A recent review for the World Health Organization and the United Nations Population Fund found that youth peer education programs in developing countries are generally effective in improving knowledge among youth and to some extent, attitudes and sexual behaviors, though there is debate about whether adult or youth curriculum focused interventions are more effective.<sup>5</sup>

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<sup>5</sup> WHO, Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries : UNAIDS interagency task team on HIV and young people/editors: David Ross, Bruce Dick, Jane Ferguson, WHO, Geneva, 2006

## 5. Together We Can (TWC) peer education programme

The TWC Peer Education Programme is a Red Cross Red Crescent youth focused curriculum-based intervention designed to address issues related to HIV and AIDS that uses a peer-to-peer approach. In the main, it is an in-school programme, which has to some extent, been extended to out-of-school youth in clubs (for example in Haiti 16% of those targeted represented out-of-school youth and in Guyana 10% of those targeted were out-of-school youth). The programme is not necessarily targeted at vulnerable youth, although there is evidence of the inclusion of some vulnerable youth groups in TWC programmes. For example, in Jamaica where youth are vulnerable because of poverty, violence and sexual behaviour, the programme tries to ensure that 15% of those who are included are vulnerable youth.

In Guyana and Haiti 70% of peers reached through TWC workshops are invited three to six months after they have completed their last TWC curriculum-based session to attend a follow-up activity. These are intended to provide a “booster effect” to increase the likelihood of long-term message retention.

More than half of the National Societies in the Inter-Americas region are implementing HIV and AIDS programmes targeting young people using the TWC peer education methodology.

The programme had its origins in Jamaica in 1992 in a one-year operational research peer education programme funded by the World Health Organisation. A three-year collaborative programme (1993-1996) between the Jamaican Red Cross and the American Red Cross, funded by AIDSCAP (the Family Health International Agency) and USAID followed the operational research. The programme objectives were aimed at providing youth with the opportunity to:

- Learn correct information about HIV and AIDS
- Examine their behaviour to determine their risk
- Support their peers in delaying and abstaining from sexual activity, reinforcing fidelity, and teaching correct and consistent condom use as effective strategies to reduce risk
- Develop skills to help maintain these safer sexual practices.

To support the delivery of the programme, a *Peer Educator’s Handbook* and an *Activity Kit* for participants in the programme have been developed. In 2004, a consultancy firm was hired to develop a *Monitoring and Evaluation Toolkit* to assist in measuring the impact of TWC programmes in the Caribbean and Central America evaluation sites. It was reported that there had been confusion related to the toolkit, as it contained conflicting information and a suggestion had been made that it be discontinued until a revised edition is available. No revised edition had been produced at the time the evaluation.

The TWC programme has received widespread international recognition and is now implemented, not only in the Caribbean but also, in a number of countries in Central America, South America and Africa. The American Red Cross, Norwegian Red Cross, Netherlands Red Cross, Norwegian Agency for Development, United Nations Children's Fund (UNICEF) and the Caribbean Regional Representation Office have supported TWC in the Caribbean. For the current status of TWC programmes in the Caribbean see Table 1 below.

**Table 1: Current status of TWC programmes in the Caribbean**

Caribbean Regional Representation					
	% of 15-49 year olds living with HIV	Ever conducted TWC	Currently conducting TWC	How is/was the programme funded?	Who provides/ed technical support?
<b>Antigua and Barbuda</b>	Not known	Yes	Yes when funding permits	Private funding	Local support
<b>Bahamas</b>	3.5%	Yes	Yes	Internal funding	Need more support from regional level
<b>Barbados</b>	1.2%	Yes	No	Not known	Not known
<b>Belize</b>	2.0%	Yes	Yes	CRRO	CRRO

<b>Dominica</b>	Not known	Yes	No	CRRO	NA
<b>Grenada</b>	Not known	Yes	No	CRRO	
<b>Guyana</b>	2.7%	Yes	Yes	CRRO + ARC	ARC
<b>Jamaica</b>	1.22%	Yes	Yes	CRRO GA Global Fund International HIV/AIDS Alliance (2009) NRC (2008)	MoH CRRO UNAIDS NAC
<b>St. Kitts and Nevis</b>	Not known	Yes	No		CRRO
<b>St. Lucia</b>	Not known	Yes			
<b>St. Vincent and The Grenadines</b>	Not known	Yes	Yes	Government of St. Vincent and World Bank	Government of St. Vincent and World Bank
<b>Suriname</b>	1.2%	Yes	No	EU (2005) US Embassy (2006) Netherlands Embassy (2006) CRRO (2006 and 2007)	Sub-regional office of the IFRC
<b>Trinidad and Tobago</b>	2.5%	Yes	Yes	CRRO (2007) NRC DfID NACC REPSOL	Medical Director CRRO

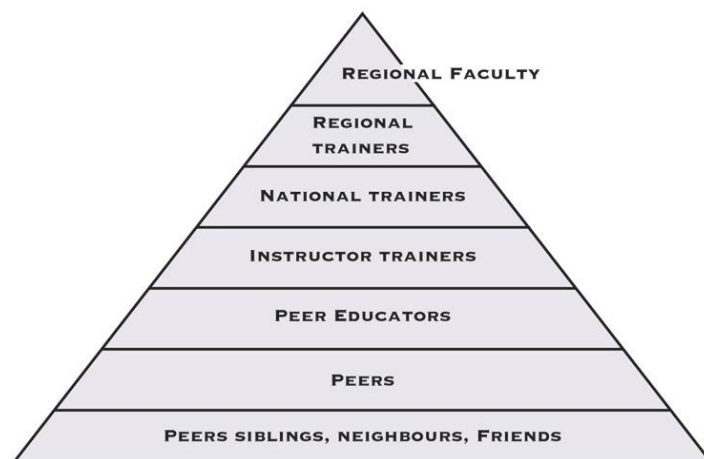
<b>Regional Representation for the Latin Caribbean (LCRR)</b>					
	% of 15-49 year olds living with HIV	Ever conducted TWC	Currently conducting TWC	How is/was the programme funded?	Who provides/ed technical support?
<b>Cuba</b>	0.1%	Has never implemented TWC			
<b>Haiti</b>	2.1%		Yes	CRRO + ARC	ARC
<b>Dominican Republic</b>	1.1%	Yes	Not known		Federation Secretariat

National Societies discontinued their TWC programmes for a variety of reasons, including lack of funding, that the material is too juvenile for the older youth groups (realistically it is only suitable for the maximum age group up to 18 years) and that a new programme needs to be developed for more mature audiences.

## **6. Model: Together We Can peer education programme**

The programme has a highly structured model and utilises a pyramid cascade training approach (see diagram below)

## STRUCTURE OF TWC PROGRAMME



Regional Trainers train National Trainers, who in turn train Instructor Trainers. In Haiti and Guyana, the National Trainer Post and the Instructor Trainers posts have been combined into a paid post of Field Manager. In the other National Societies, the posts are about to be combined but remain voluntary. The Instructor Trainers then train the peer educators. The peer educators then train their peers. Note that National Societies use different terminology to describe “peers”, including “peers reached” and “youth multipliers” (in Guyana and Haiti). Throughout this document, they are referred to as “peers reached”.

In Guyana, the youth multipliers take home four assignments that consist of reaching out to the same 10 peers (called Youth Participants) on four separate occasions with TWC HIV skills practice and prevention messages. Youth multipliers are also invited for follow-up workshops geared towards reinforcing knowledge and skills at 3-6 months and 9-12 months after the initial workshop.

As far as peer educators are concerned, some, National Societies, though not all use “near peers”, with peer educators often being five years or more older than the peers they educate.

The Federation, through CARAN (see 8 below) produced a comprehensive document, *TWC training structure*. For each level, the document outlines who is responsible for certification, the criteria for recruitment and the responsibilities (see Appendix 1: TWC Training Structure).

At peer level, the TWC programme is delivered through 4 blocks, each of which contain a number of different activities. A pair of peer educators, where possible a male and a female, facilitates a series of trainings laid out in the Handbook, with on average ten young people. These young people are then encouraged to share key messages about what they have learned with their peers in school or in the community. Peer educators are encouraged to work with a minimum of three separate groups.

### 7. Regional Faculty

The initial TWC programme in Jamaica adopted a faculty model to implement training. The American Red Cross trained potential trainers from Jamaica. This resulted in the establishment of a National Faculty of experts in Jamaica in HIV peer education whose function was to oversee the training of instructor trainers. As TWC expanded throughout the Caribbean, this National Faculty became a Regional Faculty, which provided overall quality control and maintenance of standards and integrity of the methodology within the programme.

The Regional Faculty trained and certified regional trainers throughout the Caribbean. These Regional Trainers became responsible for training their own and other National Trainers, who were also certified by the Regional Faculty. The Faculty was also involved in an exchange of best practice. On a regional level, all decisions regarding TWC were decided by the Faculty; in some instances after consultation with the Regional and National Trainers.

There is a National Faculty in Jamaica but the Regional Faculty no longer exists and has not been replaced. A number of those who participated in the review were not aware that the Faculty is no longer in existence.

It was reported that a sub-committee of the newly established Regional Health Network may fulfil this role. This network was born out of request from National Societies. It is anticipated that the Network, which is modelled on the Disaster Management Network would play a similar role to CARAN but would be broader and include First Aid, HIV, H1N1 and other health issues.

## 8. CARAN

In the Caribbean, between 1999 and 2001, the American Red Cross worked with the Federation and the Netherlands Red Cross to establish the Caribbean Red Cross AIDS Network (CARAN). It was intended that CARAN would bring together a multidisciplinary group, comprised of professional and experienced volunteers from Red Cross National Societies, government organisations and non-governmental organisations from across the Caribbean to create and foster a system for the exchange of information, experiences and best practices amongst members, UN agencies and other national, regional and international organisations.

With the assistance of the JRC, CARAN prioritized TWC as its core HIV and AIDS strategy for the region and created a regional team of TWC trainers and faculty with the goal of training National Trainers in each country and disseminating TWC through CARAN. It was reported that the structure developed by CARAN did not work well and that CARAN became non-operational in 2006.

## 9. Caribbean Regional Representation

The Federation's zonal office in Panama and the Caribbean Regional Representation Office (CRRO) in Port of Spain, Trinidad, together serve 16 National Societies including Antigua and Barbuda, Barbados, Bahamas, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname and Trinidad & Tobago Red Cross. In addition to this, the newly established Regional Representation for the Latin Caribbean (LCRR) in Santo Domingo covers Cuba, the Dominican Republic and Haiti. The zonal and regional offices also serve 16 overseas branches and committees of the British, French, Netherlands and US Red Cross.

The Caribbean Regional Representation uses the Global Health and Care Strategy but has priority programmes:

- **HIV and AIDS:** A strategic decision was taken that the Caribbean Regional Representation would offer support in report writing and work plan development to the four Caribbean Global Alliance countries. Information, for example, about regional conferences is shared with Global Alliance countries but not with other National Societies.
- **Club 25:** This programme currently runs in seven Caribbean countries including Dominica, Dominican Republic, Guyana, Haiti, Jamaica, St. Lucia and Suriname. It aims to promote the value of saving lives by giving blood. Through Club 25, young people are encouraged to attend a blood centre, learn about healthy lifestyles and to give blood regularly, aiming for about 20 blood donations by the age of 25 years. They also share what they have learned with their peers and their communities through health promotion activities to prevent HIV and promote safer behaviours. In addition, there are opportunities to be active in addressing stigma and discrimination, and promoting first aid, good nutrition, physical exercise and road safety.
- **First Aid:** This covers all countries, though in St. Kitts there is also an organisational development component
- **Health in emergencies:** There is currently a regional pandemic influenza preparedness project due to be completed in mid 2010.
- **Community Based Health and First Aid:** The new methodology is currently being rolled out in the Caribbean with the first regional training of master facilitators conducted in late 2009 and



planned national roll-out in an initial 5 Caribbean countries in 2010. 10. The Inter-American Plan 2007–2011<sup>6</sup>:

At the Inter-American Conference of the International Federation held in Ecuador in 2007, the National Societies of the Americas, under the theme of “safer and healthier communities”, made a commitment to scaling up the impact of individual and collective work during the next four years including intensifying and scaling up contributions to community health, through social mobilization, more effective advocacy and strong partnerships. The commitment included the following in relation to HIV and AIDS. “We will intensify our efforts on HIV and AIDS, focusing on prevention, care, treatment and support, and reducing stigma and discrimination.”

At the same conference a commitment was made to “significantly increase our work to promote respect for diversity and human dignity, and to reduce intolerance, discrimination, violence and social exclusion”, including giving “priority to reducing stigma related to HIV and AIDS, and to addressing the increasing problems related to all forms of violence. We aim to ensure that the Red Cross is inclusive and open to all, fully respecting our fundamental principles and humanitarian values.”

The plan acknowledges that there is a strong need to work on specific issues related to HIV and AIDS, including the raising of awareness of the risks of unsafe sexual behaviours, discrimination and stigmatization of people living with HIV (PLHIV), gender differentials in vulnerability to HIV and AIDS, and the availability of voluntary counselling and testing. The plan also refers to the need for National Societies to develop and maintain internal sensitivity and competence to adequately establish links and work for and with PLHIV.

#### **10. President’s Emergency Plan for Aids Relief [PEPFAR]**

The TWC programmes in Haiti and Guyana receive financial and technical support from the American Red Cross through PEPFAR. Haiti and Guyana are the only countries in the Caribbean supported through PEPFAR. The U.S. Government (USG) PEPFAR team is, however, in the process of developing a Caribbean Regional Partnership Framework to provide increased US government assistance to Caribbean governments and regional entities as they work to reduce the incidence and prevalence of HIV in the region. The five-year regional strategy will support and strengthen Caribbean regional, national, and local efforts to prevent and control the HIV epidemic and mitigate its consequences under a Partnership Framework which outlines mutual contributions in the area of service delivery, policy reform and financing.

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<sup>6</sup> Inter-American Plan 2007–2011, IFRC, Geneva, 2008.

## **SECTION 3: PURPOSE OF REVIEW**

### **1. Key objectives of the assignment**

- i. Assess the effectiveness of the current TWC programme against its objectives, with a view to determining whether the intervention is making an impact on the targeted groups.
- ii. Assess the relevance of TWC i.e. whether the methodology is responding to local epidemic situations, whether we are targeting the right people in the right way and at a scale to reduce HIV transmission.
- iii. Assess the efficacy of the programme, and whether internationally recognised peer education standards outlined in the International Federation's document are being met, and make recommendations for improvement.
- iv. Determine the most appropriate regional level monitoring mechanism to ensure that internationally recognised peer education standards are adhered to and maintained.
- v. Make recommendations as to the way forward for HIV peer education programming in the Caribbean region.

### **2. Main tasks of the assignment**

- To undertake site visits to the Caribbean Regional Representation Office and to three Caribbean National Societies to gain an understanding of the implementation of TWC, the profile of people reached, the institutional context, and the role of the TWC programme in the local HIV situation and response;
- To assess the extent to which current programmes reflect accepted peer education standards;
- To assess the extent to which the most vulnerable groups are being reached through TWC peer education;
- To determine whether National Societies have targeted, or plan to target, vulnerable populations, and how this is to be undertaken;
- To identify factors that limit National Societies from reaching vulnerable populations;
- To identify the support that the Federation could provide to help National Societies to reach vulnerable populations;
- To determine the extent to which TWC integrates with other Red Cross programmes and builds capacity in National Societies;
- To review the updated TWC curriculum (2008) and the Haitian TWC adaptation conducted with American Red Cross support. Identify the ways in which the TWC methodology has been modified and why; determine whether the modified methodologies adhere to internationally accepted peer education standards;
- To identify lessons learned and provide recommendations for guiding, planning and implementing future peer education initiatives in accordance with internationally accepted standards;
- To prepare and submit an Evaluation Work Plan and an Evaluation Report to Head of Office of the CRRO.

For full ToR see Appendix 2: Consultant Terms of Reference.

## SECTION 4: METHODOLOGY, INCLUDING CONSTRAINTS AND BIAS

### 1. Methods used as part of the review

**Country visits:** Three-day site visits to Haiti, Jamaica and Trinidad, plus 2 days with the CRRO

**Desk research:** TWC *Peer Educator Handbooks* and *Activity Kits* for the Caribbean and for Haiti, programme documentation and web-based research related to HIV within the Caribbean context, including UNGASS country reports

**Face-to-face and telephone interviews:** These used separate prepared questionnaires based on the evaluation objectives and tasks and the *Standards for HIV peer education programmes*. In depth interviews were conducted with senior TWC programme representatives in Belize, Guyana and St. Lucia

**E-mail:** This was used as a follow-up to site visits and telephone interviews

### 2. Review participants

For details of review sites, review participants and methodology see Table 2 below.

**Table 2: Review sites, review participants and methodology**

<b>Entity</b>	<b>Who</b>	<b>Designation</b>	<b>Method</b>
<b>IFRC Americas Zone</b>	Julie Hoare	Health and Social Services/HIV Coordinator	In-depth telephone interview
<b>Caribbean Regional Representation</b>	Tanya Wood	Regional Representative	Face-to-face meeting
	Ravia Harribans	Health Programme Manager	In depth face-to-face meeting and e-mail
	Caribbean Health Network	Belize, Guyana, Jamaica, Haiti and Trinidad and Tobago Red Cross Societies and a representative of the International Federation's Health and Care Advisory Board	Short face-to-face meeting
<b>Antigua and Barbuda</b>	Gerald Price	Director General, Antigua and Barbuda Red Cross	Short face-to-face meeting
<b>Belize</b>	Tashera Swift	Co-ordinator TWC programme, Belize Red Cross	In-depth telephone interview and e-mail
<b>Grenada</b>	Samantha Roberts	Member of the Health and Care Advisory Board of the IFRC	Face-to-face meeting
<b>Guyana</b>	Pryadarshni Rai-Griffith	HIV and AIDS Coordinator, Guyana Red Cross	In-depth telephone interview and e-mail
	Ashanta Osborne Moses	HIV and AIDS Field Manager, Guyana Red Cross	Face-to-face meeting and e-mail
<b>Haiti: Field visit</b>			
<b>Site 1:</b> Petion Ville: A wealthy suburb of Port-au-Prince that is a mixture of commercial and residential			
<b>Site 2:</b> Cité Soleil: Densely populated shantytown located in Port-au-Prince. Most of its residents live in extreme poverty.			
	Dr. Amedee Gedeon	President, Haiti Red Cross (HRC)	Face-to-face briefing meeting
	Dr. Marie-Yves Duperval	Director of Community Health, (HRC)	Face-to-face briefing meeting
	Daniel Gedeon	TWC National Youth Coordinator, HRC	In depth face-to-face meeting and skype
	Piearrette Altéma Yvonn Leclerce	Field Managers, Petion Ville	In depth face-to-face meeting

	Erlonie Elias Josue Jean	Field Managers, Cité Soleil	In depth face-to-face meeting
		Site 1: Peer educators: Petion Ville (4 males and 4 females aged 17 – 23 years – median age = 20.5 years)	Focus Group Discussion
		Site 2: Peer educators: Cité Soleil) (4 males and 4 females aged 21 – 31 years – median age = 24.6 years)	Focus Group Discussion
		Site 1: Youth multipliers: College Astrhone Isaac (Private school): Petion Ville (4 males and 4 females aged 14 – 19 years median age = 16.6 years)	Focus Group Discussion
	Mrs. Astrhone	Site 1: Principal: College Astrhone Isaac	Short face-to-face meeting
		Site 2: Youth multipliers: Ecole Baptiste Bon Berger (Private church school): Cité Soleil (3 males and 5 females aged 13 – 18 years – median age = 16 years)	Focus Group Discussion
	Erold Joseph	Director of School Health, Ministry of Education	Short face-to-face meeting
	Bernadette G. Christian Jacques-Antoine Jasmin Jocelyn Cassis Kedma Joseph	Department of Public Health Communication Ministry of Health	Focus Group Discussion
	Nirvah Jean Jacques	Adaptation Core Group Member Consultant	In depth face-to-face meeting

**Jamaica: Field visit:**

**Site 1:** Willowdean Group of Schools (High School and Preparatory Division): Seventh Day Adventist Institution private fee paying school subsidized by the church but open to all with children from lower middle and middle class income brackets. Outskirts of Spanish Town, St. Catherine Parish

**Site 2:** St. Andrews. Volatile community in which there has been a police and army presence, which has calmed things down

**Site 3:** Manchester. Includes mixed population from urban and rural settings. 60% of children from rural setting commute to the urban setting to complete their education.

	Lois Hue	Senior Director Youth & HIV/STI Programmes Deputy Director General JRC	In depth face-to-face meeting and e-mail
	Marvin Gunter	National Director for HIV and Youth Programmes	In depth face-to-face meeting
	Maxine Ellis	HIV and Youth Officer, St. Catherine's and Kingston	Face-to-face meeting
	Michaela Cameron	HIV and Youth Officer, Manchester	Short face-to-face meeting and e-mail
	Jeffrey Patrick James	Regional Trainer	Face-to-face meeting
	Mrs. Lawrence Brown	Guidance Counsellor Willowdene Group of School	Short face-to-face meeting

		<b>Site 1:</b> 15 peer educators (5 male: 11 – 26 years) and 10 females aged 10-17 years): Prep (Primary school) x 5, Secondary school x 10: Median age = 13.3	Focus group discussion
		<b>Site 2:</b> 2 peer educators (1 male: 22 years and 1 female: 22 years – staff of Rise Life Management)	Face to face meeting
		<b>Site 2:</b> 2 female peers reached (aged 18 and 13 years)	Face to face meeting
		<b>Site 3:</b> 2 peer educators (1 male: 21 years and 1 female 21 years)	Face to face meeting
<b>St. Lucia</b>	Terry Gaillard	Director General, St. Lucia Red Cross	Short face-to-face meeting
	Bennett Charles	Regional Trainer	In-depth telephone interview and e-mail
<b>Trinidad and Tobago: Field Visit</b>			
<b>Site 1:</b> Port of Spain: Capital of the Republic of Trinidad and Tobago			
<b>Site 2:</b> San Fernando: The larger of Trinidad and Tobago's two cities			
	Angela Gouveia	Director General, Trinidad and Tobago Red Cross (TTRC)	Face-to-face briefing meeting
	Margarita Elliot	HIV and AIDS Programme Coordinator, TTRC	In depth face-to-face meeting
	Akeisha Benjamin	Programme Officer for the HIV and AIDS Department, TTRC	In depth face-to-face meeting and e-mail
	Avenida Stewart Stirling Kent	Site 1: National Trainer Site 1: Instructor Trainer	Joint in depth face-to-face meeting
	Roderick Doldron, Melissa Joseph Leah Isaac	Site 2: National Trainer Site 2: National Trainer Site 2: Instructor Trainer	Joint in depth face-to-face meeting
		Group 1: Peer educators (5 males and 19 females aged 15-18 years – median age = 16.4 years): Diago Martin North Secondary School: Large mixed school (1000) pupils in a per-urban location	Large group discussion
	Aniah Conrad	Teacher: Diago Martin North Secondary School	Short face-to-face meeting
		Group 2: 3 peer educators (1 male and 2 females aged 11, 12 and 16 years): Primary school x 1, Secondary school x 2	Focus group discussion
	Cheryl-Ann Baldeosingh	Youth Officer 1, Ministry of Youth and Sports	Telephone interview
<b>American Red Cross</b>			
	D. Kendal Repass	Senior HIV/AIDS Initiative Manager/Senior Representative American Red Cross/Tanzania Delegation	In-depth telephone interview

	Lindsay Lincoln	Together We Can Project Officer, International Services, American Red Cross	In-depth telephone interview and e-mail
	Meg di Carlo	Global HIV Advisor, American Red Cross	In-depth telephone interview
	Matthew Marek	Haiti Country Representative American Red Cross	Joint interview
	Militza Michelle	TWC Programme Coordinator: American Red Cross	

### 3. Constraints

Considerable information was gained throughout the evaluation. However, there were a number of constraints:

- The prepared interview questionnaires were designed to reflect the evaluation objectives, which included an evaluation of the *Standards for HIV peer education programmes* and were, therefore, lengthy. In the allocated time in each of the three countries visited, three days was a challenging time to capture all the information needed to meet the overall objectives of the evaluation and information was not, therefore, always triangulated.
- No peer education sessions or peer education training was observed, as these were not part of the programme cycle at the time of the evaluation.
- Though the evaluator was able to interview peer educators in all three sites, a very small sample of “peers reached” took part in the evaluation. In Trinidad and Tobago, the Programme Officer for the HIV and AIDS Department was unable to arrange for any peers reached to be interviewed. In Jamaica, only two peers reached were interviewed. The lack of availability of peers reached to be interviewed may, in part, be due to the high percentage of work with in-school youth, with youth being unavailable due to commitments in school. For example in Manchester in Jamaica approximately 90% of the TWC programme was conducted with in-school youth. The peer educators in Jamaica were expected to bring their peers reached to take part in the evaluation and did not do so. They may not have realized the importance of doing this. In Haiti, two groups of peers reached took part in focus group discussions.
- The evaluator requested meetings with partner organisations, including organisations of people living with HIV, and the Ministries of Health and Education. Face-to-face interviews took place with the representatives from the Department of Public Health and the Ministry of Education in Haiti but not with other partner organisations. In Trinidad and Tobago and in Jamaica those organizing the interviews were unable to find people from partner organisations or ministries who were able to take part in interviews. However, in Trinidad and Tobago a phone interview took place with a representative from the Ministry of Youth and Sports.
- Conducting a multi-site evaluation with phone interviews was a challenge. For Belize, Guyana and St. Lucia telephone interviews took place. The information gained from these National Societies was, therefore, not triangulated.
- There was no official repository of all TWC related documentation.
- The evaluator was unable to conduct her own overall assessment of the knowledge, skills and attitudes of peer educators and the peers reached and information for this component was gained from monitoring and evaluation documents, which were not available for Jamaica, St. Lucia or Trinidad and Tobago.
- An additional component was added to the review related to the establishment of a regional Federation-wide HIV network and an HIV reference centre. Insufficient time was available to do justice to this component.

#### **4. Bias**

Bias may have been introduced in Haiti as the HRC TWC National Youth Coordinator translated for the evaluator, although responses would indicate that bias was not introduced.

## SECTION 5: EFFECTIVENESS OF THE CURRENT TWC PROGRAMME AGAINST ITS OBJECTIVES

### 1. TWC programme objectives

The overall TWC programme is geared at

*“stabilising HIV/STI prevalence in the Caribbean. It is hoped that there will be an increase in safe sexual practice among youth between the ages of 10 – 13, 14 – 19 and 20 – 24 years by providing them with information and education about the means of transmission and prevention of HIV, AIDS and other STIs, and assisting them in developing prevention skills.”*

Individual countries have developed their own specific TWC related objectives. For example in Haiti and Guyana, the goal of the programme is to *reduce the incidence of HIV among youth ages 10-24 years*, through three strategic objectives:

**SO1:** *Strengthen HIV-related life skills for 10-24 year old youth*

**SO2:** *Strengthen each National Red Cross Society’s capacity to manage and expand youth HIV prevention projects*

**SO3:** *Enhance the community environment for the adoption of safer sexual practices*

The Jamaica TWC programme has one overall objective that

*“By June 2011, the Sexual Decision Making volition of 12,000 young people (10-19 years) have been improved through the facilitation of peer focused and led interventions aimed at increasing knowledge, improving skill and attitude formation/change.”*

### 2. Introduction: Evaluating effectiveness

Evaluating the effectiveness of HIV prevention programmes usually requires **quantitative** measurements, which will help to assess the extent to which the objectives of the programme were achieved.

Short-term and intermediate programme effects (outcome) and long-term programme effects (impact) are usually measured. Changes in attitudes towards HIV and AIDS, the reduction of risk behaviors and adoption of protective behaviors, and changes in STI rates are considered the most appropriate short-term or intermediate outcome measures for interventions designed to reduce sexual transmission of HIV.

Long-term effects can include impact on HIV and AIDS trends, sustainability issues, and improved societal response. It is recognized that one of the most difficult questions to answer in any evaluation is that of attributing any measured effect to the programme being evaluated.

A review of the published peer-reviewed and non-peer-reviewed literature has revealed some evidence of peer education’s effectiveness in certain populations and contexts. When asked why they use peer education, participants in the review stated that it is an effective strategy, although not all programmes represented had outcome data to support their perception of peer education’s effectiveness for their intended audience. This is the case with the TWC programme.

### 3. Findings: Effectiveness: Together We Can

Overall, the total number of peers reached by TWC through the four blocks in the *Peer Educator Activity Book* during the period January 2008 – March 2009 in the six evaluation sites is 16,806 (see Table 3 below)



**Table 3: Peers reached**

Country	# peers reached
Belize	494
Guyana	1,994
Haiti	5,475) <sup>7</sup> <sup>8</sup>
Jamaica	7,843
St. Lucia	Not available
Trinidad and Tobago	1,000

Statistical data is collected and analyzed as follows:

- **Haiti and Guyana:** Quantitative data related to the knowledge, attitudes and skills is collected through pre and post-tests with a sample of **peers reached** and of all **peer educators**. Data is analyzed and overall statistical information presented in annual reports. [As far as the additional component of peers reached reaching their own peers in the community, this is not monitored.]

It should be noted that as part of the process of winding up the projects in Guyana and Haiti in June 2010, the American Red Cross intends to evaluate the TWC programme model and the performance of the TWC programme in achieving the programme's goals and strategic objectives. This will be achieved through the use of qualitative methods, i.e. in-depth interviews and focus group discussions.

- **Belize:** Quantitative data related to the knowledge, attitudes and skills is collected through pre and post-tests with all **peer educators**. Data is analyzed following an individual training and statistical information related is presented in the report of each training. Belize does not collect data in relation to peers reached.
- **Jamaica, St. Lucia and Trinidad and Tobago:** Quantitative data related to the knowledge, attitudes and skills is collected through pre and post-tests with all **peer educators**. Though these are analysed by the trainers in order to guide the training agenda, by ensuring that gaps are identified, myths, misinformation and misconceptions are corrected, they are not analysed and presented as statistical data. Jamaica, St. Lucia and Trinidad have not collected data in relation to peers reached.

No National Societies have measured changes in behaviour by having an intervention group and a control group.

### **3.1: Guyana: Peers reached: Quantitative data**

In Guyana, as far as peers reached are concerned, data analysis of pre and post-tests administered by peer educators to peers reached (during the first and last days of TWC workshops during the period November 2008 and September 2009) indicated the following

- **Knowledge:** That the greatest gains occurred in knowledge, showing an increase of 100% for females and 144% males.
- **Attitudes:** For females there was a 27% increase in relation to the statement "HIV+ female teacher allowed to teach in school; for males the increase was 51%.
- **Self-efficacy:** The stated increase in ability to negotiate abstinence was 10% in females and 22% in males. The stated increase in the ability to negotiate condom use was 4% in females and 13% in males.

Guyana also administers pre and post-tests at follow-up interventions. Follow-up interventions are design to booster effect, particularly around self-efficacy and skills. These follow-up intervention tests shows higher pre-test scores compared to the initial TWC curriculum pre-tests, which would suggest some retention of what was learnt during the TWC sessions. However, the extent of this retention is low given that Follow-up 1 pre-test scores are lower than TWC post-test scores. There

<sup>7</sup> Youth are also reached through peer-to-peer-homework assignments (31,508: January 2008 to March 2009

<sup>8</sup> This figure increased to 12,706 for the six months April to September 2009.

was also a decline in males' perceived ability to negotiate abstinence and condom use from Follow-up 1 pre-test to Follow-up 1 post-test.

### **3.2: Haiti: Peers reached: Quantitative data**

In Haiti, as far as peers reached are concerned, data analysis of pre and post-tests administered by peer educators to peers reached (during the first and last days of TWC workshops during the period October 2008 and July 2009) indicated the following:

- **Knowledge:** That the greatest gains occurred in knowledge, showing an increase of 148% for females and 128% males.
- **Attitudes:** For females there was a 62% increase in relation to the statement "HIV+ female teacher allowed to teach in school; for males the increase was 43%.
- **Self-efficacy:** The stated increase in ability to negotiate abstinence was 25% in females and 48% in males. The stated increase in the ability to negotiate condom use was 10% in females and 7% in males.

Haiti also administers pre and post-tests at follow-up interventions. The follow-up intervention tests for Haiti shows higher pre-test scores compared to the initial TWC curriculum pre-tests, which would suggest some retention of what was learnt during the TWC sessions. However, the extent of this retention is slow given that FU1 pre-test scores are lower than TWC post-test scores. There was also a decline in males' perceived ability to negotiate abstinence and condom use from Follow-up 1 pre-test to Follow-up 1 post-test.

### **3.3: Guyana: Peer educators: Quantitative data**

As far as peers educators are concerned, data analysis of pre and post-tests administered at the training of peer educators (October 2007 to August 2008) showed that in Guyana

- **Knowledge:** The greatest gains occurred in knowledge with comprehensive correct knowledge for both genders showing an increase of over 100%.
- **Attitudes:** Accepting attitudes towards HIV positive individuals also improved.
- **Self-efficacy:** TWC Workshops improved stated abilities to negotiate condom use, with a 14% increase in the stated ability of females to negotiate condom use and a 17% increase in the stated ability of males to negotiate condom use. In the case of female respondents, there was a 10% increase for negotiating abstinence, while the increase for males was only 4%, although this figure reflected an improvement from results seen at the midyear point.

### **3.4: Haiti: Peer educators: Quantitative data**

In Haiti, data analysis of pre and post-tests administered at the training of peer educators (October 2007 to August 2008) indicated that:

- **Knowledge:** The greatest gains occurred in knowledge, showing an increase of over 160%.
- **Attitudes:** Accepting attitudes towards people living with HIV improved.
- **Self-efficacy:** The stated ability to negotiate condoms increased by 14% in females and 8% in males. As far as abstinence is concerned, the stated ability to negotiate abstinence increased by 31% in females and by 2% in males.

### **3.5: Belize: Peer educators: Quantitative data**

Quantitative data was provided from pre and post-test information obtained from a training of peer educators in 2007, which indicated a marked improvement in three statements related to attitudes. For example, "I am willing to sit next to a person who has HIV". Although the numbers are too low to be statistically significant and there was a 40% difference in pre and post test samples, they provide a snapshot of the positive outcome of a typical peer educator training.

### **3.6: Jamaica: Peer educators: Qualitative data**

In Jamaica, data obtained at peer educator training through pre and post-tests is not currently analyzed. However, limited qualitative data that indicated effectiveness was available. For example, at a workshop held in 2007 at a Technical High School, camp setting, youth were provided with the opportunity to speak privately with Instructors about their non-sex lives or active

sex lives. In, 2009, youth “A” and “B” from that workshop related that “A” decided to not have sex after talking with her boyfriend about his expectations from having sex and realizing that it would not make them closer. Youth “B” who was worried that she might be pregnant, got information about the department of a health clinic that deals with youth related health issues. She is now practicing secondary abstinence and has chosen not to have unprotected sex when she decides to have sex again.

### **3.7: Haiti and Jamaica: Peers reached: Qualitative data**

Though it is recognised that information from focus group discussions is not statistically significant, information gained from a small number of peers reached would indicate that the programme has, had an impact. On being asked, “Overall, how useful was this programme for you?” peers reached stated the following:

*“If it were not for the TWC programme maybe I would have had sex by now”.*

*“It has influenced me to abstain from sex and to pass on information on to my friends. It has expanded my vocabulary in relation to ‘abstain from sex’”.*

*“I have learned how to protect myself. If I have sex I should use a condom”.*

*“We talked about having sex for an offer. It happens a lot”.*

*“Before TWC I did not know that someone who is big and fat and has nice hair could have HIV. Now I know differently”.*

*“Before the TWC programme, I was afraid of people living with HIV and of mystery deaths, but after having gone through the programme [realise that] you can live, eat and talk with people with HIV. Before you get married, you should have an HIV test.”*

In Haiti, Field Managers reported that youth in their communities testified that their lives have changed after being part of the programme. A principal in Haiti reported, “Youth have become more responsible. Before the programme, there were a number of teenage pregnancies but now the youth are more responsible”.

Peers reached in Haiti responded positively to the idea of their peers educating them about HIV

*From my experience, the peer educators do not scold us. It is good for youth to tell us about the body and how pregnancy starts, without yelling at us.*

*It is a great occasion and a great advantage to have youth training youth. We get to share and sharing ideas is a great advantage.*

*It was good. I identified with the trainers.*

### **3.7: Haiti: Peer educators: Qualitative data**

Information gained from peer educators in Haiti was more substantive than was obtained with peers reached and included:

*“I was bought up in a vagabond type family – always had girlfriends. My brothers came into town and introduced me to a flight attendant. My brother got a room in a hotel and I would have had sex but because of TWC I did not have sex. If it was not for TWC, I could have been a father by now”.*

*“The boys frequently hit upon me. I am now able to distinguish the boys or young men that are genuine and those that are offering things simply for sex.”*

*“The programme has enabled me to practice abstinence and given me an aptitude to manage a group and stand in front of a group and to manage my life” [male]*

*“Before the programme, I used to chase girls. I have now learned to respect women. My friends have noticed a change in me. I am no longer vulgar. My friends say who would ever think that ..... is giving them advice. Psychologically I feel mature and have a different attitude to life.”*

*“It has been useful for me as it has helped me change my behaviour and to learn certain things I did not know, e.g. I would not have been close to a PLHIV but now know not to discriminate. I*

*have also learned better how to protect myself from HIV. Now I am knowledgeable and able to share this with my peers.” [female]*

*“I did not know the family planning methods. I am now able to share this with other youth and to be a leader in my community.” [male]*

*“Before the programme I thought that having several girls was cool. I now practice secondary abstinence.”*

*“Before the programme my behaviour was inappropriate. Since I have been through the programme, I have learned that a PE is a model so have changed my behaviour” [female]*

*“Before, when I found myself in a difficult situation, I did not know how to deal with it. SOCA [a decision making model promoted by TWC] has helped me manage.”*

### **3.8: Implementation of Together We Can**

TWC is a curriculum-based programme and for maximum effectiveness, all Blocks within the *Peer Educator Handbook* need to be covered with peers reached. However, interviews with peer educators and their supervisors indicated that the whole curriculum was not always covered.

At a school in Trinidad and Tobago, in which 24 peer educators took part in a focus group discussion, when asked about their roles and responsibilities, one of them responded that, “A particular year is targeted and they get a 25 minutes sessions in the library.” In this instance, the teacher responsible for the programme reported that the school had received its own funding to train the peer educators but wanted more administrative and technical support to implement the programme. No TWC trainer or staff member was involved in the implementation of the programme in the school.

Another peer educator, aged 11, reported that she educated peers up to the age of 15 years on her own. She commented that she had been asked “lots of questions” and did not know what was right or wrong. Her peers said that she “talked like a parrot” and a number did not continue with the sessions.

In Jamaica, two peer educators, one of whom had been a peer educator for five years and was now a National Trainer, described a “pick and mix” approach. “We ask the peers what they want to know or we decide which blocks to do with them.” The peer educators reported that there were too many activities in the Blocks and it took too long. Another in-school group of peer educators in Jamaica reported that they carried out their peer education sessions with family, friends and neighbours. They did not necessarily use the full curriculum.

Whilst it is recognised that these are small samples, it is nevertheless information that needs to be taken into account when measuring the overall effectiveness of the programme.

One e-mail respondent commented that, “TWC has proved to be an expensive, labour intensive programme with a very high turnover of persons trained and requires a person on staff to maintain the continuum of training - a condition we are not in a financial position to maintain!”

### **4. Conclusions: Effectiveness: Together We Can**

Peer education programmes need to set realistic behaviour change goals that take into account challenges faced by the intended audience, including where peers reached are on the behavior change continuum. Overall, the TWC programme curriculum takes into account the needs of those who are sexually active and those who are not yet in a sexual relationship, through the promotion of condom use, mutual fidelity if sexually active and abstinence. However, it does not fully address some of the challenges of modern day life, for example sexual relationships with an older person in return for money, goods, favours or protection.

Overall, the effectiveness and impact of the TWC programme has been challenging to evaluate, with only Haiti and Guyana producing quantitative data to measure the overall effectiveness of the programme in relation to peers reached.

In relation to peer educators, quantitative information from pre and post-tests of peer educator training in Haiti and Guyana, would indicate that within those settings the programme has been

effective, particularly in relation to knowledge and attitudes, although less effective in relation to self-efficacy. Additional time in the curriculum needs to be allocated to issues associated with negotiation, “saying no”, negotiating mutual fidelity and condom use. Qualitative data from gained from peer educators in Haiti emphasizes the positive impact that the programme has on peer educators. Although, not statistically significant, quantitative data related to peer educators in Belize would indicate that the programme is effective. No quantitative data is available from Jamaica, St. Lucia and Trinidad and Tobago.

In order to ascertain overall effectiveness of a peer education programme, it is important that the quality and scope of activities delivered by peer educators are routinely and robustly monitored and that a checklist is provided to assist with this. In some sites, it was ascertained that peer educators were not routinely monitored.

The way in which some peer educators manage the implementation of the TWC curriculum, i.e. adopting a “pick and mix” approach to sessions implemented with peers reached will affect its overall effectiveness as it is a curriculum which is designed to be delivered in total.

## **5. Recommendations: Effectiveness: Together We Can**

If a comprehensive review of a programme’s effectiveness is to take place, data collection, in particular, needs strengthening. The way in which supervision occurs in some locations, also needs to be strengthened. It is, therefore, recommended:

- That peer educator sessions are routinely monitored and that a checklist is provided to assist with this (see Appendix 3: Sample Observation Checklist)
- That the peer educator activities related to self-efficacy are strengthened through the allocation of greater time and discussion to the issues of negotiation
- That in any HIV prevention programme that a greater emphasis be placed on data collection in relation to the knowledge, attitudes and self-efficacy of the target group and that staff receive training in data collection, analysis and dissemination
- That any peer educator training emphasise that peer educators should cover the whole curriculum, whilst recognising that there may need to be greater emphasis on some parts to take the needs of the target group into account
- That adult leaders and teachers in a supervisory role are appraised of the fact that there is an expectation that peer educators will cover the whole curriculum
- That National Society staff or volunteers who conduct field supervision be encouraged to check with peer educators and peers reached about their use of the *Peer Educator Handbook* and the *Activity Kit*

## SECTION 6: INTEGRATION WITH OTHER RED CROSS PROGRAMMES AND BUILDING CAPACITY IN NATIONAL SOCIETIES

### 1. Findings: Integration

Some TWC peer educators are recruited from amongst existing volunteers within the youth programme, whilst others are completely new to the Red Cross. Some peer educators very much saw themselves as Red Cross volunteers. However, others saw themselves as TWC volunteers.

In all evaluation sites peer educators and staff and senior volunteers reported that as a result of the knowledge gained through the TWC training, TWC peer educators played a valuable part in other HIV and other programmes. These included work such as the promotion of VCT, anti-stigma campaigns, health fairs, information sessions e.g. workplace sessions or PTA or community meetings and community outreach sessions. Work was also undertaken with other Red Cross youth groups and with Club 25.

The evaluation revealed that following their involvement with TWC many youth became active volunteers within the youth programme. However, the evaluator did not obtain figures for the number of those who became volunteers.

### 2. Findings: Capacity Building

As far as capacity building is concerned, Output 4 of the Global Alliance relates to “strengthening National RCRC Society capacities to deliver and sustain scaled-up HIV programme” through

- Improving governance, accountability and leadership of RCRC National Societies for discharging planned commitments
- Improving volunteer and staff support and management
- Strengthening programme cycle management

Although not directly attributable to TWC, Global Alliance National Societies have strengthened or intend to strengthen their capacity in a number of ways. For details of this, see Table 4 below:

**Table 4: Strengthening National Society capacity**

<b>Improving governance, accountability and leadership of RCRC National Societies for discharging planned commitments</b>	
<b>Belize</b>	<ul style="list-style-type: none"> <li>• Build capacity of Central Executive through Governance training</li> <li>• Strengthen branches through training in leadership, volunteer management, fundraising and financial management to support the National Society</li> </ul>
<b>Guyana</b>	<ul style="list-style-type: none"> <li>• Create a five year strategic plan for the National Society</li> <li>• Disseminate information to GRCS governance and management to increase their awareness of Red Crescent programmes and build a well-functioning National Society</li> <li>• Regularise Red Cross branches to support implementation of the Global Alliance programme</li> </ul>
<b>Haiti</b>	<ul style="list-style-type: none"> <li>• Conduct review of HRC Governance accountability and leadership</li> <li>• Sensitize and build capacity of governance through workshops</li> <li>• Apply the well functioning branch and NS tool kit</li> <li>• Create and establish a system of management which facilitates relationships between Program Managers, Regional Branches and the Central Office for the communication of technical direction, policies, responsibilities and sanctions</li> <li>• Monitor and evaluate HRC governance accountability and leadership</li> </ul>

<b>Jamaica</b>	<ul style="list-style-type: none"> <li>• Conduct a review of governance and management structures and systems</li> <li>• Monitor and evaluate in a systematic manner governance, management and accountability</li> <li>• Continue the application of the well functioning branch and National Society tool</li> <li>• Enhance management system to facilitate direct and intimate relationships between branch directors and the office of the Director General for the communication of technical direction, policies, responsibilities and sanctions</li> <li>• Define and calibrate the distinctions and expectations of management and governance</li> <li>• Sensitise and build capacity of governance through training</li> </ul>
<b>Improving volunteer and staff support and management</b>	
<b>Belize</b>	<ul style="list-style-type: none"> <li>• Develop and implement orientation for all staff and volunteers on the structure of the Red Cross and Red Crescent, dissemination of principles and values, and basic knowledge of current programs</li> <li>• Recruit Volunteer Coordinator to ensure accurate coordination of volunteers countrywide</li> <li>• Utilising the Volunteer Management Toolkit, design and implement initiatives to attract and retain volunteers to the National Society</li> <li>• Build capacity for program staff and volunteers through training in relevant fields;</li> <li>• Implement database to record volunteer profiles</li> <li>• Design and implement staff exchange program with other Caribbean countries participating in Global Alliance</li> <li>• Recruit full time PLHIV Program Assistant to assist in implementation and monitoring activities</li> <li>• Recruit communication officer to coordinate all media campaigns and manage the profile of the National Society</li> </ul>
<b>Guyana</b>	<ul style="list-style-type: none"> <li>• Fill position of volunteer coordinator that will spend 50 per cent of his/her time on the volunteer management system to support the implementation of the HIV programme</li> <li>• Review and disseminate GRCS policies (health, blood, HIV, First Aid);</li> <li>• Implement volunteer management toolkit</li> </ul>
<b>Haiti</b>	<ul style="list-style-type: none"> <li>• Elaborate and implement a workplace code of conduct</li> <li>• Disseminate code through General Assembly and employee/ volunteer meetings</li> <li>• Develop and maintain a data base network of all HRC staff and volunteers</li> <li>• Develop an incentive package for HRC volunteers</li> <li>• Develop and implement a volunteer management unit to include hiring of volunteer coordinator</li> </ul>
<b>Jamaica</b>	<ul style="list-style-type: none"> <li>• Retain existing programme staff</li> <li>• Hire additional staff for scaled up activities</li> <li>• Build the capacity of programme staff in each branch to support volunteer management</li> <li>• Enhance volunteer manual facilitating clear outlines of expectations, targets, responsibilities and sanctions</li> <li>• Enhance and disseminate existing employee manual</li> <li>• Continue capacity building training for staff and volunteers in result based management, theoretical frameworks and models, and evidence based strategies to effectively deliver programmes</li> <li>• Set up programme/fund that provides loans to staff and volunteers for formal education</li> <li>• Continue to provide incentives for volunteers and staff in the HIV Programme;</li> <li>• Enhance and utilise volunteer database</li> </ul>
<b>Strengthening programme cycle management</b>	
<b>Belize</b>	<ul style="list-style-type: none"> <li>• Host regular trainings on program cycle management for governance, staff and volunteers</li> </ul>

<b>Guyana</b>	<ul style="list-style-type: none"> <li>• Staff and key volunteers will be trained in planning, monitoring, evaluations and reporting (PMER) and project management.</li> </ul>
<b>Haiti</b>	<ul style="list-style-type: none"> <li>• Retain existing program coordinator, and field managers to cover North, North-East, and West areas</li> <li>• Hire additional field managers for program expansion to cover North-West, South, and Central areas</li> <li>• Provide training to program managers based on a needs assessment</li> </ul>
<b>Jamaica</b>	<ul style="list-style-type: none"> <li>• Streamline programme management meetings with branch directors and programme staff</li> <li>• Empower management and volunteers in new parishes to initiate HIV programmes in a structured and systematic fashion</li> <li>• Enhance process and outputs of the departments and core management</li> </ul>

### 3. Conclusions

Within the time allowed, it was challenging to comprehensively address the extent to which TWC was integrated into other National Society programmes. However, the evaluation revealed that TWC peer educators did play a valuable role in National Society HIV programmes beyond TWC. A review of the curriculum did, however, show that the TWC peer educator Training does not include any orientation to the Red Cross Red Crescent and its guiding principles nor to the role that volunteering plays within the Red Cross Red Crescent.

Although not entirely attributable to TWC but to HIV programmes overall of which TWC is the major component, the way in which the capacity of Global Alliance National Societies had been built was evidenced by the different activities being undertaken in relation “strengthening National RCRC Society capacities to deliver and sustain scaled-up HIV programme”. St. Lucia reported that organisational capacity had been built as the National Society now had National and Regional HIV Trainers. No information was forthcoming from Trinidad and Tobago.

### 4. Recommendations: Integration and building capacity

- That peer educator training include a brief orientation to the Red Cross Red Crescent, its guiding principles and the role that volunteering plays.



## **SECTION 7: RELEVANCE OF TWC**

The relevance of TWC is addressed through three separate sections

**Section 7.1:** Relevance: Is the methodology responding to local epidemic situations

**Section 7.2:** Relevance: Is the curriculum relevant

**Section 7.3:** Relevance: How does TWC fit in with national responses to HIV prevention education

### **SECTION 7.1: RELEVANCE: IS THE METHODOLOGY RESPONDING TO LOCAL EPIDEMIC SITUATIONS**

Overall, TWC provides in-school youth and youth in formal groups with an opportunity to meet outside the conventional setting of a classroom or church. It allows youth to interact, to learn and share information and to talk with people who can be trusted to give objective information for informed decision making.

Assessing relevance also involves an assessment of whether the methodology is targeting those most vulnerable to HIV within the Caribbean context.

#### **1. Overview: Vulnerable populations**

According to UNAIDS, sex workers, MSM, injecting drug users and prisoners have a higher prevalence of HIV infection than the general population. These groups are particularly vulnerable because they are often hard to reach, stigmatized, discriminated against, and associated with activities that are criminalized in some instances, and their human rights are often abused. These populations are often excluded from sexual and reproductive voluntary counselling and testing (VCT) and other welfare services. Often they exclude themselves out of fear. Women who are marginalized from society, such as female sex workers are even more vulnerable.

The Global Alliance on HIV and AIDS 2007 recognised that “to be effective national societies also need to gain the trust of and fully involve other key vulnerable populations often beyond their current comfort zone, such as injecting drug users sex workers and men who have sex with men.”

However, it is also recognized that in addition to key populations, attention needs to be paid to the following:

##### **1. People living with HIV**

*The vast majority of people living with HIV (PLHIV) are not aware of their HIV status. As a result, they do not seek treatment and are not motivated to change behaviour.*

##### **2. People with sexually transmitted infections (STIs)**

*People with STIs are at risk of HIV. In low-level epidemics, reducing the rate of untreated STIs is a key HIV prevention strategy.*

##### **3. Women and girls**

*The effects of gender inequality result in women and girls being more at risk of exposure to HIV. Girls and women often have less access to education, health information and services. They lack decision-making skills and power and have fewer economic openings.*

##### **4. Young people and children**

*Young people aged 15 to 24 years account for an estimated 45 per cent of new HIV infections worldwide and many young people still lack accurate information on how to avoid exposure to the virus. Some children are particularly vulnerable to HIV and should be given priority. These include:*

- i. Out-of-school girls, especially those aged 10 to 16 years living apart from their families
- ii. Street children
- iii. Children in the care and justice system
- iv. Economically and sexually exploited children
- v. Children living in extreme poverty
- vi. Disabled, migrant, minority and indigenous children

## 2. Local epidemic situation

UNAIDS cites heterosexual transmission, often tied to sex work, as the primary source of HIV transmission in the Caribbean. The recent IFRC report mentions that even if many countries in the Americas can be considered as having low level epidemics among the general population, prevalence rates among highly vulnerable communities such as MSM, prisoners, sex workers and injecting drug users are typically very high, going over 5%. It also names other most-at-risk populations such as vulnerable young people, migrants and displaced people.

As far as youth are concerned, a 2002 school-based survey covering nine Caribbean countries<sup>9</sup>, asked 15,695 students from 10 to 18 years old to fill out confidential questionnaires on behaviour that might affect their health. The survey found that 22% of the girls and 52% of the boys had had sex and that of these, 10% of the girls and 33% of the boys had had six or more sexual partners.

## 3. Findings: TWC and vulnerable populations

The overwhelming majority of TWC work is with in-school youth and to a lesser extent with formal out-of-school groups, such as the Scouts, sports groups, community clubs and youth groups from faith-based organisations.

National Societies use or have used the TWC curriculum or parts of the curriculum with key vulnerable populations, including MSM and with other vulnerable youth in formal settings. For example

### 3.1: Belize Red Cross

- Conducted TWC in prisons
- Used TWC with the community policing unit to support them in conducting community sessions with the "ballers" on the streets in areas that the police department consider to be a high risk for crimes.

### 3.2: Guyana Red Cross

- Conducted a small number of TWC interventions with the *New Opportunity Corps* for juveniles (up to 16 years) committed to reform schools.
- Working with a partner organization has trained youth living with and affected by HIV as peer educators, who now are responsible for conducting peer education sessions with their peers.

### 3.3: Haiti Red Cross

- TWC has targeted non-traditional youths through IDEJEN, an NGO with a 12-month programme that targets youth with little or no education. It provides youth with a 6-month intensive education programme and a 6-month technical skills development in plumbing, carpentry and electrics.
- TWC also operates in hard-to-reach areas in rural zones and in highly unstable areas such as Cité Soleil. Here, the project has reached gang members among the numbers of at-risk youth it serves and the same gang members allow the National Society's peer educators and volunteers to conduct educational activities with local youth.
- A component of the current TWC programme is "Inter-personal community events", including work in resource-constrained and unstable communities. These are one-off one-to-one street outreach through which young people go door-to-door using a brochure as a launching point. The brochure includes messages from a well-known male actor and a female singer related to risk situations.

### 3.4: Jamaica Red Cross

- Recognises that if working in a resource-constrained community, the chances of accessing youth who are vulnerable because of poverty, violence or living in abusive households are increased. For example, undertake TWC peer educator training through an inner city counselling centre in a resource-constrained community.

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<sup>9</sup> Antigua, Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica, and St. Lucia

- TWC also works with local NGOs, Rise Life Management and Children First who work with vulnerable youth. JRC trains some of their youth as peer educators who in turn train peers.
- JRC also runs a school that brings together vulnerable youth from the local communities. JRC TWC programme ensures that the pupils are participants in the programme, either as peer educators or as peers reached.

### **3.5: St. Lucia Red Cross:**

- In 2004, SLRC implemented TWC with United and Strong an NGO representing the LGBT community
- In August 2009, the SLRC worked in collaboration with the National Aids Programme Secretariat of St. Lucia, who also funded the project, to train Prison Officers, civilian staff and inmates within the Bordelais Correctional Facility. A total of 27 Prison Officers and civilian staff, including in-house medical staff and administrative staff, were trained. Eighteen inmates were trained. The group included remand inmates, inmates sentenced to life and model well behaved inmates. Out of all the participants, four from the civilian and prison officers were not certified as peer educators and in the group of inmates, two were not certified. While the civilian and prison officers group enjoyed the activities, it was recognized that they might find the activities a little difficult to use in their setting, although the games presented a great discussion point with potential peers. The inmate population found it easier to engage other inmates in the games but also saw them as great discussion points to facilitate the sharing of knowledge.

### **3.6: Trinidad and Tobago Red Cross:**

- Trained men from an organisation of MSM who in turn educated members of their organisation using TWC.
- Near peers educated male and female street children from Credo for Justice Foundation (male) and Sophie's house (female)

## **4. Findings: Other National Society work with vulnerable populations**

In recognition of the importance of targeting according to vulnerability, some National Societies have also worked or intend to work with vulnerable groups through other programmes. The following examples emerged from those National Societies involved in the evaluation

### **4a. Belize Red Cross**

- Worked with people in prisons and people living with and affected by HIV. The sessions were to further educate the groups on methods of protection as well as informing them of the various sexual and reproductive health services available and advocating for people to know their status, reduce their risk and pass on what they learnt.
- Expanded the Faces campaign to include vulnerable groups, MSM, CSW and at risk youth (teenage girls) through IEC for targeted vulnerable groups
- Networks with other organisations, including MSM
- Advocated for the implementation of life skills programmes for vulnerable youth

### **4b. Guyana Red Cross**

- Conducted some activities in prisons, particularly condom promotion
- Conducted HIV education and awareness, including condom promotion in a border community with soldiers
- Developing an education strategy for working with most-at-risk populations and positive prevention approaches

### **4c. Haiti Red Cross**

- Distributed condoms to high-risk targeted groups.
- Aims to conduct a needs assessment with commercial sex workers (CSWs) in order to ascertain the most appropriate intervention for this group, i.e. is it training CSWs as peer educators or re-orientation into different type of work or both.

- Trained volunteers to disseminate information and condoms to CSW

#### **4d. Jamaica Red Cross**

- Partner with organizations actively working with vulnerable groups;
- Currently working with young MSM using an outreach model of peer education that utilizes the AIDS Risk Reduction Model<sup>10</sup> (ARRM) approaches within a challenging environment. The Jamaican culture has always held and carried homosexual activity as deviant and antisocial behaviour, as such it is frowned upon and is punishable under the law to a maximum of 10 years imprisonment at hard labour.

The National Society has produced comprehensive *HIV and AIDS Peer Education Training Manual: For use in Targeted Interventions for Men Who Have Sex With Men*. This manual was created to provide a systematic guide for the training of Jamaican men who have sex with men, to become effective HIV and AIDS peer educators. It hopes to equip gay men with the knowledge and skills they need to prevent the transmission of HIV amongst themselves and women in the general population with whom they have sexual relations.

Peer educators are trained to conduct a two-off interaction. The primary interaction utilizes a peer risk assessment tool and takes approximately two hours to conduct. The secondary interaction is a follow-up that takes half an hour to an hour. Peer educators, who are expected to reach 10 peers, are provided with a manual to guide the interaction and receive a small stipend for each peer reached. The project has trained 22 young men, who have reached 200 peers. It is hoped that this number will ultimately increase to 400.

- Supporting PLHIV on positive prevention
- Working with orphans and vulnerable children with life skills education for HIV prevention

#### **4e. St. Lucia Red Cross**

- Have conducted HIV education sessions with marginalized young women who attend a development centre, which focuses on girls who have been sexually abused or need some form of protection.
- Have conducted HIV education sessions in a programme run by the Catholic Church, which provides technical and vocational skills to young men and women who have not been able to attain secondary school education or have performed poorly in the traditional secondary school system.

#### **4f. Trinidad and Tobago Red Cross**

- TTRC has implemented "Project Life", a prevention of mother to child transmission programme (PMTCT). This programme used volunteers to educate pregnant women and to assist in preparing HIV positive women to begin antiretroviral treatment. The programme complements the Ministry of Health Programme to address PMTCT

### **5. Findings: Factors that limit National Societies from using TWC to reach vulnerable populations**

From interviews and a review of the curriculum, it would seem that TWC is more appropriate for in-school youth and out-of-school youth in formal groups. However, this was not a view that was shared by everyone, with some staff saying that some vulnerable populations were a captive audience as they had little else to do and the issue was how to access the population rather than the content of TWC *per se*.

The following were cited as reasons for the non-involvement of vulnerable populations in TWC:

- For vulnerable groups, the structure of TWC is an issue. It requires attendance at between 14 and 22 activities according to site and vulnerable populations not always able to commit to this level of attendance.

<sup>10</sup> Introduced in 1990, AARM provides a framework for explaining and predicting the behaviour change efforts of individuals specifically in relationship to the sexual transmission of HIV/AIDS. A three-stage model, the ARRM incorporates several variables from other behaviour change theories, including the Health Belief Model, "efficacy" theory, emotional influences, and interpersonal processes.

- There is an over dependence on flipcharts and written materials and the programme does not, therefore, cater for youth who are non-literate or have a low level of literacy skills.
- The peer educator curriculum is demanding and can be at too high a level for some vulnerable populations. For example, in Haiti, twelve high-risk youth were trained as TWC peer educators but only two passed the assessment.
- The curriculum is appropriate for building based work with youth who belong to an existing group, e.g. a school or club. It is less appropriate, for example, for young taxi drivers, young internal migrant workers and street children who are not necessarily part of a building based group.
- It adopts a similar approach for all three age groups 10 – 14 years, 15 – 19 years and 20 – 24 years (although the Haiti version has side bars for 10 – 14 year olds), with no age differentiation
- There may be health and safety issues associated with targeting vulnerable populations *per se*, i.e. working in violent resource constrained settings
- Current TWC volunteers may not be peers of vulnerable populations and there may be issues associated with integrating volunteers into other communities
- Current model uses a captive audience in school or in existing groups, with less dependence on outreach skills
- Finding unattached youth (i.e. those who do not belong to clubs) is challenging and with TWC there is a need to find individual youth in quantities that would make a workshop sensible.
- Many vulnerable youth live in settings where “trust does not come cheaply” and are sceptical of anybody who comes in from the outside.

## **6. Conclusions: Increasing National Society capacity to work with vulnerable population**

**a. Relevance: Working with vulnerable populations:** The impartial image of the Red Cross in the Caribbean allows valuable work with vulnerable and marginalized groups to be undertaken by National Societies.

It needs to be recognised that not all youth are equally vulnerable to HIV. Some young people are more at-risk of HIV or are in situations of greater vulnerability, for example in Haiti HIV prevalence is nearly double for women aged 15-24 years who have a partner ten or more years older. In order to be more relevant in the prevention of HIV, it is, therefore, increasingly important that National Societies prioritize their target groups and focus interventions and resources where they are likely to have the greatest impact.

The current thrust with TWC is in-school youth in a range of schools. However, it would appear that no analysis is undertaken on which school populations may face heightened vulnerability and within a school, what segments of the school population are most vulnerable to HIV infection. It is important for National Societies to recognise that individual youth may live in significantly different peer cultures and that broadly focused interventions may have limited success when youth in reality divide themselves into discrete subgroups with different norms and leaders. It is, therefore, important to take a decision on what segments of the youth population need to be targeted by an HIV prevention programme.

It is vital to work directly with most-at-risk populations to try to prevent further infections. For example, surveys throughout the Caribbean have identified extremely high infection rates among sex workers, with the sex work scene changing continuously, peer education models and programmes should be continuously adapted to these changes. In addition to sex workers, emerging evidence from the Caribbean indicates that substantial transmission is also occurring among MSM, with the stigma associated with homosexuality impeding HIV prevention initiatives with this target group.

In addition to HIV prevention activities and of equal importance is the need to address vulnerability by advocating on behalf of the most vulnerable communities confronted with the threat of HIV, improving access to services and reducing stigma and discrimination.

If National Societies are to increase their work with vulnerable populations, it is important to understand the local specificities of the HIV pandemic. This can be achieved through a situation

analysis. Chapter 4 of *HIV prevention: Principles and guidelines for programming* recently produced by the Federation may help with this.

The NGO Code of Conduct Checklist on Key Populations (<http://www.hivcode.org/silo/files/key-populations-oct-08-.pdf>) includes questions to assess whether an organization is effectively addressing key populations within its HIV programme (see Appendix 4: The NGO Code of Conduct Checklist on Key Populations).

One way of ensuring a greater impact of HIV prevention programmes is focussing on areas likely to have a higher incidence of infection. The Priorities for Local AIDS Control Efforts (PLACE) method is a monitoring tool to identify areas likely to have a higher incidence of infection. (See <http://www.cpc.unc.edu/measure/publications> (search Haiti). Within these areas, PLACE:

- Identifies specific venues in which social and sexual networking occurs, coupled with high risk behaviour, where HIV prevention programmes should be focused to reach those most-at-risk of acquiring and transmitting HIV by targeting specific locations where youth congregate and find sexual partners
- Provides indicators that monitor HIV prevention programme coverage
- Identifies gaps in prevention programmes.

In studies that used the PLACE methodology, the study results effectively mobilized local populations to make progress in addressing gaps in prevention programmes. It needs, however, to be recognized that the method is site dependant and that it may not be safe for volunteers to be out at night in entertainment areas without proper supervision and without a vehicle.

## **7. Recommendations: Working with vulnerable populations**

- That National Societies segment their in-school and out-of-school target population according to who is most vulnerable to HIV infection and actively seek new vulnerable populations.
- That the Federation Secretariat conducts through e-mail, a learning needs assessment of staff and appropriate volunteers in relation to working with vulnerable populations and that this assessment informs the agenda for a workshop on work with key vulnerable populations. At this workshop current best practice could be shared, both of using TWC with vulnerable populations and for the use of other models of peer education with vulnerable populations, for example the young men who have sex with young men peer education programme in Jamaica. Other models utilised by National Societies in the Americas and in other regions and current tools for accessing vulnerable populations could also be shared.

Starting points for involvement in such a workshop could be the Jamaican Red Cross, with its young men who have sex with young men project, Caribbean Vulnerable Communities (CVC) Coalition (<http://www.cvccoalition.org>), International HIV/AIDS Alliance Caribbean Office and Jamaica AIDS Support for Life (JASL) (<http://www.jamaicaaidssupport.com/>).

CVC is a coalition of community leaders and non-governmental agencies providing services directly to and on behalf of Caribbean populations who are especially vulnerable to HIV infection or often forgotten in access to treatment and healthcare programmes. The Coalition's objectives include developing and supporting culturally appropriate prevention programmes and models geared towards vulnerable populations

The Coalition work with groups including MSM, sex workers, people who use drugs, orphans and other children made vulnerable by HIV, migrant populations, ex-prisoners, and youth in especially difficult circumstances. The Coalition has about ninety members from across the Caribbean, and work in, Antigua, Belize, Bahamas, Dominica, Jamaica, Haiti, the Dominican Republic, St. Lucia, Barbados, Grenada, Curaçao, Trinidad and Tobago, Guyana, Puerto Rico, St. Vincent, French Caribbean and Suriname.

JASL conducts peer education with vulnerable populations.

## **SECTION 7.2: RELEVANCE: IS THE CURRICULUM RELEVANT**

In order to further assess the relevance of TWC, it is necessary to assess the curriculum to see whether it reflects current HIV and AIDS information and whether is relevant to the lives of young people. Within the training framework, the following are trained:

- Regional Trainers
- National/Instructor Trainers or Field Managers (Guyana and Haiti)
- Peer educators
- Peers reached or Youth Multipliers (Guyana and Haiti)

This review, in the main, assesses the curriculum that peer educators use to train their peers. This curriculum is also in most countries used to train peer educators. This curriculum is contained in the TWC *Peer Educator Handbook* and *Activity Kit*. There is also a video. This was designed to reinforce the training of Instructor Trainers.

### **1. Findings: Regional Trainers**

In the past Regional Trainers were trained by the Faculty. Periodic workshops are held for Regional Trainers, the last of which was in November 2008. This workshop had the following objectives

- To train National Trainers from Red Cross societies from the Caribbean region to become regional trainers.
- To evaluate current Regional Trainers for re-certification.
- To review and make amendments to the TWC curriculum with the Regional Trainers.

### **2. Findings: Training: National Trainers and Instructor Trainers**

National Trainer and Instructor Trainers training takes between two days and two weeks and is led by a series of Power point presentations on the following:

- Adult Learning, Exploring Values, Understanding Behaviours – A Youth Centred Approach (16 slides)
- Communication (16 slides)
- Drivers of the Epidemic and Psychosocial Impact / Influence (10 slides)
- Facilitations Skills 101 Four elements of facilitation (8 slides)
- HIV and AIDS 101 (19 slides)
- Sexuality (16 slides)
- Understanding Barriers – Sensitive topics (7 slides)
- Understanding the Regional Training Structure (25 slides)
- Stigma and Discrimination (17 slides)

The training includes an opportunity to practice facilitation. In Trinidad and Tobago, a National Trainer reported that “real people” came in to be the participants in the teach-back sessions, rather than a simulation in the workshop setting and that this was valuable. In Haiti, extracurricular activities are a part of the training, including trust games and team building exercises. Field manager trainings last two weeks in Haiti, as field managers have added responsibilities such as managing and supervising peer educators, writing-up of technical/ finance monthly reports, managing project equipment and material, etc.

### **3. Conclusions and Recommendations: Training: Regional Trainers, National Trainers and Instructor Trainers**

Although Regional Trainers, National Trainers and Instructor Trainers (Field Managers in Guyana and Haiti) were interviewed as part of the evaluation, the review did not include an in-depth review of the their training. Within the time available, the evaluator took the decision to concentrate on peer educator training and the activities conducted with peers reached.

From documents provided and from the interviews the training would appear to be comprehensive and participations in the review said that as a result of their training they were equipped to train others. No recommendations are made in relation to these trainings.

#### 4. Findings: Training: Peer Educators:

Though a document entitled *Guide for Training Peer Educators* (undated and with no author) encouraged National Societies to utilize a standard agenda for the initial peer educator training, it would appear that different curricula are used by different National Societies, with no standard length of initial training. Some National Societies use the TWC *Peer Educator Handbook and Activity Kit*, supplemented by Power Point presentations, to train peer educators, others use the *Guidelines for National Societies*.

Country	Curriculum	Length of training
<b>Belize</b>	Own curriculum using <ul style="list-style-type: none"> <li>○ Peer Educator Handbook + Activity Kit</li> <li>○ Supplemental information, including PowerPoint presentations</li> </ul> Includes session on monitoring and Evaluation	3 days
<b>Guyana</b>	Guide for Training Peer Educators	Minimum of 30 hours and maximum of 40 hours
<b>Haiti</b>	Own curriculum using <ul style="list-style-type: none"> <li>○ Peer Educator Handbook + Activity Kit</li> <li>○ Supplemental information, including PowerPoint presentations (though not all peer educators concurred with this)</li> </ul> Includes session on monitoring and Evaluation	5 days
<b>Jamaica</b>	Guide for Training Peer Educators	2 days
<b>St. Lucia</b>	Own curriculum using <ul style="list-style-type: none"> <li>○ Peer Educator Handbook + Activity Kit</li> <li>○ Supplemental information, including PowerPoint presentations</li> </ul> Includes session on monitoring and Evaluation	3 days
<b>Trinidad and Tobago</b>	Own curriculum using <ul style="list-style-type: none"> <li>○ Peer Educator Handbook + Activity Kit</li> <li>○ Supplemental information, including PowerPoint presentations</li> </ul> Includes session on monitoring and Evaluation	4 days

Peer educators, in the main, reported that they were given enough information to train their peers. However, one group of those who received two days training commented that they were given “surface level information” and needed more information on different diseases, how you can contract them, their severity and treatment. However, another group in the same country commented, “it was just the right amount of information – perfect information.” An ex-peer educator who was now a trainer reported that as a peer educator she needed more information, that there was nothing on testing, ARVs and that there was a lack of information on symptoms of



different STIs. There was also nothing on forced sex and “offers in exchange for sexual favours” or that a recognition that girls can have other relationships. She also felt that there was a lack of age-related activities

## **5. Conclusions: Training: Peer Educators**

Over the years, each National Society has developed its own way of implementing TWC peer educator training. All, however, utilize teaching methods that are youth-centered, interactive, and participatory. The most common teaching methods include working in groups, brainstorming, role-playing, using case studies and participating in discussions following Powerpoint presentations. No individual curricula were available for review, other than the one used in Jamaica, the *Guide to Training Peer Educators* and National Societies’ agendas for peer educator training. However, what was ascertained is that the *Peer Educator Handbook* and *Activity Kit*, supplemented by PowerPoint presentations are the main methodology used. This may have its limitations, as there are areas of the *Peer Educator Handbook* and *Activity Kit* that need strengthening (see 9. below).

The *Guide to Training Peer Educators* recommends that the Peer Educators’ workshop is held over two weekends totalling 24 hours. The newly released Federations’ Standards for HIV peer education programmes recommends that peer educators receive a minimum of four to five days, initial training (Standard 7.7: Initial training). Three National Societies conduct their training in less than four days. Whilst it is recognised that this may be due to financial constraints, it is an area that needs consideration if peer educators are to have the necessary knowledge, attitudes and skills relevant to their responsibilities.

## **6. Recommendations Training: Peer Educators**

For recommendations related to the curriculum see 12 below. It is, however, recommended

- That individual National Societies give strong consideration to extending the length of peer educator training to four days

## **7. Background: TWC Peer Educator Handbook and Activity Kit**

The well-known TWC curriculum for training peers is laid out in the *Peer Educator Handbook*. It is the result of over fifteen years of use and adaptation. The concept of TWC dates back to the early 1990s. The Jamaican Red Cross, in partnership with the IFRC, held a workshop of about ten National Red Cross societies to review the Red Cross’ role in responding to a growing recognition of the need to tackle HIV among youth, particularly given its sexual spread and the lack of dialogue around reproductive health among youth and between generations.

While satisfied with the activities put together in the “Action for Youth” curriculum created by the IFRC, workshop participants cited a need for a less piece-meal and more systematic curriculum.

The American Red Cross’ *Act Smart* and IFRC’s *Action for Youth* inspired the initial multi-session curriculum entitled *HIV/AIDS Peer Educator’s Handbook – Action for Youth*. Having demonstrated success, the American Red Cross and Family Health International supported the field-testing, revision and Caribbean-wide spread of what became known as the *Together We Can* (TWC) curriculum from 1993-1996. During this process, the Jamaican and American Red Cross societies revised, evaluated and field-tested the TWC programme and materials. Several Jamaican schools contributed through supporting peer educators; and several community based organizations served as sites for field-testing. The initial curriculum was intended for 15 to 19 year olds.

In 1995, a further “*Evaluation of Peer Education for HIV/AIDS Prevention by Young People in Jamaica*”, led to the adaptation of the programme and materials by a team, which included the Jamaican Red Cross, external support and the American Red Cross. Youth peer educators and adult leaders provided feedback during the field test of the “Together We Can” programme and materials.

Since the initial 1995 *Together We Can* version, several individuals and organizations have further refined and developed the programme and materials. This has been achieved with technical and financial support from organizations such as the Norwegian Red Cross in collaboration with the Norwegian Agency for Development (NORAD), UNICEF, the Jamaican Red Cross, the American

Red Cross, the Caribbean Epidemiology Centre (CAREC), Caribbean Regional Network of People living with HIV/AIDS (CRN+) and UNAIDS.

In 2002, the Red Cross Caribbean HIV/AIDS Network (CARAN) assumed coordination of TWC (from Jamaica Red Cross). The curriculum for peers was revised in 2003 and extended to 20 – 24 year olds. A further curriculum review took place in 2008, though no new curriculum has been printed. In addition to English, TWC has been translated into Creole, Dutch, Papiamentu, Spanish, French and Moldovan.

The Haitian version, *Ansanm Nou Kapab*, is the result of the translation and adaptation of *Together We Can* into Creole in Haiti in 2003, followed by further adaptations to the Haiti context the most recent of which took place in 2008, which was achieved with the support of the American Red Cross and financial support from PEPFAR.

In 2004, each National Society was tasked with looking at adapting the curriculum for early adolescents (10 -14 year olds). A guide for review of the curriculum for the 10 - 14 year age group was developed, offering suggested amendments to the curriculum, block-by-block and activity-by-activity. An adaptation workshop on the 10 -14 year olds curriculum was held in Port-au-Prince (partner NGOs and government agencies attended the workshop including the Haitian MOH and MOE, FOSREF and PSI). Among other issues, the topic of condoms came up in discussion about age-appropriate instruction. Condom demonstrations at this stage were reserved for the 15-24 year old group. Outreach is conducted with teachers to explain the programme and its contents.

One modification agreed upon was to ensure that out-of-school youth were exposed to condom use and negotiation. In 2005, the American Red Cross and the IFRC held a high level meeting at the IFRC regional office in Panama. There, both parties agreed to hire a consultant who would be tasked with producing a revised TWC curriculum in Creole for use in Haiti.

Decisions related to the *Peer Educator Handbook* and *Activity Kit* were taken at regional level through the Faculty.

## **8. Objectives: TWC curriculum**

The objectives of the TWC curriculum, specifically, are to provide youth with the opportunity to:

- Learn correct information about HIV/AIDS
- Examine their behaviour to determine their risk
- Support their peers in delaying and abstaining from sexual activity, reinforcing fidelity and teaching correct and consistent condom use when appropriate as effective strategies to reduce risk
- Develop skills to help maintain these safer sexual practices

Comments were made by those interviewed that the curriculum works best with 15 – 19 year olds and that there are challenges in using the curriculum with 10 - 14 year olds and 20 - 24 year olds.

## **9. Findings: Current status: TWC Peer Educator Handbook and Activity Kit adaptation (all countries except Haiti)**

The TWC curriculum underwent an extensive review in 2003 and a more recent review. The 2003 review occurred because the programme documentation needed to match the current reality in the world, whilst at the same time National Societies were adopting TWC using the Jamaican materials and wanted to create a standardized approach across the Caribbean. The Federation working with the Regional Faculty led this process. Those involved in the 2003 review included a representative from the Federation, one representative from the Dominican Republic and three from Jamaica. It could not be ascertained whether ToR were developed for this review.

The review included a workshop for representatives of HIV programmes across the region to explore how the TWC materials could be amended to take into account updated information, language and culture in order to make the materials appropriate for Caribbean-wide audience.

Changes were recommended and the TWC materials were updated, with the final edit being in the hands of the Federation representative. At this stage, a substantive new activity related to the

“family tree” was added but as far as could be ascertained, the final version was not field-tested. Regional Trainers then conducted workshops on the new materials.

The more recent review was conducted on behalf of all Caribbean countries that utilised TWC (except Haiti). A separate review was undertaken by the Haiti Red Cross TWC programme working together with the American Red Cross.

It was hoped that the more recent overall Caribbean review would address issues such as

- Terminology
- New scientific information
- Sessions that that peer educators had identified as challenging
- Making information more appropriate for the peers reached

At a workshop for Regional Trainers in November 2008, participants made suggested amendments to the *Peer Educator Handbook* and *Activity Kit*, including:

- Moving the human reproductive system to the beginning of the curriculum
- The addition of a fact sheet on STIs.
- The elimination of the family tree activity, which peer educators had found difficult to facilitate. In addition, the peers reached had found it difficult to grasp the concepts associated with this activity.
- Minor changes were also suggested for Activity 6 referred to as “Are You Racing towards HIV” along with improvements to the Snakes & Ladders board game for Activity 2.

The Federation then employed a consultant to collate the suggested amendments. A document was submitted by the consultant to the Federation (Appendix 5: New Information TWC Manual), which related to segments of new information being considered for addition to the TWC manual as follows:

- Antiretrovirals (ARVs), including a basic introduction and the importance of adherence
- Sexual and Reproductive Health and Rights
- Sexualities, including defining sexuality, sexual orientation, gender, gender identify, gender roles and gender roles stereotypes
- Communication and Facilitation Skills

A simple two-page narrative document was also produced (see Appendix 6: Amendments TWC curriculum), which gave directions as to the amendments that needed to be made but did not include the new information above nor the addition of a fact sheet on STIs.

Minor changes were made to the blocks. The overall revised version still contains four blocks as follows:

1. **Block 1:** Learning More about HIV, AIDS and STIs
2. **Block 2:** Our Values and the Risks of HIV and AIDS
3. **Block 3:** Avoiding HIV, AIDS, STIs and Pregnancy: Our Choices
4. **Block 4:** Practising Safer Sex

Of interest is a *Report on Field Testing of Proposed Activities*, which followed a meeting in Belize between representatives of TWC, the Federation and the Ministry of Education and a consultant. The report, which was submitted to the IECC – Information, Education and Communications Committee of the National AIDS Commission in Belize in August 2006, described field-testing two new activities with participants who had not previously participated in TWC training as follows:

- **Puberty:** An overview of adolescence, including a discussion and a quiz about puberty (what it is and its importance in human development). Participants in this field-testing, felt that it would be helpful to them if the all the major pubertal changes were included in the activity kit. They felt that the information was important to know and to have, as it could be used as a reference.
- **“Healthy VS Unhealthy” Relationships:** Focused on differentiating between some of the qualities of “Healthy VS Unhealthy” relationships, including abusive relationships. Many of the participants stated that they had not thought about some of the issues raised when

differentiating between the characteristics of healthy and unhealthy relationships. This was not included in the revisions.

It should be noted that the new curriculum has not yet been printed and that this is causing problems for National Societies who do not have peer educator handbooks or activity kits.

As far as relevance of the curriculum is concerned, one person interviewed by phone said “Some of the approaches within the manual are naïve, the kids themselves sometimes have a whole different reality and it does not prepare them for the harsh realities that they are now facing – we need to address their lifestyles.” In a face-to-face interview, a respondent commented, “Times have changed, we need to review the stories to reflect the real changes that are happening in the community. For example, girls are having anal sex to prevent pregnancy.” Another National Society contacted by e-mail wrote, “We have been of the view for some time now that the material is too juvenile for the older youth groups (realistically it is only suitable for the maximum age group up to 18 years).” In an in-depth interview another said, “TWC is relevant and serves the purpose for which it was intended that is HIV prevention for young people. However, we need to recognise that one programme will not address every young person’s needs. We need to look at creating other interventions for defined groups of young people.” Another respondent said, “No changes are needed to the curriculum. There is a need to balance what peer educators can handle. For example, in schools, peer educators may not be able to discuss issues such as transactional sex in a meaningful way. It will depend on the level of detail, bearing in mind conservative teachers, principals and guidance counsellors.”

One National Society contacted by e-mail felt that the curriculum was too prescriptive and may need to be scaled down to fewer sessions in order to increase participation.

#### **10. Findings: Current status: TWC Peer Educator Handbook and Activity Kit adaptation: Haiti**

In order to bring about a comprehensive review of the curriculum in Haiti, initially, a local consultant was appointed, who presented the following key observations to the Federation, American Red Cross, Jamaican Red Cross and Norwegian Red Cross. During an interview with the evaluator, the consultant recalled that:

- There was no overall philosophy guiding the programme
- There was a need for the inclusion of strong values to motivate youth and to bring about a belief that youth have the capacity to maintain positive behaviour or change behaviour but that in order to do this you need to observe certain rules.
- Too many colours at random, although a possibility aligning a purpose to the colours.

In 2007, the American Red Cross appointed a consultant to support the adaptation process in Haiti and to develop an adaptation guide/toolkit. In addition, the same local curriculum adaptation consultant who had made the initial observations was part of the adaptation team. The purpose of the adaptation process was in the main

- To improve curriculum responsiveness to the unique cultural and linguistic characteristics of 10-14 age group
- To review, simplify and translate take-home messages
- To incorporate referrals

The adaptation process was finally completed in February 2008 but released in its final version a year later and resulted in a curriculum that contained the following four blocks

1. **Block 1:** Who I am and what I want
2. **Block 2:** Risks to my body and my life goals
3. **Block 3:** Values that guide my decisions and my behaviour
4. **Block 4:** I choose to protect myself against STIs, including HIV, and unintended pregnancy and parenthood

Sessions related to values clarification, risk situations, skills building sessions and transactional sex have been updated or included. In addition to this, the new curriculum uses a Behaviour-Determinant-Intervention (BDI) model. Activities are based on the types of behaviors that should

be changed to reach specific health goals, with the model following the causal links between the TWC curriculum's activities and the curriculum's ultimate health goal. The TWC health goal is to reduce the incidence of HIV, STIs, and unintended pregnancy and parenthood. In order to demonstrate the links between curriculum activities and the health goal, the BDI model depicts the behaviours that impact the health goal as follows:

- Increasing abstinence
- Reducing the number of sex partners and increasing fidelity
- Increasing condom use
- Increasing use of reproductive and sexual health services.

The determinants (risk and protective factors) and the behaviours that they determine

- Knowledge
- Attitudes, perceptions, norms and values
- Skills and self-efficacy

The block approach to the curriculum has been retained but there have been changes in particular the inclusion of sidebars for amending sessions for 10-14 year olds to make them more appropriate. There would appear to be a small number of areas that would benefit from strengthening.

The adaptation process included representatives from the Department of Public Health and the Ministry of Health gave the curriculum its stamp of approval. However, those involved in the adaptation process reported that they were not provided with feedback on what had happened to their suggestions and asked whether it would be possible for a group from the department to observe a peer education session.

It should also be noted, that the initial field-testing of the new curriculum was unsuccessful. It was reported that the peer educators strayed too greatly from the curriculum, rendering a thorough review of all of the new curriculum content not possible to the extent desired. Therefore, field-testing was redone following refresher training for a different set of more experienced peer educators. This may have introduced an element of bias into the field-testing.

Interviews with Field Managers revealed that when the new curriculum is delivered by peer educators who are less experienced than those involved in the field-testing, some exercises take a significantly longer time to deliver, with the result that the overall curriculum takes longer to deliver. Schools allow for a 1-hour session and because sessions take longer to deliver, in order to complete the curriculum it may be necessary to increase the number of visits to one cohort of peers reached. It was reported that activities 4, 6, 7, 8, 9 and 10 take time and that with these activities in particular, peer educators can get lost and may not follow the order in the activity.

The HIV prevention youth project coordinator in Haiti commented that "the end result of the adaptation process is a comprehensive HIV prevention curriculum that promotes self esteem and values while enhancing analytical and communication skills through practical exercises that are highly structured with detailed information current on HIV&AIDS along with reproductive health.

The process was not necessarily the most efficient. Prior to its production, countless hours had to be spent on the actual adapted material to revise grammar and wording for clarity in order to convey desired notions. It is extremely important that an adaptation be lead by local technical experts who understand the culture and language while non-local experts can follow the process and provide technical advice. It is just as important that the consultant be engaged fulltime on an adaptation of this magnitude."

## **11. Conclusions: Curriculum adaptation (all countries except Haiti)**

There was no firm agreement amongst respondents on the relevancy of the TWC curriculum.

It is recognised that TWC is a generic peer education HIV programme and that there has been a recent review of the curriculum, with modifications suggested in relation to the use of appropriate language, deleting some activities that have not worked and moving exercises to blocks that are more appropriate. However, the curriculum as written needs strengthening to make it more

relevant. In addition, the curriculum does not reflect current information nor does it provide guidance on how to work with 10 -14 year olds.

## 12. Recommendations: Curriculum adaptation (all countries except Haiti)

It is recommended that, in order to make the curriculum more relevant that consideration is given to the inclusion of the following in any future HIV prevention curriculum. If it is decided to include these elements, it is further recommended that this be done by a technical expert in curriculum development to ensure that the content reflects current information and standards.

- **Antiretroviral (ARV) treatment:** ARV treatment is included in some peer educator training but is not included in either the TWC *Peer Educator Handbook* or the *Activity Kit*. This is an area that now needs to be addressed in the actual curriculum to encourage the uptake of ARVs by enabling programme participants to understand the role of ARVs in prevention, where ARVs can be accessed, how ARVs help people living with HIV and AIDS and caring for a person living with HIV who is undergoing ARV treatment, including the need for compliance.
- **Gender:** This is a curriculum area that needs strengthening to allow time for issues such as risk and community context issues, for example, sex for offers and managing risk to be discussed in single sex groups.
- **HIV and AIDS and STI information:** This is a curriculum area that needs strengthening. Information about HIV and AIDS is found in the answers to the Snakes and Ladders Game on page 8 of the *Activity Kit* and on page 45 of the *Activity Kit*. On page 12, there is a quiz related to sexually transmitted infections (STIs). Peer educators commented that they were given supplementary information related to HIV and AIDS as there is insufficient information in the TWC *Peer Educator Handbook* and in the *Activity Kit*. Similarly, there is a lack of specific information related to the overall symptoms of STIs, with only one symptom “problems taking a leak” being referred to in the quiz. Trainers reported that they used external materials to give peer educators more information on STIs but that neither the *Peer Educator Handbook* nor the *Activity Kit* included basic facts related to the overall symptoms of STIs.
- **Positive living:** Coupled with an understanding of ARVs, an activity related to positive living will enable programme participants to identify ways in which a person with HIV can live a positive life.
- **Prevention of mother to child transmission:** It was reported that peer educators are aware of this issue but that it is not in current curriculum. As nearly 20 percent of live births in the Caribbean and Latin American Region are by adolescent mothers and TWC is targeted at people up to the age of 24 years, the inclusion of information related to the prevention of mother to child transmission is imperative.<sup>11</sup>
- **Risk:** Peer educators and peers reached who were interviewed as part of the evaluation, rightly perceived risk as having sex without a condom. However, their perception of risk also included having a manicure and not specific risk situations such as having an STI, multiple and concurrent partners. Case studies, in the main, use situations in which the characters are of similar age and in a relationship and whilst this is relevant, consideration needs to be given to strengthening the sessions that are related to risk to include the following
  - **Forced sex:** The Caribbean-wide school based survey found that of those who had had sex, 48% of the girls and 32% of the boys said their first sex was forced or somewhat forced and not consensual. TWC sessions in Guyana highlighted the incidence of sexual abuse among children. Whilst it is recognised that addressing sexual abuse can be done through a separate initiative, at the very least, young people need to know where to go for support if they have been raped or sexually abused.

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<sup>11</sup> Fast facts on Adolescents and Youth in Latin America and the Caribbean, UNICEF, undated

- **Intergenerational sex:** The issue of sex with a person who is older is a risk factor. For example, in Haiti HIV prevalence is nearly double for women aged 15-24 years who have a partner ten or more years older (4.1% compared to 2.4%).<sup>12</sup>
- **Multiple and concurrent partners:** Multiple and concurrent partners can increase risk. For example, Population Services International (PSI) Caribbean in Trinidad and Tobago conducted formative research, which found that young women in the target group manage and maintain concurrent relationships in order to gain 'the look'.<sup>13</sup> A PEER Study carried out on young women and sexual relationships in Kingston Jamaica found that multiple partners were likely to be the norm and were a rational response to social and economic realities rather than being purely the result of individual behaviour preferences.<sup>14</sup> A study conducted by PSI of the Garifuna population in Belize found that 59% of men and 33% of women had had multiple partners in the last 30 days.<sup>15</sup> Partner reduction has been associated with declines in HIV at the population level in both concentrated and generalized epidemic settings. Though multiple partners are covered in two activities *Racing Towards HIV?* and *Some People We Might Know*, the case studies could be strengthened and more youth specific dealing with the real life situations that youth are currently facing (currently two out of the four case studies relate to married couples with the male having multiple partners).
- **Transactional sex:** This is a growing issue. For example, a 2009 study commissioned UNICEF on child sexual abuse in the Eastern Caribbean has discovered that the problem of transactional sex is escalating. Whilst recognizing that adult men commit the majority of child abuse, with most victims being girls, the study also indicated that the abuse of boys, mostly by men also, was a significant and growing problem. The study identified emerging forms of abuse, including the use of boys in an organized network to service cruise ship passengers.<sup>16</sup>
- **Sexual and reproductive health:** Diagrams are included in the *Peer Educator Handbook* but there is no actual activity related to this. Those who supervise peer educators said that some peer educators found this confusing. Mention is made of biological vulnerability but it is not addressed in any activity.
- **VCT:** Whilst it is recognised that different countries have different approaches to VCT and youth, this would appear to be an area that is not addressed in the current *Peer Educator Handbook* or the *Activity Kit*. Some peer educators or peers reached had not heard of VCT or testing for HIV.
- **Guidance on working with 10 – 14 year olds:** Guidance and appropriate case studies for 10-14 year olds or that the curriculum be for 15 – 19 year olds.

In order to support curriculum development, it should be noted that most recent and comprehensive publication that provides standards for youth sexual health education applicable to international settings is a paper by Senderowitz and Kirby (2006)<sup>17</sup>, which lists 24 standards for effective reproductive health and HIV prevention curriculum-based programmes (see Appendix 7: 24 Standards for effective reproductive health and HIV curriculum-based prevention programmes).

<sup>12</sup> ENQUÊTE MORTALITÉ, MORBIDITÉ ET UTILISATION DES SERVICES, 2005-2006, Ministère de la Santé Publique et de la Population (MSPP), 2006

<sup>13</sup> 'Money make the nookie go 'round': Young women and sexual relationships in two locations in Trinidad, Options Consultancy Services Ltd and Population Services International, December 2007

<sup>14</sup> Report of Findings from HIV/Aids Knowledge Attitudes and Behavior Survey, Jamaica, Hope Enterprises Ltd., 2008

<sup>15</sup> Multiple Partnerships and HIV among the Garifuna.

Minority Population in Belize, Population Services International, 2009

<sup>16</sup> Perceptions of, Attitudes to and Opinions on Child Sexual Abuse in the Eastern Caribbean, UNICEF, 2009

<sup>17</sup> Standards for Curriculum-based Reproductive Health and HIV Education Programs, Judy Senderowitz and Douglas Kirby, Family Health International, 2006

### 13. Conclusions: Haiti curriculum

TWC has undergone substantial adaptation, including:

- The addition of sidebars for amending sessions for 10-14 year olds to make them more appropriate
- The inclusion of case study related to transactional sex,
- The inclusion of an activity related to “My body”, which explains changes that occur during puberty, how male and female reproductive systems function and how pregnancy occurs from conception until birth.

However, case studies are still related to boyfriend/girlfriend rather than to some of the more challenging situations which youth face, with the exception of one case study related to transactional and intergenerational sex.

### 14. Recommendations: Haiti curriculum

It is recommended that consideration be given to the inclusion of the following in any future HIV prevention curriculum

- **Gender:** Though there has been some recognition of gender perspectives, e.g. particularly in the body mapping activity and in the condom negotiation activity, it has not been addressed in full.
- **Positive living:** (see above)
- **Risk** (inclusion of some of the more challenging situations which youth face)
- **STI information:** Though the solutions to the quiz give some information related to STIs “STIs can give infected persons rashes, pimples and inflammation, thick bleeding or fluids that release a strong odor, and make a person feel a burning sensation when they urinate”, this is an area that could be strengthened.

### 15. Findings: Video

In 2004, the Federation Health Delegate based in Panama, commissioned a video, which was funded by a US based youth organization called Common Cents and distributed/promoted in the region by the CRRO HIV Coordinator and Youth Officer. It was developed for Instructor Trainers to ensure quality control of the methodology. It was felt that a one-time training in country by Regional Trainers may not have lasting effects on all participants. The Health Delegate was concerned that as the TWC programme expanded across the region, the best trainers might not be available to go to each territory. A video would, however, serve as a reminder of the training process.

The video was discussed at meetings, including CARAN meeting. It was designed so that segments could be played during training. It features, amongst other things, a “how NOT to conduct sessions”, with the appropriate methodology shown after.

No National Societies were aware of this video, other than the Senior Director Youth & HIV/STI Programmes of the Jamaica Red Cross and the TWC National Youth Coordinator, Haiti Red Cross. The Haiti Red Cross, were unable to use the video as it was in English.

### 16. Conclusions: Video

Although designed to enhance the programme, it would not appear to be a cohesive part of the programme since 4 out of 6 of those with some responsibility for TWC were unaware of its existence. This could be because once produced it was not relevant or a lack of its inclusion in the overall documentation of TWC, i.e. as one staff member left his or her replacement had no knowledge of the video. There have been a number of changes of staff at the Federation and the evaluation has revealed that institutional memory within the CRRO needs strengthening.

### 17. Recommendations: Video

It is recommended that:



- Programme documentation at the CRRO is strengthened and a full package of tools related to any programme, i.e. training manuals, supplemental material and videos are housed together and are easily accessible by staff, volunteers and evaluators
- A list of TWC materials is created, so that new staff are orientated to the whole TWC package

### **SECTION 7.3: RELEVANCE: HOW DOES TWC FIT IN WITH NATIONAL RESPONSES HIV PREVENTION EDUCATION**

#### **1. Findings: National Responses to HIV prevention education in school**

A rationale for the introduction of TWC in the early 1990s was the lack of a dialogue around reproductive health among youth and between generations, coupled with a need to address HIV-related issues with Caribbean youth, particularly given the sexual spread of HIV. HIV was not a part of the school curriculum.

Typically, HIV information in schools is delivered through Health and Family Life Education. Information obtained from UNGASS reports (2008) in relation to the evaluation sites shows that for Belize, Guyana and Jamaica, HIV is part of the curriculum in primary and secondary schools and in teacher training. Indeed, in Jamaica the Ministry of Education has introduced a policy that discourages NGOs from working in schools. It was reported that teachers and principals still ask for the programme. For St. Lucia, HIV is part of the curriculum in primary and secondary schools but it is not included in teacher training. Though the UNGASS report for Trinidad and Tobago indicates that HIV is not included in any curricula, information gained through the evaluation, demonstrates that more recently teachers have been trained. In Haiti HIV is not included in any curricula but information obtained through discussions with the Ministry of Health and with the Ministry of Education indicated that they are working towards this. For details of the status of Health and Family Life Education in evaluation sites see Table 5 below.

**Table 5: Family Life Education in Evaluation Sites**

<b>Country</b>	<b>Status</b>
<b>Belize</b>	The Ministry of Education has introduced the Health and Family Education in all schools. In 2007 it was implemented in 80% of schools (UNGASS Country Report 2008). Belize Red Cross has trained high school counsellors as instructor trainers who use some of the TWC activities with students.
<b>Guyana</b>	Guyana has endorsed the delivery of life-skills based Health and Family Life Education from Grades 1-9 as a core subject. This includes emphasis on HIV/AIDS and Human Rights and the Rights of the Child Education. (Caribbean Symposium on Inclusive Education, 2007). However, it is not known how many schools have actually been implementing this curriculum, as the UNGASS report contains no data on this.
<b>Haiti</b>	There is no systematic way to implement life skills education in school. However, NGOs, including the Red Cross, are working with the government on the development of a curriculum (Focus group discussion: Public Health Communication Department)
<b>Jamaica</b>	Health and Family Life Education conducted in 24% of 1014 primary school and secondary schools (Ministry of Education, HFLE Program monitoring, 2007). Since 2009 Ministry of Education has conducted several trainings for primary and secondary schools, including private schools.
<b>St. Lucia</b>	90.8% of all schools have teachers trained in Family Life Education but it is not known if they are teaching the subject (UNGASS Country Progress Report, 2008)

<b>Trinidad and Tobago</b>	<p>The Curriculum Development Division, Ministry of Education, has developed sample lesson plans for Health and Family Life Education (<a href="http://www.moe.gov.tt/lesson_plan_pdfs/HFLE%20SAMPLE%20LESSONS.pdf">http://www.moe.gov.tt/lesson_plan_pdfs/HFLE%20SAMPLE%20LESSONS.pdf</a>) It is not known how many schools have actually been implementing this curriculum. The Ministry of Education is currently undertaking a study to ascertain why the curriculum is not being used. Teachers had reported that they had not been trained to use the curriculum.</p>
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Youth did report, however, that

*TWC gives a lot more detailed information. Even when the subjects are discussed with teachers present, peer educators have been able to give a lot more detailed information, including how to protect ourselves from HIV and I am able to share this with my friends.*

## **2. Findings: National Responses to HIV prevention education for out-of-school young people**

Of the evaluation sites, UNGASS reports indicate that the governments of Belize, Haiti and Jamaica have all developed an HIV education strategy for young people. At the time of reporting no such education, strategy had been developed for Guyana, St. Lucia or Trinidad and Tobago.

## **3. Conclusions: National Responses to HIV prevention education for in-school young people**

When TWC was first introduced into the Caribbean, it was a ground breaking and innovative programme that received international acclaim. However, since TWC was first introduced, there has been a considerable shift in addressing HIV within the school curriculum, with many countries implementing Health and Family Life Education in school. This challenges the relevancy of Red Cross implemented TWC programmes in school settings in those countries.

Currently, TWC is not implemented on a sufficient scale to reach enough in-school youth through use of the four blocks *in the Peer Educator Handbook* to curb the epidemic. Reaching a critical mass of youth may be better achieved by integrating HIV education into the school curriculum and system. Through their extensive experience of working with youth, National Societies could liaise with the Ministries of Education or Youth and Support re the feasibility of the Red Cross taking on an advisory or training support role. This approach may ensure that the added value brought by TWC through its use of dynamic interactive educational techniques such as: role-playing, group discussions, quizzes, coupled with a non-judgmental approach could be introduced into the school system.

## **4. Recommendations: Relevance within the school setting and with out-of-school young people**

Although TWC has been relevant in the school setting and with out-of-school young people, TWC would appear to be at a juncture and facing a number of options and therefore recommendations for the future cannot be taken in isolation (see Section 12, overall recommendations).

## SECTION 8: EFFICACY OF THE PROGRAMME AND THE EXTENT TO WHICH THE STANDARDS FOR HIV PEER EDUCATION PROGRAMMES HAVE BEEN IMPLEMENTED

### 1. Introduction

A separate section is devoted to the extent to which the *Standards for HIV peer education programmes* have been implemented. An appendix compliments this section. The appendix addresses the degree to which each standard has been met in each of the six evaluation sites, (see Appendix 8: Analysis of compliance to Standards for HIV peer education programmes).

It should be recognised that Belize, Bahamas, Guyana, Haiti, Jamaica and Trinidad and Tobago have received a copy of the standards, whereas St. Lucia had not. The IFRC in Geneva reported that the *Standards for HIV Peer Education* have been distributed to Zone Offices and Regional Delegations where they are being held at the moment until the *HIV Prevention Guidelines* arrive. The official launch date for both publications will be 1<sup>st</sup> December 2009 (World AIDS Day) at which point, the Zones will begin distributing the publications together.

It should be recognised that

- Training on the use of the Standards has not been conducted in the Caribbean to date and is planned for 2010.
- This is a “snapshot” at a given point in time of National Societies compliance with *Standards for HIV peer education*.
- National Societies receive different levels of funding and different levels of technical support, which may reflect the degree of compliance.

Compliance with the following standards was not checked as part of the review

- **Standard 4.5:** An in-depth analysis of staff capacity to work with vulnerable populations was not undertaken, as any such assessment would need to be much broader in scope than was possible in the overall time allocated to an interview.
- **Standard 7.2:** Due to the programme cycle it was not possible to observe National and Instructor Trainers conducting training sessions and to ascertain whether they had the knowledge and skills relevant to conducting participatory training of Instructor Trainers and peer educators.
- **Standard 8.4 [part]:** Similarly, no sessions were observed in which peer educators trained their peers.
- **Standards 10.9 and 10.10:** As this was a technical review, these standards were not explored. However, the evaluation did reveal that financial constraints were affecting the implementation of some programmes, with one-off trainings being conducted using specific funding for that training, rather than a planned programme of training. Where financial constraints existed, some of the responses from peer educators indicates that the programme may have been less robust and quality may have been compromised.

### 2. Findings: HIV peer education standards that have been met

It is positive to report that a number of HIV peer education standards have been met. For details of compliance with HIV peer education standards see Table 6 below.

**Table 6: Compliance with HIV peer education standards**

<b>Standard 1: Involvement of people living with HIV and key populations (Standards: 1.1 – 1.5)</b>		
<b>1.3</b>	Equal opportunities	People living with HIV and key populations have an equal opportunity to be a member of staff or a volunteer with the peer education programme.

1.4	Orphans and vulnerable children	The access of children living with or directly affected by HIV to Red Cross Red Crescent youth peer education programme is promoted. Some National Societies found this difficult to ascertain as parents do not usually disclose the status of their children
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**Standard 5: Planning**

5.1	Inclusion in National Society health or HIV strategic plan	Peer education is part of the National Society health or HIV strategic plan
5.2	Overall goal and objectives	The National Society has developed a clear mission statement in relation to its HIV programme.
5.5	Model of peer education	The National Society has a comprehensive model of peer education, which identifies the roles and responsibilities at different levels within the programme.

**Standard 6: Recruitment and retention of peer educators**

6.1	National Society volunteer policies and systems	All National Societies had a volunteer policy or use the IFRC Volunteer Policy.
6.2	Recruitment plan	Though National Societies did not have a recruitment plan as such, they had clear selection criteria and a selection procedure.
6.5	Feedback mechanism	Methods for continuous feedback with peer educators had been established.

**Standard 7: Training**

7.1	Training framework	There is a training framework, though the M & E component needs strengthening (see below).
7.3	Working with gatekeepers	Gatekeepers are informed about the programme through meetings but not through training.
7.5	Learning needs assessment	Note the training curriculum links with the <i>Peer Educator Handbook</i> and no separate learning needs assessment is conducted. All potential peer educators take part in a pre-test and Trainers check these and the results of the test inform the training curriculum.

**Standard 8: Implementation of peer education programme activities (Standards 8.1 – 8.6)**

8.5	Information sharing	Information, IEC materials, experiences, technical expertise, lessons learnt and effective practice within branches were shared until recently through the Regional Faculty
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**Standard 9: Supervision and support of peer educators**

9.3	Community based support	The majority of the work is in schools. Peer educators that did work with out-of-school youth were, in some instances, able to identify existing individuals and organisations that they could draw upon for support.
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**Standard 10: Management and governance**

10.1	Roles and responsibilities	Each programme had a designated manager.
10.4	Organizational capacity	Staff reported that they had sufficient organisational capacity to support TWC programme
10.5	Human Resource management	Evidence was gained that management values, supported human resources
10.6	Systems	Representatives of staff and volunteers were able to explain the way in which decisions about programme operations are taken.

<b>10.7</b>	Administration and logistical support	At National Society level, respondents indicated that there was sufficient administrative and logistical support
<b>Standard 11: Monitoring and evaluation</b>		
<b>11.1</b>	Inclusion in work plan	For Global Alliance countries M & E was included in the programme logframe.
<b>11.4</b>	Involvement of peer educators and key stakeholders	Staff and peer educators were involved to some extent to decisions related to M & E.

### 3. Conclusions: HIV peer education standards that overall need strengthening

Whilst there has been compliance with a number of standards, a number of standards need strengthening. While individual National Societies may have met a standard in full, this section refers to the overall Caribbean-wide standards that need strengthening.

There are three standards, which should underpin all HIV prevention interventions and all these standards need strengthening.

- **Standard 1:** Involvement of people living with HIV and key populations (Standards: 1.1 – 1.5)
- **Standard 2:** Gender Equality (Standards: 2.1 – 2.3)
- **Standard 3:** Advocacy (3.1 – 3.2)

#### **Standard 1: Involvement of people living with HIV and key populations (Standards: 1.1 – 1.5)<sup>18</sup>**

Table 7: Involvement of people living with HIV and key populations outlines the status of elements of this standard that need strengthening.

**Table 7: Involvement of people living with HIV and key populations**

#	Standard	Current status of standard
<b>1.1</b>	<b>Meaningful involvement of people living with HIV and key populations</b>	PLHIV contribute as speakers at National Trainer or Instructor Trainer level and in some, but not all, peer educator training. In Jamaica PLHIV are involved in programme development and in St. Lucia they are involved in planning the training.
<b>1.2</b>	<b>Targeting according to vulnerability</b>	National Societies use or have used the TWC curriculum or parts of the curriculum with key vulnerable populations, including MSM and with other vulnerable youth in formal settings. However, the overwhelming majority of TWC work is with in-school youth and to a lesser extent with formal out-of-school groups, such as the Scouts, sports groups, community clubs and youth groups from faith-based organisations.

The participation of PLHIV in any HIV prevention programme is imperative. This is a programme area that needs strengthening.

For details of the different ways in which PLHIV can participate in HIV prevention programmes see Table 8 below.

**Table 8: Participation of PLHIV in HIV prevention programmes**

<b>Participation of People Living with HIV</b>	
<b>Decision-makers</b>	PLHIV participate on an equal basis in decision-making or policy-making bodies at National Society and Branch levels
<b>Experts</b>	PLHIV are recognised as important resources who have information, knowledge and skills and participate on an equal basis in the design, planning, implementation and monitoring and evaluation of HIV prevention programmes and projects at National

<sup>18</sup> Note that the number in brackets refers to the number of sub-standards for a given standard

	Society and branch levels
<b>Implementers</b>	PLHIV participate in HIV prevention programmes or projects as peer educators or outreach workers but are not involved in programme design or the way in which programmes are implemented
<b>Speakers</b>	Individual PLHIV are used to provide personal stories or testimonies at workshops in order to set the scene, are involved in public disclosure, “coming out”, at events and speak at conferences or meetings.
<b>Contributors</b>	PLHIV have minimal involvement. For example, a relative of a well-known person who has recently died of AIDS speaks about the person publicly or the face of a well-known person with HIV is used on posters or billboards.
<b>Target population</b>	HIV prevention activities are targeted at PLHIV and PLHIV are the recipients of services

Whilst it is recognised that some work is done with vulnerable populations, the overwhelming majority of TWC work is with in-school youth and to a lesser extent with formal out-of-school groups, such as the Scouts, sports groups, community clubs and youth groups from faith-based organisations. This is, therefore, a key programme area that needs strengthening. For details, see Section 7.1.3.

### **Standard 2: Gender equality (Standards: 2.1 – 2.3)**

Table 9: Gender Equality outlines the status of the different elements of this standard, all of which need strengthening.

**Table 9: Gender equality**

#	Standard	Current status of standard
<b>2.1</b>	<b>Promotion of equal responsibility and representation</b>	Males and females are given equal responsibility. As far as representation is concerned, overall it is a predominantly female programme with male peer educators under represented. In Jamaica, following a campaign to attract male peer educators, there has been an increase in males to the point where, in some peer educator training, there has been equal representation of males and females.
<b>2.2</b>	<b>Gender mainstreaming</b>	Overall, there is little in the curriculum, which would suggest a gender analysis has been implemented to ascertain how gender inequalities expose women and girls to the risk of HIV and how gender inequalities reinforce the subordination of women and girls.  During the training, the majority of the curriculum is conducted in mixed sex groups. In Guyana peers reached are separated into male and female groups during particularly sensitive activities and in the revised Haiti curriculum peers educators divide peers into same sex groups for a body mapping exercise. In Jamaica, peer educators commented that the “Risk Game” is more likely to succeed in single sex groups as boys become defensive. Peers reached commented that “There are some girls, but not all, who would prefer, to discuss things without guys, particularly things about sex.”
<b>2.3</b>	<b>Capacity building</b>	Peer educators were able describe ways in which males and females can protect themselves and others from HIV but were unable to give examples of how gender roles impact on the spread of HIV.

Although some activities allow gender issues to be raised, for example pressure lines, there is a significant need for programme participants to develop a deeper understanding of the specific

vulnerabilities of women and girls. This would result in a more gender sensitive programme that addresses issues such as gender inequality and sexual and gender based violence, and their impact on HIV prevention.

Effective teaching and learning involves open discussion and whilst it is recognized that girls and boys need to learn to communicate with each other, they also need to be allowed the space to discuss gender issues and power dynamics in relationships in single sex groups. Working in single sex groups can give girls legitimacy to talking about sex without the risk of being stigmatized as sexually promiscuous.

### Standard 3: Advocacy (3.1 – 3.2)

Table 10: Advocacy outlines the status of the different elements of this standard that need strengthening.

**Table 10: Advocacy**

#	Standard	Current status of standard
3.1	<b>Creating an enabling environment</b>	Whilst advocacy work is not a specific feature of TWC, it has been a key component of wider HIV programmes conducted by National Societies through the Faces campaign. Some National Societies have advocated with the Ministry of Education for inclusion of TWC or a modified version of TWC in the school curriculum.
3.2	<b>Services</b>	In the main, advocacy work has not been undertaken with service providers, though in Jamaica the National Society has advocated with the Ministry of Health for more youth friendly services, including the availability of condoms for youth peer educators. St. Lucia is implementing a pilot programme to develop youth friendly health services in a rural clinic.

An area that needs strengthening is advocacy work in relation to creating an enabling environment to ensure that friendly, accessible, affordable and appropriate sexual health services and resources to support peer education activities are available. This can include training of service providers. For example, a Population Services International (PSI) Programme in Botswana, as part of a youth stay healthy with condoms and reproductive health services campaign, identified twenty-eight places frequented by youth (such as clinics and shops that sold condoms). Staff who worked at these places, including clinic staff, attended a half-day training workshop to orientate them to the PSI programme. In addition to this, PSI programme staff made follow-up visits to the clinics and shops to ensure that they were well staffed and stocked with adequate written materials and other resources for youth.

### Standard 5: Planning (Standards: 5.1 – 5.7)

Table 11: Planning outlines the status of the different elements of this standard that need strengthening.

**Table 11: Planning**

#	Standard	Current status of standard
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5.4	<b>Steering group</b>	There are no steering groups as such. Guyana has “community councils”, which are generally made up of varying stakeholders within a community with whom the National Society is working, composition may include; regional authorities, teachers, parents, local organizations, etc. Haiti conducts town hall meetings and involves community councils. These are not specifically set up for TWC but are existing groups within the community. It was reported that there have been different levels of success within this approach. Jamaica has no steering group but National Society has an HIV Advisory Committee, which provides feedback on plans and gives advice.
5.6	<b>Workplan</b>	Some programmes using a workplan, operations plan or log frame, whilst others who had limited funding worked as and when funding becomes available.
5.7	<b>Sustainability</b>	<p>Sustainability of TWC is an issue. Some National Societies reported that they face funding constraints. As a result of this, they were exploring how to take the programme forward. For example, the Jamaican Red Cross is exploring entrenching TWC in the school curriculum through work with individual schools. Though Haiti is not currently facing financial constraints, it is working with the Ministry of Education to include elements of the TWC curriculum in the school curriculum. The American Red Cross has written a sustainability document for the two National Societies that it supports (see Appendix 9: American Red Cross: TWC Sustainability Plan), which includes</p> <ul style="list-style-type: none"> <li>• Working with business to provide material or in-kind support</li> <li>• Building capacity of NS to carry on work or incorporating elements into other activities such as Club 25 or youth volunteer activities</li> <li>• Transitioning youth volunteers into other RC activities</li> </ul>

Addressing sustainability is the main element of this standard that needs strengthening. If National Societies do not have consistent funding, the programme can become a series of one-off interventions, some of which are compromised and do not offer the full TWC programme.

Some National Societies reported that they face funding constraints and as a result of this were exploring how to take the programme forward. For example, The Jamaica is exploring entrenching TWC in the school curriculum through work with individual schools. Though Haiti is not currently facing financial constraints, it is working with the Ministry of Education to include elements of the TWC curriculum in the school curriculum.

### **Standard 6: Recruitment and selection of peer educators (Standards 6.1 – 6.7)**

Table 12: Recruitment and selection of peer educators outlines the status of the different elements of this standard need strengthening.

**Table 12: Recruitment and selection of peer educators**

#	Standard	Current status of standard
6.3	<b>Pre-selection workshop or meeting</b>	Guyana and St. Lucia held a sensitisation or orientation meeting for potential peer educators but the other National Societies did not.
6.4	<b>Written contracts</b>	Peer educators were able to describe their roles and responsibilities, which are laid out in the document, <i>TWC Training Structure</i> . No peer educators were, however, required to sign a contract.



<b>6.6</b>	<b>Incentives</b>	Currently, due to financial constraints three out of the six National Societies involved in the review, do not provide incentives for peer educators.
<b>6.7</b>	<b>Exit interviews</b>	Four National Societies do not document the reasons why peer educators leave the TWC Programme.

### Standard 7: Training (Standards 7.1 – 7.10)

Table 13: Training outlines the status of the different elements of this standard need strengthening.

**Table 13: Training**

#	Standard	Current status of standard
<b>7.4</b>	<b>Working with service providers</b>	Interaction with service providers would appear to be on an “information” level. As far as could be ascertained no National Society provides training for service providers to ensure that their services can be accessed by the target population and are delivered in a non-judgemental way.
<b>7.6</b>	<b>Peer trainer and peer educator curriculum</b>	<p>There is/is not a standard written curriculum for the training of National or Instructor Trainers. Though a document entitled <i>Guide for Training Peer</i> (undated and with no author) encourages National Societies to utilize the standard agenda for the initial peer educator training, it would appear that different curricula are used by different National Societies. Some National Societies use the <i>TWC Peer Educator Handbook</i> and <i>Activity Kit</i>, supplemented by Power Point presentations, to train peer educators, others use the <i>Guidelines for National Societies</i> [for details see Section 7.2: Training: Peer Educators: Findings]. The <i>Peer Educator Handbook</i> and the <i>Activity Kit</i> outlines the training of peers reached. However, not all peer educators use the total curriculum.</p> <p>The training component of TWC is supported through the <i>Peer Educator Handbook</i> and <i>Activity Kit</i>. However, many peer educators reported that they only received one <i>Activity Kit</i> and that this meant that activities were not done as in the Handbook.</p>
<b>7.7</b>	<b>Initial training</b>	Three National Societies provide training of less than four days, with one providing two days’ training.
<b>7.8</b>	<b>Refresher or follow-up training for peer educators</b>	The extent of refresher training for peer educators varied from none to five days.
<b>7.9</b>	<b>Certification</b>	All National Societies provided certificates but peer educators who were interviewed, reported that they had not received certificates.
<b>7.10</b>	<b>Monitoring and Evaluation</b>	See Section 11 below .

The following are the key elements of this standard that need strengthening:

- Content of the training of peer educators [for full details see Section 7.2: Training: Peer Educators: Findings].

- Length of the initial training. The standards recommend that peer educators receive a minimum of four to five days' initial training. It is recognised that some National Societies comply with this standard.
- The extent of refresher training. Again, It is recognised that some National Societies comply with this standard.
- Monitoring and evaluation. It is recognised that some National Societies comply with this standard.

### **Standard 8: Implementation of peer education programme activities (Standards 8.1 – 8.6)**

Table 14: Implementation of peer education programme activities outlines the status of the different elements of this standard need strengthening.

**Table 14: Implementation of peer education programme activities**

#	Standard	Current status of standard
8.1	<b>Community sensitization</b>	Some community sensitisation takes place but it is not a feature of all programmes
8.2	<b>Workplan development</b>	In some National Societies peer educators develop workplans with the support of the Instructor Trainers/Field Managers. In others, reports from peer educators indicated that peer education activities were conducted on <i>ad hoc basis</i>
8.3	<b>Provision of peer educator kits</b>	Peer educators reported that there were either insufficient or no activity kits for use with peers reached
8.4	<b>Working with the target population</b>	As far as repeated contacts with the target group were concerned, in Belize, Guyana and Haiti peer educators completed all the activities in the Activity Kit. At a school in Trinidad and Tobago, peer educators reported that they get a 25 minutes session in the library with their peers. Eight out of 15 peer educators from an in-school group in Jamaica reported that they carried out their peer education sessions solely with family, friends and neighbours and in a one-off manner. Three reported working with their classmates. In another site, peer educators described a “pick and mix” approach due to time constraints. “We ask the peers what they want to know or we decide which blocks to do with them.” They described implementing the blocks at random. In St. Lucia, it was also reported that peer educators do not always do all the activities in the blocks.  Peer educators reported working with their whole class of 25+ on their own.
8.6	<b>Targeted information, education and communication</b>	IEC materials were, in the main, generic. Some younger peer educators reported being uncomfortable with posters that showed pictures of the genitals and STIs.

Whilst, it is recognised that some National Societies do make repeated contacts with their peers, during peer educator training the need for repeated contacts needs to be emphasised during peer educator training and with adult leaders or teachers who support peer educators in the field. Also, working in pairs with 20 or less peers should be encouraged. The need for age appropriate materials needs to be discussed with adult leaders or teachers who support peer educators in the field.

### **Standard 9: Supervision and support of peer educators (Standards: 9.1 – 9.3)**

Table 15: Supervision and support of peer educator outlines the status of the different elements of this standard need strengthening.

**Table 15: Supervision and support of peer educators**

#	Standard	Current status of standard
9.1	<b>Meeting-based supervision</b>	The standards recommend a minimum of one meeting a month. Supervision varies from twice a month in Haiti with Red Cross staff, to ad hoc supervision being provided by adult leaders or teachers, to no meeting based supervision.
9.2	<b>Field-based supervision</b>	The number of field-based supervision contacts varied from site to site. However, some peer educators reported that they had not received any field-based supervision.

Whilst recognition is given to financial constraints, peer educators should receive more follow up and support after training to ensure the accuracy of their information and to limit the numbers dropping out.

**Standard 10: Management and governance (Standards 10.1 – 10.10)**

Table 16: Management and governance outlines the status of the different elements of this standard need strengthening.

**Table 16: Management and governance**

#	Standard	Current status of standard
10.2	<b>Policies and guidelines</b>	No National Societies have a Gender Policy, although Jamaica is in the process of working with other organisations to develop a Gender Policy. Belize has an HIV Workplace Policy, with some other National Societies using their National or ILO HIV Workplace Policy.
10.3	<b>Staff development</b>	Training related, in the main, to the delivery of TWC rather than management training.
10.8	<b>Compliance with standards</b>	There was no common response to this question, with a variety of standards being cited, including the Regional Faculty's and the American Red Cross

The policy environment, in particular, needs strengthening. An HIV Workplace Policy usually focuses on addressing issues connected with HIV faced by employees. It is hoped that with the development of a policy and associated training that HIV and AIDS will become internalised as a personal issue for staff and their families, rather than just a professional challenge affecting the people with whom they work. HIV Workplace Policies usually aim to

- Prevent stigma and discrimination in the workplace against people living with HIV and AIDS
- Provide all staff with the information necessary to increase their awareness of issues related to HIV and AIDS
- Support access for an organisation's employees to VCT, PMTCT and treatment services
- Reduce the personal, family, organisational and social impact of HIV and AIDS amongst staff

**Standard 11: Monitoring and (Standards: 11.1 – 11.5)**

Table 17: Monitoring and Evaluation outlines the status of the different elements of this standard need strengthening.

**Table 17: Monitoring and evaluation**

#	Standard	Current status of standard
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11.2	<b>Data collection system</b>	<ul style="list-style-type: none"> <li>• Only Haiti and Guyana conduct pre and post-tests with peers reached (a sample) to monitor changes in beneficiary knowledge, attitudes and skills acquisition and with all peer educators. Data is analyzed and overall statistical information presented in annual reports.</li> <li>• Belize collects data through pre and post-tests, with all peer educators. Data is analyzed following an individual training and statistical information is presented in the report of each training. Belize does not collect data in relation to peers reached.</li> <li>• Jamaica, St. Lucia and Trinidad and Tobago collect quantitative pre and post-test data in relation to peer educators. Though these are analysed by the trainers in order to guide the training agenda, they are not analysed and presented as statistical data. Jamaica, St. Lucia and Trinidad have not collected data in relation to peers reached.</li> </ul>
11.3	<b>Training in data collection and analysis skills</b>	Staff from Belize, St. Lucia and Trinidad and Tobago had not received training in data collection and analysis skills. One person from Jamaica had received training in data analysis but currently data is not entered into a database.
11.5	<b>Assessing knowledge, attitudes and skills of peer educator and the target population</b>	Knowledge, attitudes and skills of peer educators are assessed through pre and post-tests at the initial training. However, in Jamaica and Trinidad and Tobago this information is not analyzed and documented. Only Guyana and Haiti collect data in relation to peers reached.

Whilst it is recognised that some National Societies have robust data collection and analysis systems, overall this is an area that needs strengthening so that all data collected is analysed. There is scope for cross-learning with those National Societies that analyse data, accompanied by training in data analysis

#### 4. Recommendations: Key HIV peer education standards that need strengthening

Three key HIV peer education standards that underpin HIV prevention work need strengthening in the following ways.

Whilst there has been compliance with a number of standards, there are standards that need strengthening. Three key HIV peer education standards that underpin HIV prevention work need strengthening in the following ways:

- **Standard 1:** That individual National Societies strengthen links with organisations of PLHIV and work towards their involvement in programme development.
- **Standard 1:** That individual National Societies segment their in-school and out-of-school target population according to who is most vulnerable to HIV infection and actively target new vulnerable populations. This may require developing new intervention models with most at-risk youth populations
- **Standard 1:** That the Federation conduct through e-mail a learning needs assessment of staff and appropriate volunteers in relation to working with vulnerable populations and that this assessment informs the agenda for a workshop on work with key vulnerable populations.
- **Standard 2:** That National Societies conduct a gender analysis.
- **Standard 2:** That individual National Societies discuss the comparative advantages and disadvantages of conducting some elements of the programme in single-sex and mixed sex groups.

- **Standard 3:** That advocacy work is undertaken in relation to creating an enabling environment to ensure that friendly, accessible, affordable and appropriate sexual health services and resources to support peer education activities are available.

In addition to these three standards, if the National Societies are to continue using peer education as a prevention strategy (see Section 12: Recommendations for the way forward for HIV peer education programming in the Caribbean region), the following need to be addressed:

- **Standard 5:** That the Health Network discuss generating financial resources to ensure the sustainability of their HIV peer education programmes. Despite being considered by some as an inexpensive intervention (due to reliance on volunteers), good quality peer education can be costly because of the need for financial resources for training, support, supervision, supplies and allowances.
- **Standard 7:** That prior to its re-print and funding permitting, the Federation commission an amendment of the *Peer Educator Handbook* and *Activity Handbook*, in countries other than Haiti, to ensure that the new curriculum incorporates issues relevant to societal gaps and missing information. See comments made in Section 7.2: Training: Peer Educators: Findings.
- **Standard 7:** That individual National Societies give strong consideration to extending the length of peer educator training to four to five days and that at the same time consideration is given as to how refresher training can be incorporated into the programme by those National Societies that no longer do this.
- **Standard 8:** That individual National Societies emphasise during all trainings, the need for peer educators to have repeated contacts with their peers in schools and formal youth settings and conduct the full curriculum, in addition to one-off discussions with family, friends and neighbours. Furthermore, adult leaders or teachers who support peer educators in the field should be informed about this.
- **Standard 9:** That individual National Societies discuss the minimum requirement for meeting and field-based supervision, and where this involves adult leaders or teachers that guidelines are created related to their involvement.
- **Standard 10:** That the Federation work with National Societies to strengthen the policy environment, particularly in relation to HIV Workplace and Gender Policy development.
- **Standard 11:** That in any HIV prevention programme, that a greater emphasis be placed on data collection in relation to the knowledge, attitudes and self-efficacy of the target group and that staff receive training in data collection, analysis and dissemination.

## **5. Monitoring mechanism: To ensure that internationally recognised peer education standards are adhered to and maintained**

In order to ensure compliance with the peer education standards, it is recommended that the following steps are taken:

- The CRRO and Americas Zone Office arrange for representatives of all National Societies to attend a workshop on the standards. [Note: A pilot workshop was developed for South Africa and Lesotho and with modification, this could be implemented in the Caribbean.]
- That a sub-committee of the Health Network, with expertise in HIV prevention programming, be appointed to monitor the standards
- That annually National Societies report on their compliance with standards, particularly those outlined in 4 above: Recommendations: Key HIV peer education standards that need strengthening

## **SECTION 9: FEDERATION-WIDE NETWORK**

Although not in her original ToR, the evaluator was asked to look at whether a Federation-wide network that addressed HIV issues would be valuable.

### **1. Findings: Federation-wide Network**

There is currently no Federation-wide network in the Caribbean that solely addresses HIV. In the past, the Regional Faculty provided overall quality control and maintenance of standards and integrity of the TWC programme. CARAN, a network which also no longer exists, aimed to strengthen the capacity of the Caribbean Red Cross National Societies and Overseas branches to educate mobilise, advocate for and deliver HIV and AIDS activities in appropriate scale and quality.

In the absence of either the Regional Faculty or CARAN, HIV currently falls under the remit of the broader Health Network, whose scope includes topics such as First Aid, Influenza A-H1N1, HIV and AIDS and Club 25.

The Health Network was inaugurated following the May 2009 Regional Health Consultation meeting, which was convened by the Caribbean Regional Representation Office. The consultation had the objectives of reviewing the current health programming in the region and prioritizing areas for the 2010 Federation plans. Key outcomes of this meeting included:

- Consensus among meeting participants that there should be a move from large regional programmes to programming that is more tailored to specific needs
- A focus on HIV and AIDS programming in the context of the Global Alliance on HIV
- A greater emphasis on first aid programming
- Fostering greater linkages between the Health and the Disaster Management programmes
- That the Health Network guide health programming within the region

The Health Network is meant to serve as a pivotal body to guide health programme issues and it has been consulted on a number of occasions during the past months.

Following the May consultation, a meeting of the Caribbean Health Network was held in October 2009. Representatives of Belize, Guyana, Haiti, Jamaica and Trinidad National Societies and a member of the Health and Care Advisory Board of the Federation attended the meeting. The Head of Office, the Capacity Building Manager, the Pandemic Influenza Officer and the Health Programme Manager represented the CRRO. The primary objectives of the meeting were to review current health programming in the region and to formalise the Caribbean Health Network, through the establishment of roles and responsibilities through a draft ToR. The Disaster Management Network ToR informed the discussion on the development of the Health Network ToR and it was agreed that a draft ToR would be circulated to the Network for review and comment.

For information, it is proposed that the Caribbean Disaster Management Network will comprise six technically experienced persons who have authority and a minimum of 5 years experience in disaster management. The current Health Network includes four people from Global Alliance countries, two of whom have responsibilities for HIV and AIDS within their National Societies. For details of the scope of work of the Disaster Management Network see Appendix 10).

Those asked about the value of a network commented as follows:

- Any network is valuable. It can strengthen the response to HIV across the Caribbean by creating a space for likeminded National Societies to interact, share experiences and best practices and to guide each other on how to respond in the various territories. The need that led to the creation of CARAN still exists. The structure of CARAN caused issues but a network would bring considerable value and should be modelled on the experiences of the youth, communications and disaster management networks.

- There is value in a network. When the Regional Faculty was operational it promoted standards in relation to TWC, systematically conducted training, made technical inputs and provided current information. It allowed for everyone across the region to have the same key messages and assured a common standard of approach with HIV prevention. The Health Network is an overall guidance body. There needs to be a sub-committee of the Health Network with members with experience in HIV programming, which would take over the role of the Faculty.
- There is always value in a dedicated unit [to HIV], so a separate network is good. However, the Global Alliance currently addresses the needs and therefore fills the role of a HIV and AIDS network.
- CRRO should head up any network. If this is not possible, suggest a rotating coordinating body. The National Society's role to be filled by someone else during that period.
- The existing Caribbean Red Cross Regional Youth Network, which is in its second year, could be utilized to discuss issues related to youth and HIV and AIDS.
- HIV can and should be supported by the Health Network. There was an HIV network in the region for a few years, and some National Societies felt that other health issues were given the back burner because the focus and funding targeted HIV interventions. A health network should be able to make sure that the region is more holistic when looking at health.
- Network should cover all health issues, e.g. HIV, A-H1N1. Issue-based work can be limited because it only targets a particular community.
- The [newly established] Health Network is already supporting HIV work through the various projects being conducted at National Societies and with the support they receive from CRRO, for example, the Global Alliance on HIV. However, having said that, perhaps it can be seen as a strain, since HIV is very complex and its parameters too wide to be thrown in the mix of other health matters. It may warrant its own Network to focus more appropriately and effectively on HIV interventions and better results may be achieved in this way.
- If it is to be a health network, there is a need to define what is a health programme. National Societies see programmes separately rather than all health programmes coming under one framework.

## **2. Conclusions: Caribbean-wide Network**

From limited information obtained during the evaluation, it would seem that a network would be valuable. However, there would not appear to be agreement on whether this should be for HIV alone or for a broader range of issues as will be covered by the Health Network.

As far as could be ascertained, discussions related to the Health Network focussed on using the Disaster Management Network as a model rather than looking at other Regional HIV Networks. For example, the Asian Red Cross Red Crescent AIDS (ART) Network was established in 1994 with the aim of strengthening the capacity of member National Societies in South East and East Asia in the area of HIV and AIDS programme development and implementation. An evaluation of ART, conducted in 2003, found that ART has contributed substantially to enhance the capacity of RCRC to effectively deliver HIV and AIDS programmes. The evaluation describes enhancements in areas such as increased availability of resources, diversification of funding sources, expansion in areas of intervention, broadening of target groups, increased collaboration with other organizations, particularly organizations of PLWHIV. However, the evaluation also pointed to a number of weaknesses and concluded that ART has yet to reach its full potential. As a result of the evaluation, a new strategic plan for ART has been developed covering 2004-08. With the new strategic plan, ART aims at becoming a regional resource in influencing HIV policies and combating the epidemic at community level, working in partnership with PLHIV.

## **3. Recommendations: Caribbean-wide Network**

- That the CRRO and the Health Network explore other Health and HIV networks to ascertain which model is most appropriate to the Caribbean.

## **SECTION 10: HIV REFERENCE CENTRE**

### **1. Findings: HIV Reference Centre**

The establishment of an HIV Reference Centre was raised three years ago at a Regional Faculty Meeting though it was not researched thoroughly at the time.

At the Regional Health Consultation meeting in May 2009, it was agreed that the Coordinator for Health and Care, Americas Zone, and the Head of Office of the CRRO would take responsibility for discussing the next steps for the Reference Centre with the IFRC Zone Management. Subsequent to the meeting, and after some deliberation, it was decided that more research and analysis of the region's gaps and needs was critical to inform the decision to establish an HIV Reference Centre.

A Caribbean-wide resource centre to promote effective disaster management in the Caribbean has been proposed. The centre aims to support the efforts of Caribbean National Societies' to reduce risk of both natural disasters and health emergencies through the development and testing of training materials and methodologies in coordination with the different Red Cross societies of the region. National Society staff and volunteers will provide input for adapting and piloting materials through training facilitation, exchanges and internships. This centre will also offer services to government institutions, non-governmental or private ones that have a firm interest and commitment to undertake actions for the disaster preparedness.

The core functions of the Centre will be:

- To adapt existing tools and develop new tools.
- To promote the development, piloting and revision of materials through exchanges and internships for Red Cross Society staff and volunteers.
- To develop a master trainers and maintain a trainers roster.
- To maintain a digital inventory and web library of high quality resource materials in English on community based disaster risk reduction relevant to the Caribbean
- On [www.caribbeanredcross.org](http://www.caribbeanredcross.org) the Red Cross's regional website, the Centre will designate a special section designed for the exchange of experiences regarding the subject of preparedness for disasters and, above all, to work methodologies aimed to enrich the community education processes with a comprehensive approach.

During the review, key personnel in National Societies were asked whether a Caribbean wide HIV reference centre would be useful to them in their work. Respondents felt that currently HIV information is "all over the place" and takes time to access and that it would be beneficial if all HIV information was housed in one place. In addition to this, it was felt that reference centre would enable greater sharing of information, would be a valuable source for research and other materials, for example, training materials, best and good practices from across the world (including translations), information from people living with HIV and would be able to provide information on how and where to access funding. It was hoped that a reference centre would be able to provide technical advice through e-mail and assist in material development and that there would be a need for the Federation or "someone" to be proactive and alert members to information. Any such centre should include a person living with HIV, It was also felt that a reference centre should be able to support National Societies in the monitoring and evaluation of their programmes and should play a key role in assuring standards in monitoring and evaluation across the region.

However, some respondents felt that a reference centre is unnecessary as people are able to access websites and other organisations to get information and that HIV alone does not justify a reference centre. Language issues would also need to be addressed if Haiti, Dominican Republic and Cuba are to be included

No consensus was reached on whether any reference centre should be building based or web-based. Some people saw it as solely web-based but recognised that FedNet is a resource that is grossly underused especially in the Caribbean.



It was recognised that how any reference centre is marketed will impact its usage and that the target group of would need to be decided, for example, if web-based should there be a space for young people.

## **2. Conclusions: HIV Reference Centre**

The review revealed that there is a need for an HIV reference centre as there is currently no repository of information related to Red Cross HIV programmes within the Caribbean. For example, as far as TWC is concerned, information lies with individuals and there is little institutional memory through which the progression of tools and methodology can be traced. Nor are all documents dated.

However, whether there should be a wider reference centre needs further consideration as this may duplicate what is available through existing websites and may also have considerable cost implications. In addition to acting as a repository of local Red Cross information, a reference could play a role in:

- Capturing regional lessons learned
- Sharing relevant experiences from other regions
- Identifying RCRC and other tools that can be adapted to the Caribbean context
- Supporting the adaptation and/or development of tools and methodologies
- Promoting the development, piloting and revision of materials through exchanges and internships for Red Cross Society staff and volunteers
- Supporting the development of Regional Trainers

These and other ideas for a reference centre need to be researched in greater depth by the Federation and the Health Network, with outside support, funding permitting.

## **3. Recommendations: HIV Reference Centre**

- That at a minimum, a web-based repository of information related to Red Cross HIV programmes within the Caribbean be established
- That evidence is gathered related to the region's gaps and needs and that information is sought related to:
  - What is currently available on the web, particularly in relation to the Caribbean
  - Whether the reference centre should solely be a web-based reference centre or whether it should include human resources that can, for example, respond to questions
  - How reference centres address language issues
  - The current usage of FedNet

## **SECTION 11: LESSONS LEARNED**

Section 11 is replicated in full in the Executive Summary.

### **1. Greater involvement of people living with HIV and key vulnerable populations**

- The participation of PLHIV in any HIV prevention programme is imperative. This is a programme area that needs strengthening.
- Although examples were given of how TWC had been used with a small number of vulnerable groups, in the main, National Societies do not target their TWC programmes according to vulnerability. In order to be more relevant National Societies need to address the HIV prevention needs of the most vulnerable and at-risk populations.
- TWC would appear to be less suited to some vulnerable populations. For example, members of vulnerable populations who have limited literacy skills (TWC relies on flipcharts and written materials) and those who are transient or have less regular lifestyles and are, therefore, unable to commit themselves to a curriculum-based activity that requires attendance at all activities.
- The TWC curriculum would need to be adapted with specific population groups such as MSM, prisoners and sex workers to be relevant to their actual situations of risk and vulnerability.

### **2. Gender**

- Males and females are given equal responsibility. As far as representation is concerned, overall it is a predominantly female programme with male peer educators under represented.
- During the training of peer educators and activities with peers reached, the majority of the curriculum is conducted in mixed sex groups. Whilst effective teaching and learning involves open discussion and it is recognized that girls and boys need to learn to communicate with each other, they also need to be allowed the space to discuss gender issues and power dynamics in relationships in single sex groups.
- Peer educators were able describe ways in which males and females can protect themselves and others from HIV but were unable to give examples of how gender roles impact on the spread of HIV.
- Overall, there is little in the curriculum, which would suggest a gender analysis has been implemented to ascertain how gender inequalities expose women and girls to the risk of HIV and how gender inequalities reinforce the subordination of women and girls.

### **3. Creating an enabling environment**

- An area that needs strengthening is advocacy work in relation to creating an enabling environment to ensure that friendly, accessible, affordable and appropriate sexual health services and resources to support peer education activities are available. This can include training of service providers.

### **4. Model of peer education**

- TWC is the model of peer education used by National Societies in the Caribbean. Other than Jamaica, who has a peer education project with young MSM using a peer outreach education/support approach, no National Societies have given consideration to an alternative model of peer education.
- TWC is a comprehensive model of peer education, which identifies the roles and responsibilities at different levels within the programme. Internationally the programme has received several awards and has been acknowledged as an example of best practice.
- TWC is a curriculum-based intervention with between 14 and 22 activities according to site, which works well with in-school youth and youth in formal groups when delivered in its entirety.
- High quality TWC is resource intensive, in terms of both monetary and human resources
- An informal model of peer education, which is less resource intensive, may be more practical in some settings, for example with sex workers and street youth, and may provide more depth on areas important to a particular beneficiary, for example condom promotion with sex workers.

## 5. Training of peer educators

- Whilst TWC is a Caribbean-wide intervention, National Societies have adopted an individual approach to training.
- National Societies have training agendas but there is no actual written up-to-date peer educator training curriculum used by all National Societies and peer educator training varies in length from two to five days.
- Due to financial constraints, some National Societies are unable to offer follow-up or refresher training.

## 6. Peer educators

- Many peer educators were “near peers” and were, in some instances, more than five years older than their peers.
- Studies have shown that youth peer education programmes have a positive impact on the peer educators themselves.<sup>19</sup> TWC peer educators demonstrated that they were the beneficiaries of the peer education process, with quantitative and qualitative data demonstrating that peer educators had made positive changes in their own knowledge, attitudes and behaviour.
- The skills learnt through the initial training and through the implementation process has provided youth with real life skills that they have been able to use. For example, it was reported that a young woman in Grenada, who is now teaching, had said that the programme had enabled her to make better life decisions and a young woman in Jamaica, who had been a peer educator, reported that TWC had shaped her future career and that she is now an HIV consultant.
- In the main, peer educators clearly understood their roles and responsibilities.
- In some National Societies the follow up and support of peer educators after training needs to be strengthened to ensure the accuracy of peer educator information, that the programme is delivered in its entirety and to ensure peer educator retention.
- In some National Societies, due to financial constraints, there has been a lack of incentives and motivation strategies, which may contribute to peer educator retention.

## 7. Target group activities

- Attractive materials in the form of the *Peer Educator Handbook* and *Activity Kit* guide the implementation of activities with the target group. However, peer educators reported that these are not available in sufficient quantities to enable them to be used appropriately during activities. This may compromise the quality of activities, which are strongly based on the use of the *Activity Kit*.
- Although, it is recognised that peer educators can add to the information provided in the *Peer Educator Handbook* and the *Activity Kit*, the information in these materials needs strengthening. The following need to be included in countries other than Haiti: antiretroviral (ARV) treatment, including compliance, gender, HIV and AIDS and STI information, positive living, prevention of mother to child transmission, risk, (including, forced sex, intergenerational sex, multiple and concurrent partners and transactional sex), sexual and reproductive health and VCT. In addition, the curriculum does not provide guidance on how to work with 10 -14 year olds.

## 8. Support to National Societies

- Currently only the three Global Alliance member National Societies receive technical and financial support from the Caribbean Regional Representation Office for their HIV programmes. This may lead to the implementation of less robust peer education programmes in those National Societies that do not receive such support. Indeed, one National Society requested more support. Other regions do not adopt this approach but have elected to continue supporting those National Societies preparing to join the Global Alliance on HIV.

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<sup>19</sup> Philliber S. In search of peer power: a review of research on peer-based interventions for teens. In *Peer Potential: Making the Most of How Teens Influence Each Other*. Washington, DC: The National Campaign to Prevent Teen Pregnancy, 1999.

## **9. Monitoring and Evaluation**

- Some National Societies have robust monitoring and evaluation systems in place, whilst in others it is less robust and needs considerable strengthening.
- The suite of Monitoring and Evaluation Toolkits, at peer, peer educator and instructor training level, do not appear to have been utilized.

## **SECTION 12: RECOMMENDATIONS FOR THE WAY FORWARD FOR HIV PEER EDUCATION PROGRAMMING IN THE CARIBBEAN REGION.**

Whilst there are a number of recommendations made throughout this report, the following are key recommendations for the way forward. [Note that this section is replicated in full in the Executive Summary].

### **1. Peer education as an HIV prevention strategy**

In the International Federation's Global Alliance on HIV, peer education is a key approach for HIV prevention. A literature review of community-based peer education programmes targeting youth in lower income countries found that peer-led interventions are effective in connecting youth to services, distributing HIV prevention resources and increasing knowledge.

More importantly, several peer education projects also resulted in behaviour change to reduce the risk behaviours associated with sexual activity. Specifically, they led to an increase in condoms or contraceptives and a decrease in the number of sexual partners.

Although there has been limited rigorous evaluation of HIV prevention programmes, studies and national experiences over the past 20 years strongly suggest that strategies are likely to be most effective and cost-effective when **they are carefully tailored to the nature and stage of the epidemic in a specific country or community.**

In order to maximise the impact of peer education programmes, it is important that National Societies ensure that programmes:

- Are well targeted for vulnerability
- Provide consistent follow-up and support to peer educators
- Are implemented at a scale to have impact on the targeted population
- Utilize a life skills approach to HIV prevention.

### **2. The way forward**

As far as the way forward is concerned for HIV peer education programming in the Caribbean region, it is recommended that the focus of the programme remain with youth as this is an area in which National Societies have developed expertise and links. However, it would seem that TWC is at a juncture and is faced with a number of options:

#### **Option 1: Develop a new peer education programme responding to most-at-risk populations:**

Following an analysis of local epidemic patterns and the current response/gaps in each country, develop a new model which is shorter, more flexible, less intensive and less expensive, has multiple contacts to build trust and is more appropriate to most-at-risk and vulnerable populations. For example, peer outreach support, with one-to-one or small group peer led interventions. The model could, for example, be based on the model with young men who have sex with men that is currently being implemented by the Jamaica Red Cross. Other models utilised by National Societies in the Americas and in other regions could be explored and adapted, such as some of those highlighted in the International Federation's new HIV Prevention Guidelines.

#### **Option 2: Continue using TWC**

In the long-term, the continued use of the current model with existing target groups, i.e. working in the main with non-targeted and non-segmented in-school youth, youth in formal groups, including a small number of youth from vulnerable populations would not appear to be an option. It cannot be implemented at a scale to have impact on the targeted population, health and family life education either has been or is in the process of being introduced into schools and more importantly there is a need to work with key vulnerable populations in line with

- **The Global Alliance on HIV:** *"Interventions must seek out **the most vulnerable** and build resilience i.e. in line with the fundamental principles of the Red Cross Red Crescent, they must prioritise reaching and empowering the people that are most in need."*

- **The Standards for HIV Peer Education:** Standard 1.2: Targeting according to HIV vulnerability: *“Key populations that **are particularly vulnerable to HIV infection** are targeted by the peer education programme, based on local and international information on HIV vulnerability. Key populations include sex workers and their clients, injecting drug users, men who have sex with men and people in prisons, but may include other populations such as especially vulnerable youth, transgender people, migrants and mobile workers.”*
- **UNAIDS:** *“No single prevention measure or approach will effectively serve the varied populations in need in any country. As resources are limited, it is essential that strategic information [i.e. information on the epidemic and its drivers which can inform and support sound programmatic and policy decision-making to achieve programme goals] be used to guide assistance **towards populations and settings where HIV transmission occurs and which contribute most to the epidemic.**”<sup>20</sup>*

However, if National Societies want to continue using TWC as a peer education model, there would appear to be two alternatives, which could be phased into the work of the National Society

1. **Use TWC to work with key vulnerable populations:** Following an analysis of local epidemic patterns and the current response and gaps in a country, use TWC to work with relevant key appropriate vulnerable populations. That is, those who are not transient or do not lead less regular lifestyles, which mean that they are unable to commit themselves to attendance at all activities. Such an approach could capitalize on the experience that National Societies have already developed in working with key vulnerable populations and could include working with:
  - Young prisoners
  - Youth in reform schools
  - Street children living in institutions
  - An MSM organisation
  - NGOs whose focus is working with non-traditional TWC groups

This option should include a more in-depth assessment of the suitability of the current TWC model and curriculum for specific vulnerable populations, who should be involved during the assessment and adaptation processes. This option would require the adaptation of the curriculum with the target population to address their specific risk and vulnerability situation, in addition to training of youth peer educators from the target populations.

2. **Segmenting the target population:** Use the current model with an emphasis on
  - Shifting the focus from generic in-school youth and youth in formal groups by segmenting the target populations according to which in-school youth or youth in formal groups are most vulnerable to acquiring HIV.
  - Targeting youth in vulnerable locations, i.e. youth who live in locations that are violent, poor and in which sex for offers and sex work is common, or where there are high levels of youth migration. This approach would require research into youth sexual practices.

### **Option 3: Another option not listed above**

Whichever option is chosen, National Societies would need to take into account recommendations made in this report, including the need for:

- Significant changes in the curriculum content to reflect the realities of the lives of youth in the targeted populations, by addressing issues such as, forced sex, intergenerational sex, multiple and concurrent partners and transactional sex where these are not already included.
- An improvement in programme quality, including the provision of follow-up training and adequate supervision and the establishment of a routine monitoring system where these are not already included.
- Compliance with standards for HIV peer education programmes, in particular those standards that should underpin any peer education programme (see 3 below: Addressing standards and Section 8.3 and 8.4).

<sup>20</sup> Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access, UNAIDS, Geneva, 2007

### 3. Addressing standards

Implementing an effective youth peer education project such as TWC requires rigorous standards. Overall, National Societies need to address the three key standards that underpin HIV prevention peer education programmes related to the involvement of people living with HIV and key vulnerable populations, gender equality and advocacy as follows:

- **Standard 1:** That individual National Societies strengthen links with organisations of PLHIV and work towards their involvement in programme development and that partnership agreements with such organisations are drawn up and signed.
- **Standard 1:** That individual National Societies segment their in-school and out-of-school target population according to who is most vulnerable to HIV infection and at the same time actively target new vulnerable populations.
- **Standard 1:** That the Federation conduct through e-mail a learning needs assessment of staff and appropriate volunteers in relation to working with vulnerable populations and that this assessment informs the agenda for a workshop.
- **Standard 2:** That National Societies conduct a gender analysis (See *Standards for HIV peer education programmes*: Appendix 2: General analysis for an HIV peer education programme).
- **Standard 2:** That individual National Societies discuss the comparative advantages and disadvantages of conducting some elements of the programme in single-sex and mixed sex groups.
- **Standard 3:** That advocacy work is undertaken in relation to creating an enabling environment to ensure that friendly, accessible, affordable and appropriate sexual health services and resources to support peer education activities are available.

In addition to these three standards, if the TWC programme is to continue, a number of other standards need to be addressed (see Section 8.3 and 8.4).

### 4. Roadmap of the way forward

Presented below is an ideal roadmap of the way forward. It is recognised that due to financial constraints and existing plans for 2010, this roadmap may not be possible in its entirety. Discussions need to take place between the CRRO and the Zonal Office re funding for the process.

1. That at its next meeting, the Health Network appointed an HIV sub-committee, which is comprised of members who have experience in HIV programming.
2. That the CRRO conduct through e-mail a learning needs assessment of staff and appropriate volunteers in relation to working with vulnerable populations.
3. That HIV programme managers of all appropriate National Societies and the HIV sub-committee receive training (a maximum of five days) on the IFRC Standards for HIV peer education programmes and relevant sections of the HIV prevention principles and guidelines for programming facilitated by a person with experience in the Standards.
4. That following the needs assessment related to vulnerable populations, HIV programme managers of all appropriate National Societies and the HIV-sub committee receive training in working with vulnerable populations. Starting points for involvement in such a workshop could be the Jamaican Red Cross, with its young men who have sex with young men project, Caribbean Vulnerable Communities (CVC) Coalition (<http://www.cvccoalition.org>), International HIV/AIDS Alliance Caribbean Office and Jamaica AIDS Support for Life (JASL) (<http://www.jamaicaaidsupport.com/>).
5. That HIV programme managers of all appropriate National Societies and the HIV-sub committee together identify any further options and then take part in a facilitated SWOT analysis of **each option** in order to agree a Caribbean way forward for peer education work in the region.
6. That the HIV sub-committee agree an overall peer education strategy to guide future peer education work in the Caribbean.

7. That National Societies undertake an individual analysis of local epidemic patterns and the current response and gaps in a country.
8. That individual programme managers replicate the SWOT analysis within their National Societies to agree a way forward for their National Society within the newly developed peer education strategy.