TIME TO SHIFT FROM AWARENESS TO COMMITMENT

NGO MSM PROJECT ORIENTATION MANUAL
Acknowledgements

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

This orientation manual was written by John Howson and Nadia Badran. Simone Salem, on behalf of UNAIDS, and Manuel Couffignal, on behalf of the Alliance, revised and completed the report. Special thanks to Eltayeb Elamin from UNAIDS RST MENA, who provided critical feedback during the writing process.

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We sincerely thank the associations that organised and facilitated local workshops in April 2014 to review the toolkit: APCS in Algeria, AMSED in Morocco, ATL in Tunisia and SIDC in Lebanon. We are also grateful to the stakeholders who participated in these local workshops and provided valuable comments and input: ASCS, Association de Lutte contre le SIDA (ALCS) and OPALS-Fes in Morocco, Helem, Oui Pour la Vie, Lemsic and Lebmash in Lebanon, Arken and Damj in Tunisia, and Green Tea and AIDES-Algérie in Algeria.

Last but not least, we would like to thank Arab Foundation for Freedoms and Equality (AFE) and M-Coalition for their valuable comments during the review process.

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

The MENA programme’s partner associations

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

AIDS       Acquired immune deficiency syndrome
ART        Antiretroviral therapy
ARV        Antiretroviral
CCM        Country Coordinating Mechanism
CSO        Civil society organisation
Global Fund Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV        Human immunodeficiency virus
HCV        Hepatitis C virus
IDLO       International Development Law Organization
LGBT       Lesbian, gay, bisexual, transgender
LGBTI      Lesbian, gay, bisexual, transgender, intersex
MENA       Middle East and North Africa
MSM        Men who have sex with men
NGO        Non-governmental organisation
PEP        Post-exposure prophylaxis
PEPFAR     The United States President's Emergency Plan for AIDS Relief
PHDP       Positive Health, Dignity and Prevention
PrEP       Pre-exposure prophylaxis
STI        Sexually transmitted infection
UN         United Nations
UNAIDS     Joint United Nations Programme on HIV/AIDS
UNAIDS RST MENA UNAIDS Regional Support Team for the Middle East & North Africa
UNDP       United Nations Development Programme
USAID      United States Agency for International Development
VCT        Voluntary counselling and testing
WHO        World Health Organization
Introduction

Why this manual?
This orientation manual is the first of four volumes of a training toolkit that complement each other.

- The source document is the MENA regional UNAIDS handbook: *HIV and outreach programmes with men who have sex with men in the Middle East and North Africa: From a process of raising awareness to a process of commitment*.
- UNAIDS and the Alliance worked with local non-governmental organisations (NGOs) and civil society organisations (CSOs) across the region to develop a regional UNAIDS/Alliance MSM peer/outreach education training toolkit informed by global best practice.
- UNAIDS and the Alliance also developed this MSM project orientation manual together.

Who is it for?
The manual was developed to provide planners and managers working with HIV MSM programme prevention and support services with the necessary information to develop sympathetic, evidence-based and comprehensive HIV prevention and support services for MSM in the MENA region. The resource is useful to both experienced programme implementers as well as those who are beginning to plan new HIV prevention and care services for MSM.

How is it organised?
The manual is organised into three sections. The first two sections (Part A: Situational analysis and Part B: Conceptualisation) cover information related to the awareness part of the dynamic “from a process of awareness to a process of commitment”. They provide essential scientific, factual and contextual information needed by programme planners and managers in order to develop effective and ethical HIV prevention and support services for MSM that are informed and guided by human rights and public health imperatives. They are a source document, and contains links and references to other documents for those planners and managers who want to further explore the issues raised in this part of the toolkit (see Annex 2).

The third section (Part C: Towards action) covers the commitment aspect. In this section, we describe the kinds of interventions and processes necessary to develop effective programme interventions in response to the prevention and care needs of MSM in the MENA region.

Terminology
As you will discover in this manual, how to describe men who have sex with other men is complex. For our purposes here, MSM refers to gay-identified and other men who have sex with men.

While transsexuals may also have male genitalia and have sex with other men, it should be noted that they will not necessarily relate to programme interventions aimed at MSM as they may identify with the biological sex they feel they were meant to be. Therefore, when working with transsexuals, appropriate adjustments to prevention and care interventions will need to be made, and these should be informed and guided by transsexuals themselves.
**Limitations**

Since this is an orientation manual, it does not provide detailed guidance about project cycle management, from analysis, conceptualisation and design to implementation, monitoring and evaluation. These are generic programming processes that apply to any programme, and greater detail about them can be found in standard project management cycle guidance. Rather, this manual provides those thinking of developing programmes for MSM, or those already engaged with MSM, with an overview of some of the key issues and considerations necessary to develop ethical, evidence-informed programmes that are guided by global best practice, and human rights and public health considerations.

**How can you use it?**

This manual can be used in two ways:

- It can be used as an information reference and resource document.
- It can be used by trainers to develop customised MSM orientation training programmes for local and national NGOs and CSOs, as well as those in charge of resource allocation and policy development.

**How to plan an orientation training for civil society and NGO leaders**

It is essential that those who plan to use the content of this manual for training purposes have experience of working with MSM, have a positive regard and respect for MSM, are committed to human rights and the principles of public health, and are not afraid of discussing sensitive issues regarding sex and sexuality, and social norms. Ideally, experienced MSM programme staff should form part of the facilitation team.

In the table on pages 6 and 7, we outline an example of a timetable that could be used to run orientation training based on the contents of this manual. This is not prescriptive, and experienced trainers should be able to adapt the timetable to reflect the needs of their participants. Trainers may also find some of the exercises in the accompanying peer-education modules useful for their purposes.

Always remember that any training should be based on an appreciation of the adult learning principles described in the introductory section of Module 1 of the *Training manual for MSM peer educators*, and be enjoyable as well as instructional.
# ILLUSTRATIVE TRAINING OUTLINE

## DAY 1

| Session 1 | Introduction and setting the scene | ■ Introduction to workshop  
■ Participants’ introductions  
■ Participants’ expectations  
■ Aims and objectives of the workshop  
■ Short reflection on participants’ own feelings about working with MSM |
| --- | --- | --- |
| Session 2 | Epidemiology of HIV in the MENA region; statistics | ■ Global, regional and country statistics  
■ Drivers of the epidemic  
■ Types of epidemics  
■ Regional responses to the epidemic  
■ Introduction to MSM – what does MSM mean? |
| Session 3 | MSM | ■ Biology, sex and identity  
■ What influences or can explain sexual orientation?  
■ Questions and discussion |
| Session 4 | Experiences of MSM | ■ The range of sexual behaviour – the work of Kinsey and Fritz Klein  
■ “Coming out”  
■ MSM, family and society  
■ Conclusions and discussion |

## DAY 2

| Session 1 | Stigma and discrimination and MSM | ■ What is stigma and its impact?  
■ What is discrimination and its impact?  
■ Discussion |
| --- | --- | --- |
| Session 2 | Risk, vulnerability and sexually transmitted infections (STIs)/HIV | ■ What do we mean by risk and vulnerability?  
■ Brief overview of STIs and HIV  
■ STIs, HIV and MSM |
| Session 3 | Prevention and treatment | ■ HIV and STI prevention  
■ HIV treatment |
| Session 4 | Guiding approaches to inform HIV programmes | ■ Public health, human rights, combination prevention |
## ILLUSTRATIVE TRAINING OUTLINE

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<td>Guiding approaches and principles continued</td>
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<td>Session 3</td>
<td>How change happens</td>
<td>■ Bringing in global experience – combination prevention, and comprehensive prevention and treatment</td>
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<td></td>
<td>■ Introduction to multi-level responses</td>
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### DAY 4

| Session 1 | Exploring responses at the services and structural levels | ■ Services level: quality, user-friendly services – what they look like and improving access and quality |
|           |                              | ■ Structural level: addressing the policy and legal environment through advocacy and other forms of structural change |
| Session 2 | Wrap up, next steps and training evaluation | |

**Training should be enjoyable as well as instructional!**
PART A
SITUATIONAL ANALYSIS

In this section of the manual we provide important background information necessary to understand the HIV epidemic as it relates to MSM in the MENA region. Although HIV prevalence is concentrated among various groups who have a higher risk of exposure to HIV – sex workers, people who inject drugs, prisoners and MSM – the focus of this manual is to sensitise programme planners and managers to the unique issues related to men who are exposed to HIV primarily through sex with other men.
1. The scale, dynamic and focus of the HIV epidemic in the MENA region

A global epidemic

According to the most recent information from the World Health Organization (WHO)/UNAIDS, the number of people globally living with HIV at the end of 2013 reached 35 million (33.2–37.2), of whom 2.1 million were newly infected. Of these people, only 48% knew their HIV status.

By the end of 2013, 12.9 million people globally were receiving antiretroviral therapy (ART), and the percentage of people living with HIV who were not receiving ART had reduced from 90% (90–91%) in 2006 to 63% (61–65%) in 2013. However, 22 million, or three in five, people living with HIV were still not accessing ART.

The HIV epidemic in MENA

Despite the number of people who are newly infected with HIV continuing to decline in most parts of the world, unfortunately this is not the case in the MENA region. It is estimated that around 230,000 (160,000–230,000) people are living with HIV in MENA, with an overall HIV prevalence of 0.1% among adults aged 15 to 49 – one of the lowest rates in any region of the world. However, in 2013 the estimated number of new HIV infections in adults and children had reached 25,000 (14,000–41,000), showing an increase compared to 2005 that was only second to Eastern Europe and Central Asia, while everywhere else the number of new infections had declined during the same period (see Figure 1).

![Figure 1: Percentage change in the annual number of new HIV infections by world region, 2005–2013](image)


It is not just numbers of infections that are increasing. Between 2005 and 2013, the annual number of AIDS-related deaths in the region increased by 66% to 15,000 (10,000–21,000), while worldwide numbers are dropping. The increasing numbers of AIDS-related deaths in MENA are due in large part to low levels of ART use – a combination of medicines that not only extends the lives of those infected with HIV but also reduces the likelihood of viral transmission. Across the MENA region, only one in five people in need of ART are getting the medicines they require – the lowest coverage rate across the world. The lack of treatment is particularly acute when it comes to women and children. Less than 10% of pregnant women living with HIV receive antiretroviral medicines to prevent transmission of the infection to their baby – the lowest treatment rate in the world.

**Classification of the HIV epidemic in MENA**

HIV prevalence and transmission dynamics vary from one location to another, from one population to another, and across populations and locations. Therefore, there is no single description that can encapsulate the epidemic dynamics in MENA and grasp the enmeshed networks of transmission. However, the available evidence from almost all MENA countries suggests that the epidemic dynamic is highly influenced by transmission linked to behaviours like injecting drug use and transactional sex, and to populations of MSM.

In fact, more than half of new adult HIV infections are coming from key populations: a proportion remaining almost stable for more than a decade. Notably, the number of new infections in the general population has followed the same trend, highlighting transmission to partners and beyond. In Morocco, for example, the majority (89%) of HIV infections among men are due to high-risk behaviours such as unprotected anal sex with other men and female and male sex workers, and sharing contaminated needles and injecting equipment.

However, about half of Morocco’s new HIV infections are among women, with approximately three-quarters acquired from their husbands. Although there is
insufficient data to confirm what proportion of women become infected by a bisexual husband or partner, experience from countries with similar epidemics would suggest that that a proportion of heterosexually acquired HIV infection is as a consequence of the male sexual partner becoming infected through unprotected sex with another man. This infection dynamic in Morocco is similar to other countries in the region.

The table below contains the most recent HIV surveillance data about three key populations: MSM, people who inject drugs and female sex workers.

<table>
<thead>
<tr>
<th>PREVALENCE</th>
<th>MSM</th>
<th>PEOPLE WHO INJECT DRUGS</th>
<th>FEMALE SEX WORKERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;0.1%</td>
<td>Jordan, Syria</td>
<td>Syria</td>
<td>Egypt, Jordan, Yemen, Syria</td>
</tr>
<tr>
<td>1.0% to 4.9%</td>
<td>Egypt, Tunisia, Sudan</td>
<td>Algeria, Oman, Tunisia, Lebanon</td>
<td>Iran, Morocco, Sudan, Tunisia</td>
</tr>
<tr>
<td>5.0% to 9.9%</td>
<td>Morocco, Yemen</td>
<td>Egypt, Tunisia</td>
<td>Somalia</td>
</tr>
<tr>
<td>10.0% or higher</td>
<td>Algeria, Tunisia, Lebanon</td>
<td>Iran, Libya, Morocco</td>
<td>Algeria, Djibouti</td>
</tr>
</tbody>
</table>

Source: UNAIDS, AIDSIinfo [online]. Available at: https://www.unaids.org/en/dataanalysis/datatools/aidsinfo

Example: the situation in Tunisia

“It emerges from the collected data, 14.9% of respondents are married or have been married. In the Tunisian context, the institution of marriage is the only legitimate form of relationship socially, both religiously and legally binding for a family foundation and procreation. A number of men who have sex with men opt for marriage because of their bisexuality, their refusal to accept the exclusive label of “homosexuality”, their desire to give birth, their willingness to convey an image that is socially accepted, and social pressures on people to marry regardless of their sexual orientation …

Bisexuality marks the course of a number of men who have sex with men. It concerns different groups: young singles, young adults, candidates for marriage, divorced (sometimes because of their sexual preference for men), married, and sex workers.

This experience can be explained by various reasons such as:
- The refutation of exclusive sex between men in the Tunisian context;
- The substitution of sex between men by some men because of the social control against the sexes mixing;
- Social pressure on individuals to marry regardless of their sexual orientation;
- The search for financial gain in exchange for sex with male partners ...

The survey also found that 55.1% of respondents reported having had at least one female partner during their lifetime. Sex between men, especially when there is unprotected anal intercourse, increases the vulnerability of female partners of men who have sex with men and their future children vis-à-vis HIV and AIDS.”

Young men who have sex with men

The MENA region today is home to approximately 90 million young people; i.e. 20% of its population. As a cohort, young people are a vulnerable population and contribute disproportionately to the priority populations in MENA.

Young MSM are often more vulnerable to homophobia than older men, experiencing discrimination, bullying, harassment, family disapproval, social isolation and violence, as well as criminalisation and self-stigma. These abuses can have serious repercussions not only for their physical health and their ability to access HIV testing, counselling and treatment, but also for their emotional, social, educational and economic wellbeing. Governments have a legal obligation to support the rights of these under-18 year-olds to life, health and development. Indeed, societies share an ethical duty to ensure this for all young people. However, in many cases young people from key populations are made more vulnerable by policies and laws that demean or criminalise them for their behaviours, and by education and health systems that ignore or reject them, and fail to provide the information and treatment they need to keep themselves safe.

Despite data limitations, several studies have documented the nature of sexual behaviour among young people in MENA. The outcomes of behavioural surveys show substantial variability within the region. A study conducted in Egypt focused on high-risk behaviours of homeless MSM, and found that 65.8% of participants had had their first same-sex encounter before the age of 15. At the time of the study, nearly 80% of young participants had both single and multiple sex partners, and roughly 70% exclusively had had sex with men.7 In Lebanon, 54% of MSM reported having had their first anal sex under the age of 18.8 Another study focusing on MSM in Sudan revealed that more than half of participants (60.1%) were aged between 15 and 24 years, and 85.5% of them had had their first anal experience between the ages of 15 and 25.9

Risk factors that contribute to the spread of HIV and other sexually transmitted infections in MENA

As HIV is transmitted silently and the incubation period between infection and the first sign of symptoms is often many years, the HIV epidemic is sometimes described as "double blind". There are a number of factors that contribute to the increased risk of MSM to HIV and other infections across the region:

■ Those who are at greatest risk of infection are sex workers and MSM. Both of these groups are condemned by dominant social and cultural norms in the region. These beliefs and norms are also often reflected in the law through criminalisation. Those most at risk of HIV are often not very visible in society, and therefore HIV prevention and support services for them are either not well developed or easily accessible.

■ High levels of external and internalised (self) stigma often lead to low self-esteem among MSM, which is associated with increased risk-taking.

■ Discrimination against MSM is reflected in the poor track record of countries in the region in recognising and upholding their human rights.

Poor provision of and access to health and social support services that are appropriate to MSM.

Limited access to and use of condoms and condom-safe lubricants to reduce risk through penetrative sex.

Challenges in reaching MSM for HIV prevention and support, particularly since many MSM are married and outwardly living a heterosexual life.

In some areas, injecting drug use is also on the rise, and this often involves sharing drug-using equipment, which carries a high risk of HIV transmission.

MSM recreational use of alcohol and psychoactive substances is also on the increase, and their use can lead to increased risk-taking or a lower ability to manage risk.

There is a lack of educational materials customised to the sexual practices of MSM.

Other political, social and cultural factors, some of which have emerged or became more prominent with recent developments in the region, are described below:

- There are several MENA countries where adult consensual same-sex sexual conduct is illegal and punishable by death. These include the Islamic Republic of Iran, Saudi Arabia, Somalia (southern parts), Sudan and Yemen. Other countries either criminalise adult consensual same-sex sexual conduct or have criminally prosecuted lesbian, gay, bisexual and transgender people under other laws based on their sexual orientation and gender identity. These include Algeria, Egypt, Iraq, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, the Syrian Arab Republic, Tunisia, and the United Arab Emirates.

- These discriminatory legal measures make it less likely for MSM to be able to access HIV prevention services, including regular voluntary testing or access to prevention commodities such as condoms and water-based lubricants. They are also less likely to organise and participate meaningfully in the design of programmes to provide HIV services, peer outreach or other community-level initiatives, thereby limiting public health outcomes for the country.

- Further, the criminalisation of sex work and same-sex relationships in many MENA countries means that the issue is treated largely as a criminal law concern rather than a public health issue. Over-reliance on criminal law and its enforcement undermines public health programmes that have demonstrated effectiveness in improving the health of key affected populations and reducing the spread of HIV.

- The overall policy environment continues to challenge the HIV response due to ongoing or escalating conflicts in many countries. The development landscape in the region has been adversely affected by conflicts, and the humanitarian response is often prioritised over development programmes, whether in countries directly affected by the conflict or in neighbouring host countries. An example is the impact of the Syrian crisis on the economy, demographics, political instability and security in Lebanon and Jordan, as well as Iraq and Egypt. Furthermore, Syrian refugees, like the host local communities most affected by the influx, are becoming increasingly vulnerable despite the large-scale inter-agency response to date. Humanitarian needs show little signs of abating. As their displacement extends and their savings deplete, refugees' socio-economic vulnerability increases.

- Stigma against MSM in many countries, especially those affected by the Arab Spring, is buttressed by religious conservatism that further constrains the much-needed HIV response among gay and MSM communities.
Responses to the HIV epidemic in MENA

Despite the challenges, there have been a number of important responses so far to HIV in the region. Among the most significant, and considered to be a turning point in the political commitment to the HIV response, is the Arab AIDS Strategy 2014–2020, which was endorsed by the Council of Arab Ministers of Health on 13 March 2014 during its 41st Ordinary Session held at the League of Arab States. The strategy is intended to guide the development of a multi-sectoral, coordinated and consensus-driven regional response to HIV.

It is based on ten goals that are aligned to the targets set in the 2011 United Nations General Assembly Political Declaration on HIV and AIDS, while maintaining a broader vision for an AIDS-free generation beyond 2015. Targets key to the HIV response among MSM include:

- reduce HIV incidence among key populations at higher risk of infection by more than 50%
- increase HIV treatment coverage to 80% (which is also scaled up among key populations
- address stigma and discrimination.

The strategy as a major regional commitment to advancing the HIV response can act as a catalyst for increased action and accountability at country level. This guiding document was the result of a rigorous consultative process with all partners and actors, including civil society and affected populations.

Another milestone is the Arab Convention on the Prevention of HIV/AIDS and the Protection of the Rights of People Living with HIV that was passed by the Arab Parliament in 2012. Ongoing efforts with United Nations (UN) agencies, League of Arab States and civil society are in place towards ratifying it in countries of the region. The purpose of this convention is to protect the community by promoting, protecting and ensuring that all people living with HIV enjoy, in full and on an equal basis with other people, all human rights and fundamental freedoms. It is also to promote respect for their dignity, and to enable them to participate fully and effectively in their societies on equal footing with other people, within the framework of the national identity of the Arab countries. The term “people living with HIV” covers every person to whom the virus has been transmitted, regardless of the method of its transmission, and is referred to in this convention as “the person living with HIV”.

The region has also recently witnessed a strong surge by civil society at the regional level, yielding strong thematic regional networks such as the Regional Arab Network Against AIDS (RANAA), MENAROSA and M-Coalition focusing on work with key populations, particularly MSM and sex workers, as well as the meaningful involvement of people living with HIV. Another relevant actor is the Arab Foundation for Freedom and Equality, whose mission is to “encourage and support body, gender and sexual rights activists in the MENA region in their work by building their capacities, funding the activists to organise and providing emergency support to activists when needed”. Another important programmatic achievement is the USAID-funded MENA programme, implemented by the Alliance and CSOs from Algeria, Lebanon, Morocco and Tunisia, which has richly impacted on the HIV response among MSM over the last few years. Finally, the newly established M-Coalition is the first regional network of MSM in MENA to voice the needs, challenges and also possibilities for stronger involvement of this important and catalytic key group in the HIV response.

Among the important efforts paving the way for an enabling environment has been the strong voices of religious leaders within the CHAHAMA (Network of Arab
PART A: SITUATIONAL ANALYSIS

Example: Helem

Helem (Lebanese Protection for Lesbians, Gays, Bisexuals and Transgenders) is a non-profit NGO that presented its notification of association to the Lebanese Ministry of Interior on 4 September 2004.

Although it focuses on sexual orientation and gender identity issues, Helem's membership is open to anyone who shares its values based on the Universal Declaration of Human Rights. Helem is also strongly opposed to any kind of segregation, whether in the services it offers or in the struggle it leads.

Helem's primary goal is the annulment of Article 534 of the Lebanese Penal Code, which punishes “unnatural sexual intercourse”. This law is used primarily to target people with non-conforming sexuality or gender identity, through the violation of their privacy and by denial of their basic human rights. Abolishing this law, along with other laws that criminalise non-conforming sexuality or gender identity, will help to reduce state and societal persecution, and pave the way to achieving equality for the lesbian, gay, bisexual and transgender (LGBT) community in Lebanon. The presence of Helem in Lebanon is very important to this long-term work.

Example: M-Coalition – the first Arab coalition on MSM and HIV

Hosted by the Arab Foundation for Freedoms and Equality (AFE), the M-Coalition is an advocacy platform that coordinates at local, regional and international levels in order to facilitate the access of MSM to prevention, care and treatment services, and to quality support. It achieves this through advocacy, creation of a favorable environment, capacity-building and follow-up, research, exchange of good practices, and by collaborating with other structures of health and human rights, as well as relevant key policymakers.

The M-Coalition was created during a gathering in Lebanon in January 2014 to discuss the future of the HIV response among MSM in the region. The meeting, supported technically by the Global Forum on MSM & HIV (MSMGF), united 13 civil society advocates and service providers from five MENA countries (Algeria, Lebanon, Mauritania, Morocco and Tunisia) who decided to stay connected. In this way, under the name of M-Coalition, they created the first regional coalition of advocates and service providers working on HIV among MSM in the MENA region. In July 2014, the M-Coalition was officially presented during the International AIDS Conference in Melbourne, Australia.

M-Coalition members commit to increase their efforts and to unite with key stakeholders from national governments, international institutions, CSOs and the MSM community to improve the coverage and quality of HIV prevention, treatment, care and support interventions targeting MSM in Arab countries.

religious leaders responding to AIDS) regional network of faith-based organisations that brings together Muslim and Christian leaders across the Arab countries. This initiative, initiated and supported by the United Nations Development Programme (UNDP)/Regional HIV/AIDS in the Arab States (HARPAS), has mobilised 250

Christian, Muslim, male and female religious leaders in the region, who are now initiating their own outreach work, anti-stigma campaigns, and care and support programmes for people living with and affected by HIV.
Example: the MENA programme – responding to the needs of MSM in MENA

The MENA programme is a community-based outreach programme for MSM funded by USAID since 2004. For many years it has been the only continuous MSM-focused service delivery programme in the region. It is implemented in four countries – Algeria, Lebanon, Morocco and Tunisia – by six HIV-thematic organisations, one development organisation and one LGBT organisation. These partners are among the few CSOs working openly with MSM and having MSM staff.

The project has established community-based outreach programmes in various sites, where partner CSOs implement a package of combination prevention services aimed at MSM. CSOs inform programme development by carrying out participatory situation assessments of the various MSM communities and identifying their needs. They train and support teams of volunteer MSM peer educators, who implement prevention, HIV test promotion and referral activities. They offer HIV testing (rapid), pre- and post-test counselling, and psychosocial and legal support. They also try to challenge stigma and discrimination through stigma reduction workshops targeting health service providers and other audiences.

Every year, approximately 20,000 MSM are reached through one-to-one peer support and small group discussions, educational sessions and counselling. In addition, 80,000 condoms and 40,000 lubricant sachets are distributed to MSM; 3,000 MSM receive voluntary counselling and testing (VCT) services provided by the CSOs; and several thousand are referred to public VCT, STI diagnosis and treatment services.

The programme has had a significant impact on MSM lives, including their personal development (life skills, self-esteem), access to relevant prevention, care and support services, and development of prevention-seeking behaviours. The partner CSOs have become central actors in the response in their respective countries, and are regularly solicited on MSM programming by their national AIDS programmes and other strategic stakeholders. At the same time, their advocacy efforts have raised awareness on the specific vulnerabilities and needs of MSM among health authorities and service providers, and contributed to the reduction of stigma in healthcare settings.

Finally, the programme has significantly contributed to the empowerment of the lesbian, gay, bisexual, transgender, intersex (LGBTI) community by providing continuous support to the only legal LGBT organisation working specifically with the transsexual community and, through its continuous training and support, to teams of MSM peer educators. In this respect, it serves as a “school” for LGBT activists.

10. APCS in Algeria, SIDC, Helem and Oui Pour la Vie in Lebanon, ATL in Tunisia, AMSED, OPALS-Fes and ASCS in Morocco.
These initiatives, coupled with a growing number of studies on key populations, are strong indicators of an increasing willingness of national governments in the region to acknowledge HIV as a national challenge that requires intervention. Yet this commitment towards HIV prevention, treatment, care and support services at the national level varies from one country to the other within the list of their national priorities. Also, in most cases it is not coordinated or uniform across all decision-makers, such as law enforcement agents, religious leaders and the media, who are important in influencing an enabling environment for supporting responses at the regional, country and local levels, especially for interventions targeting key populations.

The region also receives leadership support from UN agencies to help to build local and regional capacities, strengthen the role of CSOs, share country and regional experiences, and develop and support programmes that are firmly based on human rights, public health and global best practice. This is done through coordinating, funding and technically supporting applications for global funding in eligible countries (and through continuous advocacy in non-eligible ones) for domestic resources on HIV and AIDS, especially on prevention efforts.

2. Men who have sex with men

Why “men who have sex with men”?

“Men who have sex with men” (MSM) is a concept developed in public health to describe sexual behaviour between men. It is a label used to describe behaviour and not identity. While some men who have sex with men will define themselves as homosexual/gay or bisexual, many will not because it does not reflect their perception of their own identity. For instance, sex between men can take place between men in single-sex only environments such as prisons and the military, and those men who have sex with other men in that context will do so because their preferred sexual partner, a woman, is unavailable. Likewise, some married men may have sex with other men while still enjoying active and satisfying sexual relations with their wives. Other married men may prefer to have sex with men but for family and societal reasons will live in a traditional heterosexual marriage. Another increasing trend in MENA countries such as Egypt and Tunisia is men having sex with men within the context of sex work.
This distinction between behaviour and identity is particularly important in the MENA region, where sexual identity is differently understood from many European and Western-based countries. For instance, scholars have argued that there is no historical concept of homosexuality within Arab history, despite many descriptions of sexual expression between men, and between older and younger men/boys, in poetry and literature. While there are a number of countries within the region who have a recognised homosexual (gay) community, in other countries sexual behaviour between men will be much more hidden and secret.

The reality is that despite protestation and denial by some, historical and contemporary evidence shows that sex between men has existed throughout history and in all civilisations. Within the MENA region it is referred to in Arab stories, novels, poems and songs, and exists among all age groups, social classes, educational backgrounds, marital statuses, races, colours, nationalities and ethnicities.

**Biological sex, gender identity and sexual orientation**

To deepen our understanding of human sexual behaviour and its association with HIV risk, it is important to understand how biology, gender and identity interact as they refer to MSM. Definitions are not always straightforward, and yet understanding them is vital to inform the basis and development of meaningful HIV prevention and care services.

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**The Spectrum of Human Biology and Anatomy**

![Image of the spectrum of human biology and anatomy]

**Intersex**

Historically, people who are intersex were known as hermaphrodite. Most people who are intersex were assigned a gender identity (male/female) by doctors and/or family, and sometimes underwent surgery to make their genitalia match their assigned gender identity. Empirical evidence has shown that children born intersex often suffered greatly from being assigned an identity that did not necessarily match how they felt about themselves. Over recent years, many people who are intersex have come to define themselves as a third sex and do not want to be assigned to a male or female identity. They do not feel that they need to be changed in any way from how they were born.

Our **biological sex** refers to our physical biology at birth defined by our genitalia. Predominantly, the human race is born either female or male, with a small percentage (between 0.1% and 1.6%) who have ambiguous genitalia or both. These people are normally described as “intersex”.

There are also a number of people who from the earliest age feel that their genitalia do not reflect how they feel; i.e. someone with female genitalia may feel that they are a man and vice versa. People who feel this way are known as transsexual.

Our **gender identity** refers to the way that we outwardly express ourselves in how we dress, behave and identify. Normally this is heavily informed and framed by cultural and social norms. Feminine identity is associated with being a women and masculine identity is associated with being a man. In reality, this is not so defined.

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12. Ibid.
and there are women who may display characteristics that would be commonly described as masculine and vice versa.

However, if a man expresses traits traditionally associated with femininity, this does not necessarily mean that they are homosexual, and a woman who expresses traits traditionally associated with masculinity is not necessarily a lesbian. In fact, gender norms are changing and evolving, and this is demonstrated by what is acceptable now for men and women regarding clothes, hairstyles, professions and so on, compared to what was acceptable in the past.

The term **transgender** describes someone who dresses, acts as, and wishes to be (or is) recognised as a member of the opposite sex from which they were born. It includes those people who identify as transsexual and transvestite.

A **transsexual** is someone who feels they are in the wrong biological body and wants to change it – or has changed it through hormone treatment and sometimes surgery. This is known as gender reassignment. Once a person has gone through gender reassignment, they often identify as the other sex from the one they were born as. However, changing their body does not mean that they necessarily change their sexual orientation. Therefore, someone who was a biological man who loves women prior to reassignment will continue to love women post reassignment, and vice versa.

A **transvestite** is someone who dresses and makes themselves appear outwardly as the opposite gender. It does not mean that a man who dresses as a woman wants to have sex with men, or vice versa. There can be many reasons why people dress as the opposite sex, including for enjoyment, relaxation, sexual pleasure, sex work, entertainment work (dancer, singer) or sometimes for ritual purposes.

**Sexual orientation** refers to sexual attraction; i.e. who arouses our sexual feelings and who we want to express our sexual feelings with through sexual and other forms of intimacy.

Someone who is **heterosexual** seeks sexual intimacy with someone of the opposite sex.

Someone who is **homosexual** seeks intimacy with someone of the same sex.

Someone who is **bisexual** seeks intimacy with both men and women.
Over a lifetime, people may not feel they are so clearly defined by these labels. Who they primarily have sex with when they are young may be different from who they have sex with as they get older.

What influences or helps to explain sexual orientation?

People often ask what influences or explains sexual orientation; i.e. why some people are heterosexual and others homosexual.

Scientists and researchers have explored many different areas of investigation. These have included the study of:

- **genes** – possible genetic differences between homosexuals and heterosexuals, and evolutionary genetics (the idea that sexual orientation has occurred to adapt to context).
  
  Exploring the hypothesis that genes have a determining effect on sexual orientation has also included the study of identical and non-identical twins. These studies have shown mixed results, with some finding a strong link between being a twin and having the same sexual orientation, whereas other have not found a significant link

- **hormones** – the influence of male and female sex hormones (testosterone and oestrogen) on foetal development

- **the brain** – the structure of the brain; i.e. whether there are any differences in the brain structure of people who are heterosexual or homosexual

- **psychology** – psychological theories, including the influence of family dynamics and relationships

- **family history** – transgenerational factors; i.e. is there a pattern of people being homosexual in particular family lines, and therefore might homosexuality be more common in one family line than another. This area of investigation is also linked to the study of genes

- **societal norms** – exploring sociological/contextual factors; e.g. the influence of social norms on sexual expression and identity; the history of same-sex relationships within a given culture.

The reality is that none of these areas of study have proven conclusive, although interesting differences have been observed. While it might appear from reading the results of one study that there is evidence that genetics has a strong influence on sexual orientation, other studies exploring the same area of investigation have not found the same results.

Historically, some psychiatrists and religious groups have tried various approaches to change people who are homosexual into people who are heterosexual through what is known as “conversion therapy”. Often the measures used have been
extreme, including electric shock therapy and intense psychological reorientation. Independent assessment of the results of conversion therapy have shown that it has little or no success, but that the psychological harm of undergoing the therapy can leave a negative legacy.

WHO, in its International Classification of Diseases (ICD-10), reviews all global evidence to define what is and is not a disease. After reviewing the entire body of research, it concluded that “sexual orientation by itself is not to be regarded as a disorder”, and therefore any non-consensual attempt to change someone's sexual orientation would be seen as a violation, as being homosexual is not a disorder.

**The range of same-sex behaviour and expression**

While there is no conclusive explanation about the factors that influence whether someone is heterosexual or homosexual, researchers have tried to understand the range of same-sex experience and, based on their research, develop frameworks that help to capture the range of human sexual experience.

**The Kinsey scale**

In 1948 the American scientist Alfred Kinsey developed a scale system to help to classify the spectrum of human sexual orientation. He developed this because his research had suggested that sexual orientation is more subtle than is indicated by the heterosexual–bisexual–homosexual continuum. For instance, some men may be predominantly heterosexual but have occasional sexual contact with other men and not define themselves as bisexual. He developed a six-point scale that people can use to position themselves along the spectrum from heterosexual to homosexual. The rating is what the person themselves thinks best reflects their experience.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Exclusively heterosexual</td>
</tr>
<tr>
<td>1</td>
<td>Predominantly heterosexual, only incidentally homosexual</td>
</tr>
<tr>
<td>2</td>
<td>Predominantly heterosexual, but more than incidentally homosexual</td>
</tr>
<tr>
<td>3</td>
<td>Equally heterosexual and homosexual</td>
</tr>
<tr>
<td>4</td>
<td>Predominantly homosexual, but more than incidentally heterosexual</td>
</tr>
<tr>
<td>5</td>
<td>Predominantly homosexual, only incidentally heterosexual</td>
</tr>
<tr>
<td>6</td>
<td>Exclusively homosexual</td>
</tr>
<tr>
<td>X</td>
<td>No socio-sexual contacts or reactions</td>
</tr>
</tbody>
</table>

You can read more about the Kinsey scale at: http://en.wikipedia.org/wiki/Kinsey_scale

**The Klein Sexual Orientation Grid**

Researchers, while fully acknowledging Kinsey's pioneering work, have observed that his scale does not take into consideration issues such as how orientation can change throughout a person's lifetime, and also how a person expresses their sexual orientation emotionally and socially rather than just sexually. In 1978, Fritz Klein developed a more refined tool called the Klein Sexual Orientation Grid (KSOG), which takes into consideration other factors that may relate to sexual orientation, such as a person's fantasy life, emotional attraction and their own self-identification.

The KSOG uses a seven-point scale to assess seven different dimensions of sexuality at three different points in an individual’s life: past (from early adolescence up to one year ago), present (within the last 12 months), and ideal (what would you choose if it were completely your choice). To complete the grid, the person uses the scoring guidance that is given after the grid.

THE KLEIN SEXUAL ORIENTATION GRID

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>PAST (UP TO LAST YEAR)</th>
<th>PRESENT (LAST 12 MONTHS)</th>
<th>IDEAL (IF YOU HAD A CHOICE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Sexual attraction. To whom are you sexually attracted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Sexual behaviour. With whom have you had sex?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Sexual fantasies. About whom are your sexual fantasies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Emotional preference. Who do you feel more drawn to or close to emotionally?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Social preference. Which gender do you socialise with?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Lifestyle preference. In which community do you like to spend your time? In which do you feel most comfortable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Self-identification. How do you label or identify yourself?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scale to measure variables
Starting with the past, individuals choose a number that most corresponds to their situation based on the guidance scale below. The process is then repeated for the “present” and “ideal” boxes, bearing in mind that there is no right or wrong number.

These tools are presented here to give some insight into the kinds of research and tools used to measure sexual orientation.

Scale to measure variables A, B, C, D and E of the KSOG

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>other sex only</td>
<td>other sex only</td>
<td>other sex mostly</td>
<td>other sex somewhat more</td>
<td>both sexes equally</td>
<td>same sex somewhat more</td>
<td>same sex mostly</td>
<td>same sex only</td>
</tr>
</tbody>
</table>

Scale to measure variables F and G of the KSOG

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>heterosexual only</td>
<td>heterosexual only</td>
<td>heterosexual mostly</td>
<td>heterosexual somewhat more</td>
<td>heterosexual/ homosexual equally</td>
<td>homosexual somewhat more</td>
<td>homosexual mostly</td>
<td>homosexual only</td>
</tr>
</tbody>
</table>
Conclusion

It is not the purpose of this orientation manual to explain the full history of research around sexual orientation. However, there are a number of conclusions that can be confidently asserted from the available evidence:

- There are people who are heterosexual and homosexual in all countries and cultures, including in the Arab world and in MENA.
- Sexual orientation (who we are sexually attracted to) is rarely a matter of choice. Most people become aware of their sexual orientation early in their teens, if not before, even if they are not able to put a name to what they are feeling.
- Homosexuality is not a disease or sickness but rather a part of the rich diversity of human experience.
- There is a wide variety of experience in our sexual fantasies, and what we fantasise about does not necessarily translate into how we behave sexually.
- Non-biased research has shown that it is not possible to “convert” someone who is primarily homosexual into someone who is primarily heterosexual. In fact, research has shown that the methods used to try to convert people’s sexual orientation can be very damaging to the individual’s wellbeing. Homosexuality is not a disease or a disorder, and it does not need to be changed.
- There is a myth that people who are homosexual are also paedophiles. This is not true. Tragically, both girls and boys experience sexual abuse, and paedophiles are just as likely to be heterosexuals. In fact, evidence has shown that most child sexual abuse occurs within families by family members.
- Sometimes parents feel that they are in some way responsible for their child being sexually attracted to people of the same sex. In fact, there is no evidence that same-sex attraction is the result of parental nurturing. There are people who are homosexual in all societies in the world. Homosexuality is not a disorder, although historically it has often been treated as such, and in some cultures and societies continues to be so.

“Being MSM is a big challenge, especially when you live with your parents. They do not stop nagging about marriage. I am looking for a woman and I want her to be lesbian so we can ‘cover up’ our sexual orientation with a fake marriage and please society.”

MARRIED MSM, 32 YEARS OLD

STORIES OF MSM LIVING IN MENA

Khalid, a 37-year-old married MSM

Khalid started to have sex with men when he was a young man. He knew that he was gay and was comfortable liking men, although he was worried that his family would find out. Other MSM friends had been “discovered” by their parents and their lives had become miserable. When he became 30, his parents started to pressure him to get married. He agreed, hoping they would leave him in peace, but he continued to have occasional male partners.

Soon after getting married, he found out that one of his previous male partners had tested HIV positive. So he started to worry about his own status. What would people think if he was HIV positive? Would they find out that he was MSM? How would he be treated? He went to a public health centre to take a HIV test, but the healthcare worker made him feel very uncomfortable. He asked lots of questions about Khalid’s sex life. When Khalid mentioned having had sex with men the counsellor said, “No, you are not one of those! You seem different!”

Khalid left the clinic without taking the test and promised himself he would never go back. He started to worry about infecting his wife, so insisted on using condoms with her. However, she got angry saying that she wanted to have children. Khalid became very depressed and worried about what to do next.
PART A: SITUATIONAL ANALYSIS

"I do not know yet if I am really homosexual. I have been doing it for a long period of time because I was seduced by others to hang out and have fun. Now I am not sure if I can get an erection whether by a woman or a man. I am so confused."

MSM LIVING WITH HIV, 37 YEARS OLD

Badiane, a 42-year-old MSM who has always wanted children

Three years ago Badiane met a woman with whom he had two children. She does not know that he used to have sexual relations with men. Last year he started getting sick, and since then has become progressively more ill. He doesn’t know his HIV status, worries about his health and is aware that he should go for an HIV test. But his biggest fear, if he tests HIV-positive, is for his children’s future and what will happen to them. So he keeps postponing the HIV test.

Mehdi, 30-year-old policeman

Men in the community make fun of Mehdi because of his walk, and this makes him less confident in his job. He has a male lover but also a girlfriend in order to keep up the appearance that he is not MSM. He has joined other policemen in arresting male sex workers. He is struggling with leading this double life and wishes he could be more comfortable with himself as an MSM.

MARRIED MSM

Feedback from peer educators and MSM consultation meetings show that one of the major challenges in the HIV response among MSM in the region is that many MSM are married and/or also in a relationship with a woman. Although this situation is not unique to MENA, experience suggests that the prevalence of married MSM is greater than in other parts of the world. This presents significant challenges to HIV prevalence among partners of MSM, as well as to prevention, treatment and care in the MENA region. The reasons for this are complex and relate to the religious, political and socio-cultural context. These influences have an impact on the responses of parents and families to their children who are MSM.

"I am homosexual and I consider myself different, thus out of the ordinary. This could be positive and does not always have to be negative."

GAY, 20 YEARS OLD

‘During my teenage years I noticed that I was different. I wasn’t like my friends, and I began to notice that I liked men. I knew if wasn’t the norm in my circle of friends and family. I felt inferior. I became very withdrawn and alone most of the time to protect myself.

‘As I am thinking I realise that I’m there like an island in the plain ocean ... anywhere I look, and as far as I can remember, I only see my own reflection. Loneliness weighs on me ... I miss my family.’

GAY, 20 YEARS OLD
3. Stigma, discrimination and their impact

In this chapter we begin to encounter some of the complexities involved in responding to the HIV epidemic among MSM in the MENA region. We will do this by looking at part of the root cause, which is stigma towards MSM and how it is manifested in discrimination and denial of human rights.

What is stigma and how does it relate to MSM?

Stigma is a set of negative beliefs and attitudes that people in a group or society have about something, and most often relates to attitudes towards individuals. It sometimes relates to particular behaviours, but more often to some fundamental characteristic of another person that they cannot change, such as the way they look, mental illness, disability or being a member of a particular nationality or tribe. What is powerful and often so damaging about stigma is that the negative beliefs and attitudes are usually held by the majority whereas those who are stigmatised are from a minority in a society.

The impact of stigma is far-reaching and pervasive. Stigma can lead to discrimination and persecution. It can also result in the person, or even group, who is being stigmatised internalising the negative attitudes and behaviour, and therefore suffering from both outward and internalised stigma.

Historically, MSM, including men who are gay and people who are transgender, have been the focus of stigma by majority populations, including in the MENA region. As opposed to discrimination, which is much easier to identify, stigma is often expressed in subtle but powerful ways. Stigma has its origins in dominant cultural, religious and societal beliefs, and therefore is not always easily recognisable or even seen as a problem by the majority – it is just the way it is. Heterosexuality is seen as the norm, and any variation from it is considered to be deviation; something abnormal and wrong that should be punished.

Homophobia

Stigma can be expressed in the way that someone speaks to another person, in the way they look at them, the way they interact with them on a daily basis, or the way that they speak about them to others. What is characteristic is that the person who is stigmatised – the person who is gay, transgender or MSM – is seen as “other”: someone who is different and undesirable, someone who is not even worthy of respect. This is known as homophobia. Stigma and homophobia can cause deep and lasting harm to people who are MSM.

Young people absorb the dominant attitudes and beliefs of the society in which they live. As they grow up and realise that they may be sexually attracted to people of the same sex, they often experience deep shame and fear as they learn that this is not perceived as acceptable in society. This can lead to isolation and self-hatred, and is often described as internalised homophobia.

The impact of stigma is pervasive and its consequences far reaching. Research has shown that men and women who are sexually attracted to people of the same sex experience much higher levels of depression than the majority, and suicide levels are several times higher than in the general population. It is not only the general public who can demonstrate overt discrimination. Healthcare workers can too, together with those in charge of allocating health and social care resources, the judiciary, religious leaders, the police, the media – all of them people who have

power and influence. The result of this is that MSM do not get the health and social support care they need, or the protection from the police or the law that is the right of every citizen. Stigma can also lead to a society's tolerance of abuse and violence towards MSM.

Recent crackdowns and arbitrary arrests of MSM groups in Lebanon and Egypt are evidence enough of violent discrimination. However, a positive note to consider has been the powerful response of civil society that led to the release of the MSM in Lebanon. Similar support was provided in Egypt through vigorous efforts from CSOs and the International Development Law Organization (IDLO).

**Self-acceptance and “coming out”**

Many men whose sexual orientation is homosexual/gay live a hidden life in fear of being found out by family and others who they feel may not accept them as they are. Despite this, many men around the world, including in the MENA region, have decided to be open about their sexual orientation. For many, this means “coming out” as gay. For some people, coming out is the end point of a struggle towards self-acceptance, and has meant overcoming their fear of persecution and violence, rejection and isolation. For others, the experience is more straightforward and self-acceptance has been easier to achieve.

The experience of the majority of people who have come out is ultimately a positive one in that they no longer have to hide who they are, and they have been often surprised by their experience of acceptance by close friends and family. They no longer feel that they have to hide who they are to themselves or others, and they can also seek the support that they need. Few who have come out regret doing it. However, the process is not always straightforward or easy. There are many gay men who have come out and have experienced rejection by friends and family, and this can be hugely challenging and hurtful to deal with. Support from friends and others within the gay community can help enormously if the person is able to access it.

For families who have found it very difficult to accept that their son or daughter is gay, getting support from other parents and families who have been through a similar process of acceptance can help them with their own experience and enable parents to continue having a meaningful, open and honest relationship with their gay child. This is sadly not the case for all families, and there are parents who reject their children because they are gay and cut off communication with them. This can be very painful for the child and leave them ostracised and estranged from those they thought had loved them most.

**The family’s understanding and acceptance**

Parents, siblings and immediate family often go through a difficult process of coming to terms with their child’s sexual orientation. They may go through a period of denial and disbelief. For those who find it difficult to accept their child as gay or homosexual, their reaction is often fuelled by fear, guilt and shame. They may want to try to understand and find explanations for why their child is gay, and some blame themselves. Given the prevalent attitudes and laws around same-sex love in the MENA countries where they live, they may experience conflicting emotions around wanting to love and support their child while also not wanting to disregard the values expressed by their societies. Finding an opportunity to talk to other parents of gay children can be helpful, although where there is little public discussion about homosexuality it can be difficult to find parents who are willing to support others openly. Some parents find it too difficult to accept their child as homosexual and simply reject them.
I LOVE THEM …….. BUT: SiDC’s and Helem’s booklet for parents of MSM

I LOVE THEM …….. BUT is a parents’ guide that was developed in 2009 within the framework of the MENA programme by SiDC, in partnership with Helem. The booklet addresses parents’ issues around the homosexuality of their children and how best to deal with their gay/lesbian children. The booklet was developed through a participatory approach involving focus groups with MSM and interviews with parents and family members of homosexuals (men and women). There was a desk review, and documentation of resources on homosexuality and misconceptions. A series of questions were also developed on the issues and concerns of parents, and advice on how to deal with these with their children. The content was developed, tested and finalised, then revised by psychologists and psychosocial counsellors. The booklet includes a definition of homosexuality, a series of questions and answers that parents ask themselves when they discover or suspect that their children are homosexuals, misconceptions about homosexuality, stages of acceptance, and references.

What is discrimination?

Discrimination is the manifestations of stigma, negative beliefs and attitudes. Discrimination is often much more easily recognisable than stigma as it can be objectively observed and assessed.

For MSM and people who identify as gay and transgender, discrimination can come in many forms. It can mean that:

- the way they express their love and affection towards someone of the same sex through intimacy and sex is criminalised
- they are not considered for employment, even though they may be more qualified for the position than someone who is not seen to be MSM
- the police do not deal with people who are violent or hateful towards MSM in the same way as they treat other people who are violent, abusive or disruptive
- the police do not investigate or take an interest in crimes against MSM
- MSM are not treated equally under the law, and as a result MSM do not feel they have any protection in the society where they live
- MSM are denied appropriate healthcare and support services, and that even when they do receive healthcare, the way they are treated by healthcare workers makes them feel reluctant to discuss their specific needs, be open about their sexual orientation and return for further services
- MSM do not have access to the services and commodities they need in order to protect their health and the health of their sexual partners
- they have no right to inherit if their partner dies, and may not receive their family inheritance either if they have been rejected by their families (some may even be threatened with death).

Why is it important to address stigma and discrimination?

MSM – be they gay, transgender or intersex – deserve to be treated with respect, live free from violence and fear, and have their human rights fully upheld by the law. Without this, they will be marginalised, and unable to demand or access the support and services they need. MSM are not second or third class citizens. They are equal citizens.
MSM in the MENA region have a much higher burden of HIV and STIs than the general population, and part of the reason for this is the stigma and discrimination that they experience. MSM need access to comprehensive prevention and care services that are non-judgemental and tailored to their specific health (physical and psychological) needs.

Given the prevailing stigma and discrimination in the region, MSM are less able to get the prevention support they need, and as a consequence, the prevalence of HIV infection will continue to increase.

From a public health and human rights point of view, it is essential that MSM are able to access the full continuum of prevention, care, treatment and support as defined by WHO/UNAIDS to prevent new HIV infections, reduce the suffering of people living with HIV, and enable people living with HIV to access life-saving ART.

Common misconceptions about homosexuality in MENA societies

- Homosexuality is a disease that can be treated
- Homosexuality is a new phenomenon
- Homosexuals are all drug users and sex workers
- Homosexual males are not real men, they cannot perform sex like other men
- Homosexuals are looking for multiple sexual partners
- Homosexuals brought HIV to our region
- Homosexuals are obsessed with sex
- Homosexuals are non-believers

Ahmed, a 22-year-old single man who is unemployed

“When I discovered I was homosexual, I discovered homophobia. I experienced my sexuality in isolation, loneliness, concealment and self-withdrawal (I am very effeminate) for fear of stigma, rejection by my family, my friends. I lived hidden because of taboos and social prejudices.

Contempt, psychological harassment and poor self-esteem undermined my personality and led me into a depression, which in turn led me to take risks in my sexual encounters. In other words, it is difficult to feel like protecting yourself and protecting others when you think you are not worth it.

Providing MSM with the services of a psychologist helped me fight my shyness; this inferiority complex which I suffered from and that ate away at me all through my teens. The most significant change [for me] remains the work on self-esteem, self-confidence and assertiveness. I have finally come to terms with myself as homosexual, I accept myself, I don’t let people insult me any longer. I respond to provocations, I defend myself, I defend the cause of my community and I have the feeling that people respect me more.”

“I’m forced to leave the country because it is difficult to live my homosexuality in the open. There are friendly places for hanging out, but I can never express myself freely.” Gay Man, 27 Years Old
Zaheer, a 25-year-old fruit seller who lives with his family in Marrakesh
Zaheer has three sisters and is very close to his mother. One day Zaheer was at home with his friend Bashir when his mother came back unexpectedly early from the market. She saw them kissing. Zaheer’s mother was shocked and no longer speaks to him. She told his father, who now refuses to acknowledge him. Zaheer’s parents did not wish to tell anyone in the community, and also insisted that his sisters must never know. In fact, Zaheer had already told his oldest sister but did not let his mother know this. The atmosphere at home is very tense and Zaheer has decided to leave as soon as he can afford to.

Mahfuz, a 26 year-old who lives with his family in Algiers
Mahfuz is from a well-respected, religious family and is well known in the neighborhood. Each day he went to the mosque to say his prayers. One day his parents caught him in a compromising position with his friend’s uncle. Mahfuz was evicted from the family house and the following Friday he was denied access to the mosque.

Nabih, a 35-year-old businessman
Nabih is unmarried and living with his family. He has a girlfriend, Saba, and a male friend, Raashid, an MSM. Both are very supportive to him, and he does not mix with the gay community. One day Nabih went to the hospital for a consultation. After the doctor asked Nabih some questions he concluded that he was MSM. Then the doctor’s attitude changed: he looked at Nabih as if he was no longer a human being. Nabih had trusted this doctor, believing he was tolerant and understanding. Now he felt insulted and ashamed. He vowed he would never go to a clinic again.

Gay man, 25, fled the country to seek asylum
“Since early childhood I know myself and my tendencies, but society led me to review myself more than once. I’m not comfortable with my own self. I feel that I cannot act according to my nature.”

TRANS, 28 YEARS OLD

‘I get hurt because of my surroundings; the way they look at me and whisper behind my back. I am in constant conflict with myself.’
GAY MAN, 21 YEARS OLD

‘I feel lonely, freaked out, rejected and scared. I am not able to identify myself. I suffer.’
QUEER, 20 YEARS OLD

My mum complained to the police because I am gay and she does not like that. My uncle is searching for me; he wants to kill me because I give a ‘bad’ image about the family. My uncle is a renowned person in the country. He sent people after me to my workplace to disclose my orientation to my boss, and they threatened me many times. Where can I go now? I do not have the right to live. What am I accused of? What is wrong with being gay? I did not choose to be so. I am simply like that.”
Problem Tree: Examples from MENA stigma training workshop

**Causes:** judgments; blaming; lack of confidence in own sexuality; conservative religious beliefs; fear of infection; ignorance; poverty; belief in myths; moral judgments.

**Forms:** Being chased from home; not welcomed at the clinic; rejected by family; finger-pointing; name-calling; being attacked; violence; losing your job; mistreated by police; blackmail; loss of inheritance; devalued.

**Effects:** isolation; loss of dignity; viewed as an object; suicide; depression; loneliness; going into hiding; increased HIV infections; increased risk-taking; breakdown of family relations; low self-esteem; loss of family honour.

“I live in a society that does not accept me. It is frustrating for me to live in this situation. This led me to be in conflict with myself.”
LEBANESE GAY MAN

“They say by our behaviour we violate the law, but we say you are violating humanity. MSM are the community with risky behaviours that is left behind. It’s time for us to be treated equally in the eyes of the law and in the eyes of the society. Every human has the right to live in peace.”
YOUNG MSM ADVOCATE
4. Risk, vulnerability, sexually transmitted infections and HIV

Introduction
Previous chapters explored issues relating to sexuality, sexual orientation, and stigma and discrimination. In this chapter we begin to look at the vulnerabilities of MSM and their risk of contracting STIs and HIV.

Two important concepts are often used to understand HIV and STI transmission: risk and vulnerability.

Risk refers to the probability or likelihood that a person will become infected with an STI/HIV. Particular behaviours increase risk, such as sharing injecting equipment and unprotected penetrative sex. The degree of risk depends on many factors, such as the HIV status of the sexual partner and whether injecting equipment contains traces of blood from an HIV-infected person.

Vulnerability refers to the range of factors outside of the control of an individual that reduce their ability to avoid risk. These may be lack of access to appropriate and accurate information about HIV/STIs; lack of access to services or commodities, such as peer education, condoms and lubricants or new injecting equipment; and the impact of stigma, discrimination and other human rights violations, as they increase MSM’s vulnerability to HIV.

Sexually transmitted infections
STIs are viruses and bacteria that are transmitted during sexual intimacy with another human being. Some have very obvious symptoms but others do not.

Bacterial STIs, such as gonorrhoea, chlamydia, syphilis and chancroid, are normally treated with antibiotics. Both sexual partners need to be treated to avoid reinfection. Unfortunately, some bacterial STIs are becoming resistant to the drugs used to treat them, and therefore there is a global rise; for instance, in multi-drug resistant gonorrhoea.

Viral STIs, such as herpes simplex types 1 and 2 (HSV) and human papilloma virus/genital warts (HPV), cannot be treated with antibiotics but can often be managed/suppressed by the use of medication and lifestyle changes. Once infected, HSV and HPV remain in the body, and post acute infection the virus often remains dormant. Various factors can lead to reoccurrence of the symptoms, such as low immunity and poor health, stress and, in the case of genital herpes, direct exposure to sunlight of the area that was originally infected.

Viral STIs are sometimes associated with mental health concerns, such as depression and anxiety. Reasons for this can include a fear of passing on the virus (herpes, genital warts or HIV) to a sexual partner; the symptoms are often uncomfortable, in particular those of genital herpes; having a herpes outbreak is often accompanied by an acute but short-lived depression; and the stress of coping with a chronic illness.
HIV, AIDS and antiretroviral treatment

HIV (human immunodeficiency virus) is the virus that causes AIDS (acquired immune deficiency syndrome). HIV is passed from one person to another through blood-to-blood and sexual contact involving the exchange of sexual fluid. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breastfeeding. HIV is found in all body fluids but only in sufficient quantity for transmission in blood, semen, vaginal fluids and breast milk.

Over time, HIV slowly damages a person’s immune system until it is unable to fight infection or prevent the development of certain forms of cancer. Without appropriate therapy, most people with HIV will develop AIDS and die.

Antiretrovirals (ARVs) are medicines that are used to suppress HIV and thereby prevent the virus from damaging the immune system. The aim of treatment is to reach a position where the level of HIV is undetectable in the blood. This does not mean that HIV is no longer present. It is just that the level of virus in the blood is below the lower cut-off point of the test. Before the introduction of ART in the mid-1990s, people with HIV could progress to AIDS in just a few years. People successfully treated with ARVs are now able to live a long and healthy life. In fact, with good treatment adherence, it is possible for someone living with HIV to have a relatively normal life span.

The risk of transmitting HIV to another person through sex increases with the amount of HIV circulating in the body. The risk of a person transmitting HIV when they have an undetectable viral load as a result of successful ART is dramatically reduced, although not eliminated. In fact, successful suppression of the virus through treatment with ART is increasingly seen as a key component of HIV prevention globally.15

Given that, the prevention impact of ART in the MENA region is compromised by the reality that only 20% of those eligible for ART in MENA are receiving it.16 Even for those who are receiving it, there is very limited access to viral load screening. This is problematic if people taking ART assume, rather than know, that their viral load is undetectable and therefore stop using condoms. Advice from WHO/UNAIDS strongly recommends the use of condoms for penetrative sex even when someone is taking ART. This becomes all the more important when STIs exist and are untreated, since they increase HIV viral shedding in the genital tract, resulting in significant increases in HIV infectiousness. Hence it is recommended that aggressive strategies for detecting and treating STIs in people receiving ART are necessary to achieve the desired protective benefits.17

Factors that influence a person’s vulnerability to HIV and sexually transmitted infections

STIs and HIV do not discriminate between heterosexual and homosexual people, and there is no mystery about how they are transmitted. If someone is exposed to the virus during unprotected sexual intercourse with someone who is infected with HIV, there is a risk that HIV will be transmitted to the uninfected partner.

15. More information can be found in WHO (2013), Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Available at: http://www.who.int/hiv/pub/guidelines/arv2013/download/en/
There are a number of factors that increase a person’s risk of being exposed to STIs, including HIV.

- **The number of sexual partners**: the more people someone has sex with, the greater is their chance of being exposed to the virus through sexual contact with a person who is infected with an STI or HIV.

- **The prevalence of STIs and HIV in a community**: if the levels of STIs and/or HIV are high in the community where a person chooses their sexual partner, then there is a higher risk that they will be exposed to infection. Moreover, as is the case in MENA, there are sections of the population among whom HIV prevalence is much higher than among the general population; for instance, among MSM. This means that the risk of exposure for a man who has sex with another man from that community will be far greater than for a man who has sex with a woman from the same community.

- **The kind of sex**: some sexual practices are more risky than others. For instance, the risk of HIV transmission from being the receptive partner during anal sex is 17 times greater than being the receptive female partner during vaginal sex,18 or being the active male partner during vaginal or anal sex.

- **Not knowing their HIV status**.

**Ways of reducing the risk of STIs and HIV**

A person can reduce their risk of infection through practising safer sex. Safer sexual practices include:

- the use of condoms and condom-safe lubricants for penetrative sex (anal and vaginal)
- reducing the number of sexual partners
- avoiding higher risk practices such as anal sex
- taking ART correctly as this can reduce the amount of virus in the body and therefore reduces the risk of transmitting the virus to a sexual partner, although it is still necessary to use condoms for penetrative sex.

The reality is that sexually active people do not always understand or know about these facts. This is particularly the case if the prevalence of STIs and HIV is not generally known in a community where there is little information available about the risk of transmission through particular sexual practices – a situation that is common in the MENA region. Also, knowledge of how to reduce risk is not enough. For example, despite common knowledge about using condom as a means of prevention, more than 50% of the 1,225 MSM targeted in an intervention programme in Lebanon from 2007 to 2011 did not use them. Common reasons given were that condoms reduce sexual pleasure and sexual pleasure has a higher value than reducing the risk of being infected with HIV and other STIs through unprotected sex.19

Throughout history, STIs have been transmitted to a wife or a husband because their spouse became infected through having sex with a partner outside the marriage. Many married women have become infected with an STI through their husbands becoming infected from a sex worker or other sexual partner. In the MENA region, it has been suggested that approximately three-quarters of married women living with HIV became infected from their husbands. As they have only one sexual partner, unless they suspect their husband of having sex with other people, they would not consider themselves to be at risk of HIV or STIs and therefore would not expect to be tested.

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5. Global and regional responses

Introduction

Since the beginning of the HIV and AIDS pandemic in the early 1980s, the global response has been characterised by action at all levels:

- indigenous grassroots responses by affected communities
- CSOs acting in the absence of government interventions and/or complementing the government response
- health and social care professionals in the areas of prevention, care and treatment
- national governments domestically through their national AIDS plans and strategies
- overseas assistance from bilateral agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)
- international leadership and guidance by such bodies as the UN.

From a global leadership perspective, there are three main vehicles that are driving the international response: UNAIDS, the Global Fund and the United States President’s Emergency Plan for AIDS Relief (PEPFAR), with the Global Fund and PEPFAR providing the largest amounts of funding to support national responses. These three bodies have systematically examined the evidence of what works and have reached a good degree of consensus about where global resources should be directed to have the greatest impact. They all work closely together to help to guide resource investment and international cooperation. However, PEPFAR has never been a donor for MENA on HIV and AIDS, and only 12 countries and territories from this region are eligible for Global Fund monies (it was unusual that in 2012, the regional CSO MENAHRA succeeded in mobilising funds through a regional proposal on harm reduction among people who inject drugs).

There are other national governments and donors for the MENA region, such as the Drosos Foundation, the Ford Foundation, OFID (the OPEC Fund for International Development), GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit) and some embassies, that support CSOs and governments to mount an effective response to the HIV pandemic. However, the Global Fund remains the largest donor by far.

For organisations, leaders and managers who are beginning, or want to begin, working in the area of HIV, it is useful to have some background about the two relevant global bodies for MENA.

UNAIDS: getting to zero. Fast tracking the response to end AIDS by 2030

UNAIDS works to prevent the transmission of HIV, provide treatment and care for people living with the disease, reduce the vulnerability of individuals and communities to HIV, and alleviate the epidemic’s impact worldwide.

UNAIDS is guided by a programme coordinating board made up of representatives of 22 governments from around the world and the 11 UNAIDS cosponsors. Five more seats, without voting rights, are reserved for a balanced mix of NGOs, including those representing people living with HIV/AIDS. This makes UNAIDS the only UN institution to have NGO participation on its governing board.

The programme brings together the efforts and resources of the cosponsors towards fast-tracking the AIDS response and setting ambitious targets that are considered
critical to ending the AIDS epidemic. Fast tracking requires transforming the UNAIDS’ vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths into concrete milestones and endpoints.

The fast track targets

- Achieving 90–90–90:
  - 90% of people living with HIV knowing their HIV status.
  - 90% of people who know their status on treatment.
  - 90% of people on treatment with suppressed viral loads.
- Other targets include reducing the annual number of new HIV infections to 500,000 in 2020, to 200,000 in 2030, and achieving zero discrimination. The targets are firmly based on an approach to leaving no one behind, which is rooted in human rights and will significantly improve global health outcomes. Hence, UNAIDS is leading the global HIV community towards an increased acceleration period over the next five years, along with focused investments for the countries, cities and communities most affected by HIV.

UNAIDS’ efforts in the region are coordinated by the regional support team located in Egypt, which supports 22 MENA countries. The MENA regional office backstops nine country offices in Algeria, Djibouti, Egypt, Iran, Morocco, Sudan, Somalia, Tunisia and Yemen. In these countries, as well as in Lebanon, the HIV response is coordinated by joint UN programmes and teams on AIDS. These are demand-driven leveraging tools to “make the money work” using the UNAIDS Technical Support Division of Labour, with the main aim of uniting UN action to supporting the national response in scaling up towards universal access for prevention, treatment, care and support.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund was created in 2002 to increase resources dramatically for the fight against the three pandemics. It spurs partnerships between government, civil society, the private sector and communities living with the diseases, as the most effective way to fight these deadly infections. The Global Fund does not manage or implement programmes on the ground, relying instead on local experts/implementers. It works with partners to ensure that funding serves the men, women and children affected by these diseases in the most effective way.

Central to the Global Fund’s commitment to local ownership and participatory decision-making is the structure of Country Coordinating Mechanisms (CCM). The CCM is a country-level multi-stakeholder partnership that develops and submits grant proposals to the Global Fund based on priority needs at the national level. After grant approval, the partnership oversees progress during implementation.

CCMs include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions, private businesses and people living with the diseases. For each grant, the CCM nominates one or more public or private organisation to serve as Principal Recipients.

20. UNAIDS: www.unaidsmena.org

The Global Fund Strategy 2012–2016 defines the organisation’s aspirations and strategic actions for contributing to the collective fight against HIV/AIDS, tuberculosis and malaria. It defines how the Global Fund aims to accelerate progress, build on past successes and investments, and evolve to address challenges and seize opportunities – how it will “invest for impact”.

The strategy sets ambitious goals: to save 10 million lives and prevent 140–180 million new infections over 2012–2016. The goals are complemented by partner-aligned disease-specific targets. It includes the following five strategic objectives and their associated strategic actions to achieve the goals and targets:

**Strategic objective 1: Invest more strategically**
- Focus on the highest-impact countries, interventions and populations, while keeping the Global Fund global.
- Fund based on national strategies and through national systems.
- Maximise the impact of Global Fund investments on strengthening health systems.
- Maximise the impact of Global Fund investments on improving the health of mothers and children.

**Strategic objective 2: Evolve the funding model**
- Replace the rounds system with a more flexible and effective model.
- Facilitate the strategic refocusing of existing investments.

**Strategic objectives 3: Actively support grant implementation success**
- Actively manage grants based on impact, value for money and risk.
- Enhance the quality and efficiency of grant implementation.
- Make partnerships work to improve grant implementation.

**Strategic objectives 4: Promote and protect human rights**
- Integrate human rights considerations throughout the grant cycle.
- Increase investments in programmes that address human rights-related barriers to access.
- Ensure that the Global Fund does not support programmes that infringe human rights.

**Strategic objective 5: Sustain the gains, mobilise resources**
- Increase the sustainability of Global Fund-supported programmes.
- Attract additional funding from current and new sources.

In addition, two fundamental enablers are necessary for the strategy to deliver results: **Strategic enabler 1**: Enhance partnerships to deliver results, and **Strategic enabler 2**: Transform and improve Global Fund governance, operations and fiduciary controls.
PART B
CONCEPTUALISATION

In this section we introduce some of the key guiding approaches and principles that have proven to be the most important when implementing HIV and STI prevention, care and treatment programmes for MSM worldwide and in MENA.
6. Guiding approaches and principles

Introduction
This chapter introduces some of the key guiding approaches and principles that have been proven to be the most important when implementing HIV and STI prevention, care and treatment.

A. Human rights
In 2006, UNAIDS published a consolidated version of the International Guidelines on HIV and Human Rights. The purpose of the international guidance was to provide a framework for a rights-based response to the HIV/AIDS epidemic by outlining how human rights standards apply in the context of HIV/AIDS and translating them into practical measures that should be undertaken at the national level. These were to be based on three broad approaches:

- Improvement of government capacity for multi-sectoral coordination and accountability.
- Reform of laws and legal support services, with a focus on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups.
- Support and increased private sector and community participation to respond ethically and effectively to HIV/AIDS.

The principle of human rights
The concept of “human rights” refers to the universal and fundamental rights that every human being is entitled to, without distinction. Mary Robinson, a former United Nations High Commissioner for Human Rights, asserted that the human rights approach is based on involvement, freedom and accountability. It is a developmental, non-discriminatory and inalienable model based on individual and global freedoms.

The primary audience for the International Guidelines on HIV/AIDS and Human Rights is national governments, who are the primary duty-bearers for upholding and ensuring that human rights are embedded in national policy and laws, and ensuring they are implemented and enforced. Some core principles form the basis of the guidelines:

- Universal and inalienable: every human being is entitled to these rights with no exception.
- Without distinction: all human rights are of equal value.
- Interdependence: all rights are closely interlinked. When talking about the right to health, one cannot overlook the right to privacy. There is a link between sexual violence and HIV/AIDS to the right to liberty and security, freedom from cruelty and inhuman and degrading treatment.
- Equality and non-discrimination: equal rights to all, with the priority given to the vulnerable and most at risk.
- Participation and inclusion: everyone has the right to free, active and effective participation in and enjoyment of social, economic, political and cultural development, where the principles of human rights are respected.
- Accountability and the rule of law: nations and officials are accountable for the promotion and observance of human rights.

Another principle of the human rights approach is to provide support to human rights defenders and develop their capacities to carry out their responsibilities.

**Human rights and HIV**

Among its fast track targets, UNAIDS has adopted zero discrimination targets by 2020 and 2030:

- **By 2020**, everyone everywhere lives a life free from HIV-related discrimination.
- **By 2030**, all people living with HIV, key populations and other affected populations fully enjoy their HIV-related rights, including protection within their communities and equal access to health, employment, justice, education and social services.

The emergence of HIV and AIDS in the mid-to-late 1980s presented the world with a challenge like no other in its history. HIV was found to be transmitted primarily through sexual intercourse. There were few recognisable symptoms of infection until major immune damage had occurred heralding AIDS. The highest prevalence of HIV was found among MSM, sex workers, people who inject drugs, and men and women in sub-Saharan Africa. These groups were, and continue to be, among the most vulnerable and least powerful in society. From the earliest days of the HIV epidemic, it was clear that unless the human rights of those most affected and at risk were protected, there was a risk of gross human rights violations occurring as a result of fear and prejudice. Moreover, there could not be an effective response to the epidemic as people living with the virus would be hidden. It was also clear from the outset that in order to respond to the HIV epidemic it was necessary to work in partnership with those most affected to come up with solutions and responses that were realistic, achievable and reflective of the contextual realities of their lives.

**Human rights and men who have sex with men**

In many countries, particularly in those where sex between men is illegal (which includes most countries in MENA), talking about the rights of MSM is not acceptable. The general public and decision-makers consider MSM behaviour “undesirable” and often “offensive”. Therefore asserting that MSM also have human rights may seem contrary to beliefs and social norms. When MSM are also HIV positive, the situation becomes even worse due to double discrimination. This situation demonstrates clearly why the principle of human rights was developed: that minorities and vulnerable populations need to be protected from discrimination by the majority, be they migrants, small ethnic groups, people with disabilities, people with a different skin colour, or those whose sexual orientation and way of living does not conform with the majority. Everyone has the right to health and to the means to protect their health and that of others. This is *enshrined within international human rights legislation*.

Some of the basic human rights related to HIV and AIDS include:

- the right to non-discrimination
- the right to privacy
- equal access to quality and appropriate health services free from discrimination
- the right to education and a discrimination-free workplace environment.

Although almost all governments in the MENA region have signed human rights conventions, and also played a part in their development, their application in practice is not always evident. Likewise, all governments in the region have national AIDS programmes that include the importance of addressing the needs of most-at-risk populations, which includes MSM. Unfortunately, translating that ambition into
supporting effective and contextually relevant programmes is not always evident. In MENA and many other parts of the world, criminalising laws continue despite evidence that criminalisation has a high cost for MSM in denial of health services, and in discrimination in healthcare, communities, employment, education and access to justice. Few people living with HIV or affected by HIV seek redress when their rights are violated, and homophobia remains widespread.

Global experience has shown that effectively embedding human rights within their own HIV and AIDS programmes can be best achieved through the active participation of those most affected in the decision-making process. Any programme developed for this purpose – from design to evaluation – should consider:

- adopting a participatory approach through active and meaningful involvement of MSM in planning and implementation
- strengthening existing capacities and identifying development needs through participatory assessment
- facilitating the inclusion of MSM in decision-making processes to ensure they are actively engage in decisions regarding resource allocation and programming priorities that reflect reality
- ensuring prevention advice is tailored to meet the needs of different audiences, including the diversity of experience of all MSM, and includes access to quality and affordable condoms and lubricants
- establishing MSM-friendly and discrimination-free services that respect confidentiality and meet the specific needs of MSM and their partners.

The key to ending HIV in MENA is preventing new infections and making sure that those living with HIV are well taken care of. The former would imply spreading sexuality education among youth, breaking taboos about sex and using a relevant language in awareness campaigns, while the latter would mean that we need to fight ferociously against stigma and discrimination to break social and legal barriers to health. The will to take care of one’s self needs to come from the individual. We just need to open the doors widely for them to cross.”

JOHNNY TOHME, REGIONAL COORDINATOR, M-COALITION

Example: Association Tunisienne de Lutte contre les MST/Sida legal clinic for key populations

Association Tunisienne de Lutte contre les MST/Sida (ATL) legal clinic is a decentralised project implemented in partnership with IDLO that targets key populations and people living with HIV. Its mission is to:

- ensure the continuity of legal services based on a dynamic and efficient approach
- ensure the participation of field workers in promoting a legal clinic for people living with HIV and key populations
- provide legal help for MSM, sex workers, people living with HIV and people who inject drugs
- contribute to the development of an adequate legal and sanitary environment for the fight against the spread of HIV
- overcome barriers to treatment using an approach based on human rights
- create a legal research centre for students.

Available legal services include listening and orientation sessions, written legal advice, and complaint (in cases of stigma and discrimination related to HIV).

Advocacy work has included:

- coordination with legal authorities and stakeholders from the public health sector
- a training session for judges, lawyers, police officers and prison staff, with the participation of human rights defenders and representatives of key populations
- a training session for medical staff
- a workshop for representatives of people living with HIV and key populations, with leaders from the health and justice sectors.
More generally, MENA has seen some advancement in the area of human rights for minorities, particularly with the establishment of AFEMENA (Arab Foundation for Freedoms and Equality) but also with best practice models in some countries. These include the launch in May 2014 of a national strategy on human rights and HIV in Morocco in collaboration with the Ministry of Health and the National Council of Human Rights. Iran succeeded in adopting an inclusive approach to all people living with HIV, key populations and CSOs in its Global Fund concept note development stage and also in the national strategic plan development process. Also Tunisia has established a human rights observatory to document all human right violations at the national level.

B. Public health

WHO defines public health as all organised measures used to prevent disease, promote health and prolong life among the general population. It aims to address the determinants of ill health and disease, and create conditions in which people can be healthy and thrive, not just be free of disease. Public health efforts are focused on entire populations and communities, and not on individual patients. They recognise that we are all interdependent, and that the health or lack of health of one person can affect the health of another.

The three main public health functions are:

- **assessment and monitoring** of the health of communities and populations at risk to identify health problems and priorities
- **formulating public policies** designed to solve identified local and national health problems and priorities
- **ensuring access** by all populations to appropriate and cost-effective care, including health promotion and disease prevention services.

Since STIs and HIV are communicable diseases, they require a public health response to manage them effectively. In the MENA region, those most at risk of HIV and STIs are sex workers, people who inject drugs, MSM and their sexual partners – all of them are often marginalised and therefore experience greater isolation and discrimination. As a result, key populations are often reluctant to seek medical support and services as they fear being discriminated against. For these same reasons they can also be difficult to reach.

In this context, if medical and social services focused only on each individual living with HIV or an STI alone, it would be impossible to address some of the underlying factors that make MSM and other key populations particularly vulnerable to STIs and HIV.

Therefore, while a human rights approach is essential to protect the rights of every individual MSM, the public health approach complements it by trying to address the key factors that render a community vulnerable to infection and disease. In the response to HIV, human rights and public health intertwine to ensure that effective measures are taken to reduce the burden of HIV infection in communities through:

- MSM-friendly STI and HIV counselling and testing services
- providing access to quality and tailored education and information, particularly oriented towards young people at risk
- ensuring access to quality condoms and lubricants
- monitoring the dynamics of HIV infection through surveillance and analysis of data to inform planning (The kinds of questions this work seeks to answer are: Who is infected? How many? Where? How? What are the factors that contribute to vulnerability and risk?)
- ensuring that there are public policies in place to provide an enabling environment for responding to the public health threat of HIV. This includes ensuring that the human rights of those at risk of infection and those living with HIV are fully respected and upheld, and that discrimination is confronted and managed
- key population user-friendly services and effective outreach prevention, care and support services, with particular access to young people at risk.

C. Prevention and treatment

UNAIDS global prevention targets for 2020 and 2030

By 2020, reduce the number of new HIV infections by 75% to under 500,000 per year, towards a reduction by 90% to under 200,000 new infections per year in 2030.

With the following two sub-targets:

By 2020 new infections in key populations will be reduced by 75%
By 2020 new infections in young women and girls will be reduced by 75%

Combination prevention

Combination prevention programmes are “rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections.”

Preventing HIV transmission is complex. People need to have knowledge about HIV and how it is transmitted. They need to have an accurate perception of their own risk, want to reduce that risk and know how they can do it: for example, by using condoms for safer sex. They also need to feel that they are able to do it: that is, possess self-efficacy. However, human behaviour is often contextual and influenced by the community and society in which we live. MSM in the MENA region may have little access to information and services, and because of discrimination and prejudice, may not be in a position to practice safer sexual behaviour without raising suspicion and fear of being “found out”. Therefore, for MSM to be able to adopt safer behaviours freely, it is necessary to address structural factors, such as the lack of services (especially for young people at risk), stigma and discrimination, and repressive laws against MSM that contribute to their vulnerability, and improve their human rights environment.

Effective prevention also means reducing the level of HIV (the viral load) of people living with HIV, since they are less likely to pass on HIV to their sexual partners if their viral load is low. Reducing viral load is achieved through ART.

Getting people on to treatment can only happen once they test for HIV and know their status. Unless sympathetic and user-friendly services for MSM are available, the chances of MSM testing and retesting for HIV are low.

Combination prevention recognises all of these factors and acknowledges the need to intervene at multiple levels: at the individual level (behaviour), by ensuring access to quality HIV testing, commodities, care and treatment services (biomedical), as well as at the systems level, as interventions to address negative social norms and discriminatory laws. This approach is supported and championed by UNAIDS, the Global Fund and PEPFAR because it is evidence based and reflects global learning.

When developing a HIV prevention programme, it is essential that a combination prevention approach guides programme interventions. Addressing only one aspect of prevention (for example, increasing access to condoms and lubricants) is insufficient to effect positive change or sustain behaviour change.

In order to fast track combination prevention, actors need to consider:

■ Renewing a national commitment to prevention
  – Commitment to a national prevention strategy needs to be cascaded to leaders at all levels (policymakers, other leaders, financing institutions and implementers). They need to be presented with clear and simple packages of investment for prevention. This has to happen at both national and at local levels, with key players from health and non-health sectors working together.
  – A financial commitment to prevention now saves money in the future. A recent UNAIDS modelling exercise\(^24\) showed that about 25% of all HIV investments should go into effective combination prevention interventions.
  – A personal commitment must be made by leaders from all spheres to become role models and advocates, and speak out in support of HIV prevention, its cost-effectiveness and the importance of different prevention options and choices.

■ Focusing on the right locations and methods to maximise impact
  – Prevention resources should focus more intensely on geographic and administrative areas at elevated risk.
  – Focusing combinations of prevention approaches with high coverage and intensity on people at greatest risk and locations where risk takes place can increase prevention benefits without increasing expenditures.
  – Since cities tend to be home to large numbers of people belonging to key populations, a strong focus on service availability for key populations in urban areas is essential, and can be the starting point for developing national programmes that gradually reach out to smaller towns and rural areas.

■ Synergies – defining effective programme packages
  – Although there are now a number of options for HIV prevention that have proven effective if used consistently (pre-exposure prophylaxis (PrEP), condoms as a triple protection tool, voluntary medical male circumcision, specific communications and social change approaches, harm reduction interventions), different settings and populations will require different combinations of programmes.
  – The best prevention impact comes from the careful selection of prevention interventions and approaches, tailored to the epidemic setting and offered as a package with consistency over time.

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Part B: Conceptualisation

Using antiretroviral drugs to prevent HIV

Applying a combination prevention approach means that prevention services should include the use of ARVs by people who are uninfected to prevent them from acquiring HIV.

Pre-exposure prophylaxis (PrEP) is the daily use of ARVs by HIV-uninfected people to prevent HIV acquisition.

Post-exposure prophylaxis (PEP) is short-term ART to reduce the likelihood of acquiring HIV infection after potential exposure, either occupationally or through sexual intercourse.

The WHO 2013 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection restate the following recommendations regarding PrEP and PEP:

- Provide PrEP in the context of demonstration projects for partners in serodiscordant relationships and for men and transgender women who have sex with men.25
- Consider PEP for women presenting within 72 hours of sexual assault, using shared decision-making with the survivor to determine if it’s appropriate.

Although ARVs can play a key role in HIV prevention, they should be used in combination with an appropriate mix of other biomedical, behavioural and structural interventions, such as condoms, voluntary safe medical male circumcision, risk reduction counseling, reduction of stigma and gender-based violence, and opioid substitution therapy.

- Packages for all populations will have a strong component of biomedical prevention tools, including ARV-based strategies and condoms; a behavioral and community component for ensuring that community norms are supportive and uptake of prevention options is high; a strong community empowerment element; and be integrated into a wider system of structural health and development synergies.

Positive Health, Dignity and Prevention

Many of the early prevention responses to HIV prevention efforts were focused on primary prevention: prevention messages and campaigns that were aimed at preventing the uninfected from becoming infected. Generally, there was little support or attention given to prevention issues for people already living with the virus. Where attention was given or raised, it was frequently in the context of heavy condemnation of people living with HIV as being the vectors of disease. This was compounded by condemnation of people living with HIV who were also MSM.

As a response, people living with HIV, under the leadership of the Global Network of People Living with HIV (GNP+), developed an approach called Positive Health, Dignity and Prevention (PHDP). PHDP highlights the importance of placing the person living with HIV at the centre of managing their health and wellbeing and at the centre of the response.

PHDP stresses the importance of addressing prevention and treatment simultaneously and holistically. It also emphasises the leadership roles of people living with HIV in responding to policy and legal barriers within the socio-cultural

and legal contexts in which they live, and in driving the agenda forward towards
better health and dignity. In considering the ongoing challenge of HIV prevention,
people living with HIV should be recognised as a part of the solution, not a
part of the “problem”. As people living with HIV who are also MSM are doubly
discriminated against, it is essential that they should not be further marginalised in
decisions regarding their prevention, treatment and care.

The public health and human rights goal of preventing new HIV infections can
only be achieved when the human, sexual, and reproductive rights of people living
with HIV are protected and supported; when the broader health and dignity needs
of people living with HIV are met; and when access to timely and uninterrupted
treatment and care encourages greater uptake of confidential voluntary counselling
and testing.

The primary goals of PHDP are to improve the dignity, quality and length of life
of people living with HIV. If achieved, this will in turn have a beneficial impact on
their partners, families and communities, including reducing the likelihood of new
infections. These important goals can only be achieved with broad stakeholder
commitment. PHDP should shape how governments, policymakers, programmers
and international agencies work with people living with HIV, moving away from
treating them as passive targets of prevention messages towards recognising them
as active participants in the global HIV response.

PHDP encompasses the full range of health and social justice issues for people
living with HIV. It espouses the fundamental principles that responsibility for HIV
prevention should be shared, and that policies and programmes for people living
with HIV should be designed and implemented with the meaningful involvement of
people living with HIV.

Attaining the goal of PHDP specifically requires promoting and affirming the
empowerment of people living with HIV through the following objectives:

- Increasing access to, and understanding of, evidence-informed human rights-
based policies and programmes that support individuals living with HIV to make
choices that address their needs and allow them to live healthy lives free from
stigma and discrimination.

- Scaling up and supporting existing HIV counselling, testing, care, support,
treatment and prevention programmes that are community owned and led,
and increasing access to rights-based health services, including sexual and
reproductive health.

- Scaling up and supporting literacy programmes in health, treatment, prevention,
human rights and the law, and ensuring that human rights are promoted and
implemented through relevant programmes and protections.

- Ensuring that undiagnosed and diagnosed people, along with their partners
and communities, are included in HIV prevention programmes that highlight
shared responsibilities regardless of known or perceived HIV status, and have
opportunities for, rather than barriers to, empowering themselves and their
sexual partner(s).

- Scaling up and supporting social capital programmes that focus on community-
driven, sustainable responses to HIV by investing in community development,
networking, capacity-building, and resources for organisations and networks of
people living with HIV.

Operationalising PHDP is not about creating new programmes, except where basic
programmes do not exist. Rather, it is about using the principles of PHDP to create
linkages among existing programmes and taking them to scale, so that they are
more efficient and responsive to the needs of people living with HIV.
STORIES FROM MSM LIVING WITH HIV

Anis, a 31-year-old single man who defines himself as bisexual. He is unemployed and lives in Lebanon

“I have been in contact with SIDC for a year-and-half and during that time I benefited from PLHIV support activities, since I discovered my positive status during the street work of the NGO’s mobile unit. I was able to benefit from the psychological and social follow-up, and also from scientific information about prevention.

Concerning the changes that I experienced following this project, I felt I am not alone. I was able to live in peace and be reassured. I was too weak when I learned about my positive status. The support I received was more emotional than material ... What I gained is the fact that I have accepted my situation as it is, and now I experience my positive status peacefully. I had dark thoughts about HIV, I thought my life was over, but thanks to you those ideas have changed and I told myself that I am still alive and that people around me are ‘good people’ and that life goes on.

I was more afraid of the future and didn’t know how I would continue living. The association helped me a lot and gave me support and I was receptive. And notwithstanding the serious situation which I faced, I was able to overcome the problems with their help and thanks to my own beliefs.

I caught the virus. It should not be transmitted to others because then the problem will worsen, since the number of PLHIV will increase and the ministry of health will not be able to provide drugs to a great number of patients.”

Mourad, a 21-year-old single man who is unemployed and lives in Algeria

“I must say that the most significant change which I had via this project is unfortunately the discovery of my positive status after my first visit to APCS voluntary testing and counselling.

It’s now two years that I have been living with ‘Abesse’ – this is the name I gave this virus that invaded my body and my life without prior permission and which I must live with all my life. This change is important for me, since on the day when I confirmed my positive status, all my life has been turned upside down.

Thanks to the support and perseverance of the association psychologist, I was able to overcome all those difficulties, I regained my self-confidence, I accepted my positive status and got free from all the dark thoughts that had haunted me. With the benefit of hindsight, I thank God and the people involved in this project who enabled me to discover my positive status before I got more ill, and who enabled me to receive early care and treatment against the virus … APCS helped me and supported me a lot, morally and financially, because without their support I would really have been lost in the wilderness, and especially in our Algerian context, it is even doubly more difficult to say that I am a homosexual living with AIDS.”
D. Harm reduction

Harm reduction is an evidenced-based approach that aims to reduce the harms associated with drug use and HIV. It is a pragmatic approach to health comprised of interventions that address harms like HIV transmission, hepatitis C (HCV) transmission, overdose and unsafe injecting. Harm reduction is shaped by both public health and human rights principles.

In the MENA region, there is evidence of an increasing epidemic of drug use. Some MSM use injectable drugs and some use recreational drugs. While the principle risk associated with HIV infection is the sharing of injecting equipment, increased risk of HIV transmission is also associated with non-injectable recreational drug use, as this could lead to behavioural disinhibition – people taking sexual risks while taking drugs that they would not take otherwise.

WHO defines harm reduction as: “Interventions that reduce the adverse health, social and economic consequences of psychoactive substance use for individual drug users, their families and their communities. Comprehensive harm reduction programmes can reduce new HIV infections among people who inject drugs.”

The harm reduction approach does not set out to stop people taking drugs but rather acknowledges that those who are currently unwilling or unable to become abstinent remain at risk of HIV and other preventable harms. Harm reduction, based on public health principles, is a client-driven approach that aims for improved health at a speed that is acceptable and realistic for the client.

Harm reduction focuses on short-term, achievable goals because it is driven by the urgent need to prevent HIV and HCV transmission, and to get services to people with HIV and/or HCV who inject drugs. While many argue that the best approach to managing drug use is abstinence and zero drug tolerance, the reality is that there is little or no global evidence to show that this has been done successfully, even in countries with the tightest drug laws. Also it does not take into account that even if the ambition of a person who injects drugs is abstinence, to avert the harm associated with injecting drug use (HIV and HCV transmission), the person would need to limit their exposure by using harm reduction measures, such as not sharing injecting equipment, while trying to achieve that goal.

Many would argue that a drug-free world is a long-term or even unattainable goal. In the meantime, HIV needs to be prevented and people need health services, education, care and support.

“While receiving my HIV diagnosis in a renowned hospital in my country, the nurse handed me a sealed results and commented, ‘Did you hang around with women to get it?’”

NEWLY DIAGNOSED MAN, 28 YEARS OLD

I walked out crying from my dentist clinic. I told him that I am positive to be aware and take more precautions. He asked me to leave and he said cannot treat me without giving me any excuses.”

MSM LIVING WITH HIV, 25 YEARS OLD

“While receiving my HIV diagnosis in a renowned hospital in my country, the nurse handed me a sealed results and commented, ‘Did you hang around with women to get it?’”

NEWLY DIAGNOSED MAN, 28 YEARS OLD

I walked out crying from my dentist clinic. I told him that I am positive to be aware and take more precautions. He asked me to leave and he said cannot treat me without giving me any excuses.”

MSM LIVING WITH HIV, 25 YEARS OLD

I went with my father to open a medical record at the ministry. The employee addressed me in front of my father with this comment, ‘Your father worked here and had a very good reputation. Why are you a bad guy? This hurts.”

TRANSSEXUAL, 35 YEARS OLD

Harm reduction programmes that are shaped by development principles take the approach beyond its public health and human rights roots to include a focus on family and partner support, income support and improved livelihoods.

Harm reduction is the only proven successful approach to HIV programming for people who inject drugs, offering interventions that can reduce the risk of HIV transmission and build a culture of care and support for HIV-positive people who use drugs.

A harm reduction approach uses the concept of a hierarchy of risk to categorise HIV infection risk related to injecting drug use.

**Hierarchy of risk**

- **Never use drugs or stop using drugs.**
  This is the most effective way to avoid HIV infection related to drug use.

- **If you use drugs, do not inject them.**
  This is a very effective way to avoid HIV infection related to drug use.

- **If you inject drugs, always use sterile injecting equipment.**
  This is the only effective way to avoid HIV infection related to drug use.

- **If you cannot always use sterile injecting equipment, re-use your own injecting equipment.**
  HIV infection related to drug use can be avoided if you re-use your own injecting equipment (so long as no one else has used the equipment).

When developing HIV prevention and care programmes for people who use drugs, it is essential that implementers take into consideration any national laws as they relate to the use of psychoactive substances. The goal of organisations working to prevent HIV and HCV transmission, as well as the care and support of people who use drugs, is to minimise the harm to the person themselves, their families and society as a whole. Global evidence has shown that the most effective way of achieving this is through the implementation of harm reduction programmes informed by human rights. As there can be a lack of understanding of harm reduction at government levels, HIV programme planners often have to invest in engaging ministries of health through education and advocacy to enable harm reduction programmes to be implemented, and thereby limit the potential harms of injecting drug use.

**E. The prevention and treatment continuum**

With the advent of combination prevention, the former distinction that was often made between prevention on the one hand and care and treatment on the other seems increasingly problematic. This is because HIV treatment is also part of HIV prevention as it lowers viral load, and HIV testing is essential to both treatment and
It is more common now to talk about the continuum of prevention and care, which incorporates:

- **primary prevention** – preventing people who are uninfected from getting infected
- **secondary prevention** through PHDP, and testing, treatment and care services.

The HIV treatment component of the continuum relates to **testing and offering treatment**, and ensures retention through:

- quality HIV testing so people can learn of their HIV status
- getting people living with HIV referred and linked to a healthcare provider or services for the specific kind of care they need, such as HIV treatment, mental health support/counselling, HIV prevention advice support
- ensuring people living with HIV have access to CD4 testing to clinically assess their eligibility for ART, and getting people living with HIV on ARV combination therapy to reduce their viral load in order to limit the risk of developing opportunistic infections and minimise the risk of transmitting infection
- ensuring that people living with HIV do not wait to receive treatment in cases where access to CD4 count machines is unavailable
- maintaining viral load reduction and avoidance of ART resistance through adherence support throughout their lives.

**F. Commonly agreed approaches to HIV programming**

**Participation**

Central to effective HIV prevention, care and support services for MSM is the principle of participation. Often, people most at risk of HIV and those in need of services are marginalised and little understood by traditional health and social support services.

By actively engaging with people most affected by HIV and those most at risk of HIV infection, programmes can be developed in partnership that can meet the specific needs of that group, rather than developing generic programmes that may miss the realities of their lives.

By actively engaging with potential programme beneficiaries, trust and confidence can be developed, together with more active engagement and commitment to the programme. Top-down approaches, where programme planners develop programmes for beneficiaries, often miss critical components that can only be known through active engagement.

By contrast, programmes where beneficiaries have been active participants in developing them are likely to have greater impact and reach. They will be developed to match the needs of MSM, and MSM will be mobilised to take action through the process of participation.

**Peer education**

Peer education is an approach that is often used to reach marginalised populations such as MSM. Part of the rationale is the assumption that those who share similar experiences and come from a similar background can be a more effective and credible source of information. Someone who shares characteristics in common with the person being reached is often more trusted by the community they
serve, and may be able to access people who are hard to reach using traditional approaches.

Research into the impact of peer education has shown that certain conditions need to be met in order for peer educators to be effective. Unless peer educators are rigorously trained, supervised, supported and receive ongoing information, the impact of their intervention may be negligible. Therefore, peer education approaches are not a cheap or easy means of accessing hard-to-reach populations such as MSM. However, with the right management, leadership, training and support, peer education approaches can be extremely successful and contribute to lasting change for those being reached, as well as for the peer educators themselves.

**STORIES FROM MSM PEER EDUCATORS**

**Jamel, a 21-year-old student who defines himself as gay. He is a peer educator with OPALS in Fes, Morocco**

“In the past, I was so much concerned with my life, it made me so thoughtful that I couldn’t sleep. I suffered a lot from stigma … I didn’t have the courage to face this situation. Today, I feel ready to defend myself – a ‘lion’. I was underestimated because of ignorance … Now I feel that I have dignity and personality, and that I have the right to live my femininity as I wish, provided that I respect the social environment [to avoid stigma and discrimination]. Now, I am supported by the NGO.

At the beginning I was a friend’s peer. During that period, I was 50% convinced of STI/HIV risk. After entering OPALS and after benefiting from several activities, including training and services from the anonymous testing centre, the way I see things has changed. For me, the NGO gave me a lot. There are multiple changes. I was in great doubt. Now, I have a great responsibility and commitment to my peers. After the trainings I attended, I wanted to put everything in practice and share the information I got. The project provided many things: prevention methods, materials, health services, a positive environment for meetings and different activities.”

**Bassem, a 32-year-old student and peer educator with ATL in Tunisia**

“Today, I feel responsible for [my] sexual behaviours. I am aware of the importance of prevention and of the risks faced by our community, starting with the high risks of HIV infection since we have a concentrated epidemic in our community.

I now feel that with the group that I joined, we are stronger. There is this feeling of belonging that I have, and which is very important, now that we are a strong and solid group and we can stand up for our rights.

This prevention and mobilisation work with the community and key actors in the HIV response has led to deep changes. Now, for example, if an effeminate gay man presents himself to any service, he won’t be turned down. There is still a lot of work to do, however I believe that we have made great strides.”
Rachid, a 30-year-old interpreter and peer educator with APCS in Algeria

“I must say that this project brought me so many changes, starting with my fulfillment in volunteer work and solidarity. I managed to overcome the fear I had of sexually transmitted diseases and AIDS. Better still, I had the opportunity to know and make friends with people living with HIV in the association, which strengthened even more my convictions about prevention.

... Thanks to this project that allowed me to get in touch with other homosexuals, including peer educators and beneficiaries, and also thanks to the different trainings which I received and the workshops addressing self-esteem and discrimination, I overcame my shyness. I now feel more self-confident, I have succeeded in dealing with my parents and convincing them of accepting my work as a peer educator.

I am proud of my work as a peer educator and I accept my community without any fear or prejudice. Also, I feel useful in preserving the health of my peers with more openness to others, without having to hide or judging others. I feel more self-assured and more at ease, and I regain my balance because, in essence, I like to help my fellow people.”

Chaker, a 31-year-old beneficiary and manager in Tunisia

“The most important thing for me was to find people willing to listen to me, as I always needed to discuss my sexual orientation, my practices and the risks involved. I found in ATL a team that was also present. All the ATL team is always, at any time, at the service of beneficiaries... I am gay and I wish less and less to live underground. Because of my sexual orientation, there is no legal setting where I can discuss openly what I think and what I experience. With ATL, I found that space and I think it is very important for Tunisian gays, since there is no space or association where young people belonging to the LGBT community can meet to discuss and talk about their lives.

I want to congratulate them for their professional approach and the tools that they used, which are very interesting, fun, educative and adapted to our specificities. We are very much at ease in a climate of trust and friendliness.”

Walid, a 31-year-old student who is single and defines himself as MSM. He is a peer educator with SIDC and Helem in Lebanon

“I am a peer educator in the project and I benefited from all the trainings in terms of information, approaches for conducting peer education, planning my field work, and, overall I benefited from the field work and the practical aspects. I was able to put into practice the theoretical information I learned.

In my position as a PE [peer educator], what has changed is that I met other groups and communities who are different from the people I knew, and I have learned how to work with approaches adapted to each of those groups. The way of working, of speaking, the content of the information destined to street youth are different from those used with young people in bars and nightclubs. I am no longer limited in using one single method or approach.

It is during my work on the street that I could feel the difference between the populations I met with, and I started using two different methods or approaches. This was very important because it makes my interventions more useful, and it increases my self-confidence and my trust in the quality of the information I am providing when I feel that the people I am talking to accept easily, ask more questions and are interested in the issue. This makes my work more significant and more useful.”
For a comprehensive approach to the training of peer educators for HIV and MSM, please see the three-module toolkit that accompanies this orientation manual.

Community mobilisation

UNAIDS defines a community as a group of people who have something in common and will act together in their own interests. From the earliest days of the epidemic, mobilising communities to respond to the threat and impact of HIV has been a key component of the response. Driving this has been the premise that communities themselves, with the necessary information and resources, are most likely to come up with meaningful and realistic solutions.

Community mobilisation is a process whereby individuals, groups or organisations analyse, plan, carry out and evaluate activities and responses in a participatory and sustained way to improve their health and wellbeing. By mobilising the MSM population in a given country, there is the potential for them to act together to develop contextually relevant interventions and programmes that may not have been possible using a more traditional top-down planning process.

Holistic

To develop effective responses to HIV and to treat people with dignity and respect, it is essential to approach work around HIV and STI prevention by considering the person as a whole. This means not reducing a person to being only an MSM who is living with HIV or who is at risk of HIV infection, but rather taking their emotional, physical, social and spiritual needs into consideration as well as their health. This is essential not only for wellbeing and respect, but also can help someone who is MSM in a hostile environment to feel more connected, respected and whole.

Multi-sectoral

Managing HIV and AIDS, and the discrimination, isolation and fear experienced by so many MSM, as well as the economic and social impact of HIV, demands responses across multiple sectors. These include health, psychology, social welfare, the police and law enforcement, the judiciary, the media, and spiritual and religious leaders, as well as government agencies, and the private and civil society sectors. HIV and AIDS is not just a health issue. People have complex human needs, and they all interact with each other. It is not possible to concentrate on one while ignoring others without this having consequences on someone’s health and wellbeing. HIV also has a social and economic impact on individuals, households, communities and countries.

An effective response to HIV and AIDS, and the challenge of meeting the needs of MSM in the MENA region, demands committed, urgent and sustained action. Healthcare workers cannot provide services if MSM are discriminated against and fear interacting with them. Experiences by MSM of physical violence and sexual assault cannot be addressed if MSM fear reporting it because the police and/or the judiciary will not treat them fairly. Issues of self-esteem and mental health are further compounded by negative and hostile social and religious norms towards MSM. Discrimination experienced by MSM at work has an impact on their ability to do their jobs and provide economic security for themselves and their families.

Those interested in developing programmes with and for MSM need to fully acknowledge the necessity, as well as the challenge, of working with other sectors to mount a comprehensive multi-sectoral response. In situations where people living with HIV and MSM are discriminated against, as is the case for many in the MENA region, learning from the experience of others and finding like-minded
individuals and organisations to partner with (in particular, UNAIDS) is essential to be able to advocate and nurture effective and sustainable programmes.

We have moved from a time when discussing MSM was very difficult and almost impossible in public with governmental partners, to a situation where this issue has been accepted with gradual maturation … One can see more and more in technical meetings the MSM representative saying: ‘I represent MSM.’ This is something new and particularly courageous in the present context, since this behaviour is still criminalised. This is something that has really changed … Through this programme, the involvement of people from this community has given a human face to the issue, in particular for technicians for whom it was something abstract in the past. So it has humanised the issue and this is very important.”

The first study that was conducted with key populations was a behavioral study with MSM … I think that was an important point in starting being objective about the epidemiological situation in Tunisia with key groups. For me, this is really the first important contribution of the project. For we moved from a time when discussing MSM was very difficult and almost impossible in public with governmental partners, to a situation where this issue has been accepted with gradual maturation.

I believe that from the moment when we had figures about behavior, and later on in 2009 about prevalence, that were confirmed in 2011, this is when we really irrefutably proved that the epidemic was concentrated in particular in the MSM population, and that we all
PART C
TOWARDS ACTION

In this section we begin to explore what is needed to mount an effective response to the HIV epidemic among MSM in the MENA region.
7. Understanding how change happens

Individuals do not live in isolation from their context, and people’s behaviour and health is deeply affected by social norms, their access or lack of access to quality health and social support services, and the legal and policy environment in which they live. This is particularly true for people who are marginalised in society. Therefore, in order to ensure that MSM can be healthy and thrive, any programmatic response needs to intervene at different levels: individual, community/social norms, service delivery and structural levels.

Programmatic responses are needed at the following levels:

- **Individual**: behaviour change; building self-esteem; psychological health and wellbeing.
- **Community**: building social capital within the gay community to support each other and fight prejudice and isolation.
- **Services**: access to quality HIV prevention, care and treatment services; condoms and lubricants; HIV testing; STI screening and treatment; ART; psychological and social support.
- **Structural** (enabling environment): advocacy; policy development; ensuring laws, statutes and societal norms are conducive to effective HIV prevention, care and support programmes for MSM.

**Behaviour is influenced by:**

- our beliefs and world view
- our psychology
- our experience, education and learning
- our stage of life and age
- observing others
- our domestic situation
- our sense of agency and power (self-efficacy) and whether we feel any sense of threat or fear that we may be at risk of HIV
- our socio-economic status and position in society
- the context in which we live – prevalent social and religious norms, national laws and policies, political governance.

In order for change to happen, we need to intervene at multiple levels (change theory) with multiple interventions (dose effect) and with sufficient coverage (scale). What we do, how we intervene, needs to be based on a hypothesis about how we think the intervention will effect/produce the change we want to observe. Our hypothesis of change needs to be based on evidence and not guesswork.

**Evidence is informed by:**

- past programme learning from our country or regional projects, or from global learning (this kind of learning is often derived from programme monitoring and learning, evaluations and operational research)
- good and emerging practice (tools, resources and case studies)
- quantitative and qualitative research.

It is always helpful when designing programmes to have a framework to structure interventions based on a logic model. This is important because it:

- ensures that you have systematically thought through what you want to achieve and how you might get there
- provides a structure to help organise thinking about why you are doing what you are doing
is transparent and democratic; i.e. it helps everyone involved to understand the rationale for what you are doing
recognises that change needs to happen at multiple levels
helps to identify the most appropriate intervention at the right level to achieve your objective.

When working with MSM, or any marginalised population, it is essential that programme design is based on a participatory situational/needs analysis that is triangulated with other sources of information/data, such as epidemiological surveys. Potential unintended consequences of interventions must have been thought through, and you must be clear about how they will be identified and mitigated. Realistically, it also needs to take into account what donors are willing to fund where local funding is not available.

8. Understanding your context

In order to develop effective programmes that will have impact, it is essential that programme implementers have a good knowledge and understanding of the population they are working with. This can be achieved in part through informal outreach, but that cannot take the place of more formal approaches.

Mapping

Mapping is an approach that has proven successful in helping programme implementers to get to know their programme beneficiaries better. It is an approach to gain knowledge and understanding of:

- the particular characteristics and dynamics of MSM in the programme area – those that are more open to having contact with a peer education programme, as well as those men who are hidden and would not want to be identified in any way
- where MSM meet in that specific geographic area – this could be places where MSM socialise and also areas where MSM may cruise27 for sex (sometimes a cruising site may be a park, a beach or another place where they feel they are unlikely to be discovered)
- the specific HIV risk behaviours of MSM in that area; for example, what their knowledge is of their risks of HIV and STIs, how many people are using condoms and whether they are using them regularly, whether they treat a regular sexual partner differently to a more casual encounter
- what time of day people meet and how often
- issues related to safety and security in the areas where they meet, such as their relationship with venue owners, the police and the local community.

There can be a tendency to treat sexual behaviours that may be risky for HIV transmission in a negative way. It is important to remember that people normally have sex because it is pleasurable, and it is the work of the peer educator to let them know how they can reduce the risk by modifying behaviour, not necessarily stopping the practice.

When undertaking mapping, it is also important to recognise that some MSM will be much easier to reach than others. Using a peer-informant28 approach sensitively

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27. “Cruise” in this instance means someone who is hanging around a certain place trying to identify if there are people who may be interested in meeting for a casual sexual encounter.

28. A peer informant approach is where a person is interviewed and asked about the what, when and who they have had sex with, and about their opinion on the best way to reach a sexual partner who might not be willing to have contact with a peer educator.
and confidentially can help a project to identify people who may need services and support but who would not be accessed by venue or street-based outreach. To do this, peers need to be trained and orientated towards the methodology, as well as grounded in the professional ethics demanded of them to undertake such sensitive work. Module 3 of the toolkit has a number of exercises related to preparing peer educators for mapping.

From a planning point of view, it should also be noted that there are risks associated with mapping and that it has to be undertaken with great sensitivity and caution. Mapping can actually draw attention to areas and raise suspicion where there was none before. It can open up areas of enquiry that mean that the MSM who use and visit the particular meeting point begin to avoid it because they fear exposure.

Since mapping is a thorough and valuable step towards identifying key groups, it is important to ensure sustainable funding for the next phase to avoid losing identified clients, their trust and the credibility of the programme.

**Synthesising local knowledge – quantitative and qualitative**

Other sources of information can be gathered from:

- epidemiological and local HIV and STI prevalence surveys
- population size estimates of MSM where they exist (these can be difficult to undertake because of political and social realities, and therefore proxy data is sometimes used from other sources)
- qualitative surveys and research
- interviews with local healthcare providers, social workers and psychologists
- reports and research from the region that may have been published locally or in international journals and publications (for example, SIDC (2012), Focus: a panorama of key affected populations in Lebanon 2007–2011).

Programme implementers working with MSM often operate with little information about the local MSM population, and it can be tempting to rely overly on the information already available. It is essential that available information is triangulated and all the information is reviewed together to check for what is consistent and what is not, and then to verify it with people from the local area.

Where insufficient information is available, it can be helpful to undertake some information-gathering though focus group discussions or one-to-one interviews.
Part C: Towards Action

9. Change framework

As previously discussed, developing an effective programme to meet the HIV and sexual and reproductive health needs of MSM in the MENA region demands that interventions are developed at multiple levels. In this chapter, we provide some examples of the types of interventions that evidence suggests are important to ensure an effective response to the HIV epidemic among MSM.

**Individual level**

At the individual level, the kinds of changes that the programme should try to make include:

- helping MSM to have an accurate perception of their risk of infection
- guidance about how to reduce risk and how MSM can access quality information and commodities such as condoms and lubricants
- approaches aimed at helping MSM to increase their self-esteem and sense of wellbeing
- increasing health and legal literacy so that MSM can become informed service users
- ensuring MSM know how to access HIV testing, and STI and HIV treatment services
- adherence support for people living with HIV.

**Example: a peer educator from APCS talks about starting an MSM project**

“At the beginning, we accepted that the project be carried out at our level without any prejudice or bias. Let me state that we had no qualifications nor the skills required for this issue, and we did not understand the internal and external obstacles [reluctance of some association members]. During the first training workshop with MSM, we realised that young people critically needed information, prevention methods and support, so we decided to engage in this project with more conviction.

But the most important change that we witnessed in our organisation, thanks to this project, is the empowerment and responsibility of MSM, who became more and more the architects of their lives. MSM now assume better their role as educators, ensure their work with beneficiaries with more confidence and conviction, without fearing being stigmatised by society. They are involved in decision-making, governance and facilitation of the organisation’s life.

Some MSM, in addition to their work with their community, have decided to get involved in the sensitisation of the general population. In other words, they get more involved in the welfare of those youth, which adds value to their actions and gives them the feeling of living in society, as according to them, remaining in their community is a kind of exclusion! This change is important for the association, as it fully meets our need of relevant and targeted AIDS action in our region, knowing that we are facing a concentrated epidemic.”

Now that I got it [HIV], I care more about the young and adolescents.”

MSM Living with HIV, 22 Years Old
Approaches include:
- community outreach
  - peer–peer promotion and condom distribution
  - services at venues and hotspots
- improving access and referral to user-friendly, quality health and social care services, including HIV testing
- supportive, well-organised self-help groups.

Social normative/community level
At the social normative/community level, interventions include assessing societal factors that inhibit and limit the self-determination of MSM by trying to create an enabling environment and addressing:
- stigma and ignorance
- discriminatory practices and behaviours
- homophobia
- harmful gender norms
- violence against MSM.

Approaches include:
- participatory reflection by communities and MSM
- local advocacy and knowledge-sharing
- sensitisation and training of influential figures/gatekeepers, such as religious and civic leaders, and the police
- discussions about these issues on community radio, social educational dramas in the community and sensitising the media.

Services level
At the services level, interventions are aimed at:
- increasing MSM’s access to commodities (condoms and lubricants) and quality services
- ensuring that services (HIV testing, STI and HIV prevention and treatment, mental health/psychological support) are user friendly, and that all staff are trained in how to work without discrimination against MSM.

Approaches include:
- procurement of essential commodities such as water-based lubricants and condoms, often achieved through a partnership between public providers such as ministries of health, national AIDS councils and NGOs
- ensuring that there are effective and geographical distribution channels to reach remote and rural areas
- training healthcare and other service providers (e.g. police), and involving MSM in this training where it is possible and safe to do so
- developing MSM-friendly services by scaling up testing facilities at NGO sites via the government
- developing effective referral processes between peer educators and service providers
- providing patient advocates where MSM are fearful of using services.

"The training I received the last period empowered me to be able to discuss HIV/AIDS prevention with peers without disclosing serology. Now I considering living positively my HIV positive status." 
MSM LIVING WITH HIV, 24 YEARS OLD
**Addressing structural barriers through advocacy**

Advocacy is a continuous process with the aim of bringing about change in policies, legislation and practices. It is usually a set of actions by individuals, groups or institutions seeking to make these changes through negotiation and sensitisation of decision-makers and those in positions of power and authority. This is in order to improve the lives of people such as MSM, who are unfairly discriminated against, and/or do not benefit from the same level of attention, resource allocation and protection as other members of the society where they live.

Advocacy is a key component of a combination HIV prevention approach and treatment and care continuum. In the context of MSM programming in the MENA region, advocacy is an important means of trying to address and change some of the structural barriers that MSM encounter when attempting to protect their health and wellbeing, including marginalisation, stigma, discrimination, human rights violations, and lack of access to appropriate healthcare services.

Advocacy initiatives can be targeted at:
- service providers
- politicians and government ministries
- religious leaders
- donors.

There are a number of publications that can be used as effective sources for developing work around advocacy objectives, and these can be found in the resource list of publications at the back of this manual.

**Structural level**

**At the structural level, interventions are aimed at:**
- identifying and trying to change laws and policies that discriminate against and limit the self-determination of, MSM
- promoting public health and the human rights of MSM, particularly to health and dignity
- promoting and monitoring the rational allocation of resources to meet the needs of MSM.

**Approaches will be largely informed by advocacy approaches, and include:**
- media monitoring and journalist training
- commission reports on the impact of abuses of MSM and successful responses to abuses, including best practices
- improving the participation of civil society in decision-making bodies
- monitoring resource allocation and ensuring that there is adequate funding for MSM-friendly and appropriate services, including legal-friendly services.
10. Partnership development

Through the process of analysing the challenges involved in ensuring that MSM have access to quality HIV and sexual health services, it will soon become evident that responding to their needs can only be achieved by working with multiple actors. These include healthcare workers, entertainment and social venue owners, the police and law enforcement agencies, religious leaders, and health and social care planners, as well as other community-based organisations working in the areas of HIV and sexual health, human rights, the private sector, international NGOs, UN entities and donors.

Without investing in developing meaningful relationships and partnerships at the outset of a programme, implementation can become challenging. Implementing any HIV/sexual health programme for MSM in a country where gay and other MSM do not have the full protection of the law can be difficult, and it is incumbent on the implementers to make life better for MSM and not risk their safety or wellbeing. Therefore, careful consideration should be given to the kinds of sensitisation and training the programme may need to undertake with critical programme partners and ensure that this is negotiated at the programme outset.

By maintaining a focus on the human rights and public health imperatives of any programmes working with MSM, a great deal of resistance to providing support to MSM can be overcome. Through education and sensitisation, using human rights language, and in particular by drawing attention to human rights considerations (especially in accessing health services), effective programmers can make an abstract and feared challenge – working with a marginalised and ostracised group such as MSM – less daunting and open the door to developing meaningful and effective partnerships. Experience has shown that when MSM have themselves been involved in developing those relationships, a richer and more effective partnership has been created.

**Example: the Network of Associations for Harm Reduction in Egypt**

FHI 360/Egypt in collaboration with the National AIDS Programme, the Drosos Foundation and the Ford Foundation, established the Network of Associations for Harm Reduction (NAHR) in 2013. NAHR is a coalition of CSOs and stakeholders dedicated to harm reduction who share the common goal of reducing stigma, promoting behaviour change and expanding harm reduction services to key populations, mainly MSM, people who inject drugs, female sex workers, people living with HIV and their related communities. Connecting comprehensive care with street-based outreach through using a combined approach of safer sex and safer injecting has proved to be successful in facilitating early detection and care for key populations.

The package of services offered by NAHR include HIV/AIDS prevention and care; street-based outreach; peer education; VCT; clinical care; distribution of syringes, condoms and strategic behavioral communication materials; support groups for people living with HIV; addiction and psychological support counselling sessions; referral of MSM and other key populations to required services; and linking HIV-positive detected clients to the treatment programmes provided by the Ministry of Health and Population. All services are voluntary, anonymous, confidential and free of charge.

NAHR advocacy efforts aimed at reducing stigma and discrimination include conducting annual meetings for key populations to assess their needs, and HIV/AIDS orientation sessions and focus groups to selected members from the general population. To ensure that the rights of key populations are not breached, FHI 360 developed a code of ethics that highlights the ethical principles and behaviours that govern the relations of all members. Advocacy efforts also include training service providers from harm reduction projects on the human rights of key populations, and Muslim and Christian religious leaders on how to communicate with young people.
11. Documentation, monitoring, reflective learning and evaluation

As for any project or programme, there are core components that are essential for effective project management and operations. These include:

- **accurate documentation and reporting** of the implementation of the project for knowledge sharing and donor reporting
- **ongoing monitoring**, which involves developing appropriate indicators and metrics that will be used to monitor progress and assess whether the project is achieving what it set out to achieve
- **reflective learning**, which is a modus operandi established by the leadership of the project to ensure that all staff, volunteers and partners continually reflect on the programme, critically analyse what the monitoring data are telling them at least once per quarter, and depending on what comes out of the reflection and learning, make project adjustments when new information emerges
- **evaluation** – the process of trying to assess the impact of the project and whether it has achieved its purpose.

As much of the project work for MSM in the MENA region will be conducted by peer educators, ensuring that these educators are actively engaged in core components of the project is not only good practice but essential. These include planning, training, monitoring and documentation. Marginalised communities in hostile situations can often feel understandably fearful and apprehensive about how any information collected might be used. By ensuring the active engagement of the peer educators and the community from the outset, it is possible to help them to understand the value and importance of documentation and monitoring, and how the information can be used to help to ensure that MSM have not only quality services but also appropriate levels of resource allocation to meet needs. No information should ever be kept regarding the identity of individuals, and MSM may need reassurance that the integrity and safety of all data collected will be maintained at all times.

The reality in the MENA region is that there are a number of different organisations and actors working with MSM. To avoid project overlap and to ensure accurate reporting, it is also good practice to work closely with other projects to ensure that the information they collect is the same as that collected by your own project. This enables accurate comparisons to be undertaken to help national AIDS programmes and UNAIDS (as the local coordinator through its joint teams) get a more accurate picture of the needs and experiences of MSM, as well as an indication of who, how and where MSM are being reached and where gaps exist.
GUIDELINE 1: States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities across all branches of government.

GUIDELINE 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

GUIDELINE 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

GUIDELINE 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

GUIDELINE 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

GUIDELINE 6 (as revised in 2002): States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

GUIDELINE 7: States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

GUIDELINE 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

GUIDELINE 9: States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

GUIDELINE 10: States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

GUIDELINE 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

GUIDELINE 12: States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV at international level.
Annex 2: Resources for HIV and health programming with and for MSM

The following list provides key references on topics relevant to rights-based, effective and integrated community-led and public health responses to men having sex with men. They are primarily intended for civil society organisations and MSM community-led organisations supporting programmes with and for MSM.

- Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (WHO, 2014).
  www.who.int/hiv/pub/guidelines/keypopulations/en/
- Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guide for collaboration interventions (UNFPA, 2015).
  www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=INTL&id=14409&thisSection=Resources
- Pehchan training curriculum: MSM, transgender and hijra community systems strengthening (India HIV/AIDS Alliance, 2014).
- Resources for action for HIV and health programming with and for men who have sex with men (MSM) (International HIV/AIDS Alliance, 2015).
  www.aidsalliance.org/resources/653-resources-for-action-for-hiv-and-health-programming-with-and-for-msm
- Sustaining the human rights response to HIV: funding landscape and community voices (UNAIDS, 2015).

In MENA
  www.aidsalliance.org/resources/680-mena-analysons-nousmeme-nos-besoins
- **Health assessment of men who have sex with men in the Arab world** (M-Coalition, 2015) / English. [www.m-coalition.org/#/resources/c1o4h](www.m-coalition.org/#/resources/c1o4h)

- **HIV and outreach programmes with men who have sex with men in the Middle East and North Africa: from a process of raising awareness to a process of commitment** (UNAIDS, 2012) / English and French. [www.unaids.org/sites/default/files/media_asset/20120920_MSM_MENA_en_0.pdf](www.unaids.org/sites/default/files/media_asset/20120920_MSM_MENA_en_0.pdf)

- **Mental health of men who have sex with men in the Arab world** (M-Coalition, 2015) / English. [http://media.wix.com/ugd/c2ad70_a8cbe35e78214b0190faa398f3dd205c.pdf](http://media.wix.com/ugd/c2ad70_a8cbe35e78214b0190faa398f3dd205c.pdf)

About the International HIV/AIDS Alliance

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

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

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

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MODULE 1
CORE KNOWLEDGE

TRAINING MANUAL
FOR MSM
PEER EDUCATORS

Training toolkit on MSM programming for the MENA region
Acknowledgements

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

This orientation manual was written by John Howson and Nadia Badran. Simone Salem, on behalf of UNAIDS, and Manuel Couffignal, on behalf of the Alliance, revised and completed the report. Special thanks to Eltayeb Elamin from UNAIDS RST MENA, who provided critical feedback during the writing process.

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

The MENA programme’s partner associations

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

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<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, gay, bisexual, transgender, intersex</td>
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<tr>
<td>MENA</td>
<td>Middle East and North Africa</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Presentation of the training manual

Objectives

The training presented in this manual has been developed to help operationalise the UNAIDS MENA regional publication *HIV and outreach programs with men who have sex with men (MSM) in the Middle East and North Africa (MENA): from a process of raising awareness to a process of commitment*.

It provides technical information and practical tools for peer educators to use as part of MSM outreach programmes in the Middle East and North Africa. These programmes aim to reduce the spread of HIV and other sexually transmitted infections (STIs) among MSM within a framework and context where their privacy, confidentiality and rights are respected.

Target group of this training manual

- Trainers from existing peer educator programmes
- Future/potential trainers who will work in outreach programmes with MSM

Contents

Practical instructions

This section includes:

- how to run peer education training sensitively using effective training approaches and tools
- the principles of adult learning
- the different personalities the trainer may encounter, with tips on how to manage them
- how to prepare for sessions and evaluate them.

The training package

This section includes:

- three modules that help to build peer educators’ capacity to implement MSM outreach
- Module 1 covers core knowledge, Module 2 covers skills development and Module 3 covers implementation and evaluation
- the modules include practical sessions and exercises with annexes of supporting material.
ILLUSTRATIVE TRAINING OUTLINE

<table>
<thead>
<tr>
<th>MODULE</th>
<th>DURATION</th>
<th>OBJECTIVES</th>
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<tbody>
<tr>
<td>Module 1: Core knowledge</td>
<td>21 hours 35 minutes</td>
<td>Analyse:</td>
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<tr>
<td></td>
<td></td>
<td>■ what is needed in the design of an effective MSM intervention programme</td>
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<td></td>
<td></td>
<td>■ the personal characteristics of MSM within their social, health, cultural, religious and legal context</td>
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<td></td>
<td></td>
<td>■ the specific needs of MSM, and the root causes and impact of stigma and discrimination</td>
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<td></td>
<td></td>
<td>■ the specific technical knowledge needed to be able to conduct effective outreach to raise awareness in the street about the risks of drug use, HIV and other STIs</td>
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<tr>
<td>Module 2: Skills development</td>
<td>28 hours 35 minutes</td>
<td>Practise skills necessary to implement outreach-based educational activities aimed at promoting behaviour change among MSM to reduce risk of HIV and other STIs</td>
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<tr>
<td>Module 3: Implementation and evaluation</td>
<td>31 hours</td>
<td>Analyse the components needed to design effective outreach programmes, including approaches to advocacy</td>
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<td></td>
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<td>Design the programme and discuss the referral systems associated with it:</td>
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<td>■ explore the importance of monitoring and evaluation (M&amp;E) systems; recognise the importance of the follow-up system of the outreach programme</td>
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<td></td>
<td></td>
<td>■ learn about measuring indicators and report writing</td>
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</table>

Methodology

This training toolkit was developed by:

■ conducting a detailed review of the toolkit *HIV and outreach programs with MSM in MENA: from a process of raising awareness to a process of commitment*

■ reviewing relevant training materials, references and tools related to MSM outreach programmes in the region (see the NGO MSM project orientation manual, Annex 2)

■ learning from case studies, success stories, documents about programme learning, testimonials, and the practical experience of other programmes working with MSM in the region

■ ensuring that scientific and theoretical content is correct

■ developing a preliminary draft to help agree training components, plus provide a guide and easy-to-apply exercise for facilitators.

Initial drafts were reviewed during workshops in Lebanon, Tunisia, Algeria and Morocco with peer educators, field supervisors, and programme managers and experts in MSM outreach programmes and HIV prevention.

Success stories were gathered from participants to reflect regional expertise.
Practical instructions

Principles of adult learning

When training adults, it is important to understand the factors that contribute to them learning in the most effective way. When children learn in schools, the situation is often one in which a teacher has the knowledge and imparts that learning to the child. Although the best teachers will help children to reflect and analyse what they are being taught, for much of the time at school children have to absorb and learn predesigned curricula, often linked to examinations.

This approach does not work well with adults. Adults bring into any training their own knowledge and experience. Adult learning tends to be focused on problem solving and collaboration. There is also an expectation of equality between the teacher or facilitator and the learner.

Research over the years has identified a number of principles that support adult learning. They include:

- Adults are internally motivated and self-directed
- Adults bring life experiences and knowledge to learning experiences
- Adults are goal oriented
- Adults are relevancy oriented
- Adults are practical
- Adult learners like to be respected

In 1984, Malcolm Knowles, one of the leading researchers on adult learning, suggested that there are four principles that should be applied to adult learning. These principles are particularly relevant to the peer education learning environment and should be applied when preparing the training sessions:

1. Adults need to be involved in the planning and evaluation of their training.
2. Experience (including mistakes) provides a good basis for the learning activities.
3. Adults are most interested in learning subjects that have immediate relevance to and impact on their job or personal life.
4. Adult learning is generally problem centred rather than content oriented.

How to use the training manual

First read Time to shift from awareness to commitment: NGO MSM project orientation manual and then Modules 1, 2 and 3 of this manual.

- Think about what you will need to create a successful training programme – knowledge, skills and logistical arrangements.
- Identify what you want to achieve, and select the training sessions and practical exercises from the toolkit that are relevant to your audience and needs.
- Prepare to deliver the theoretical content by ensuring that you fully understand the content. At the end of each training session there are handouts of the theoretical content to help participants to remember what they have learnt. These can be downloaded to your laptop and printed as handouts.
- Prepare the evaluation forms.

The references at the end of the orientation manual are a good way to gain more in-depth knowledge of the subject.

Real-life stories, experiences, testimonials and lessons learnt will make the training more personal to participants.

Asking experienced MSM peer educators to assist during the sessions can add real value and richness to the training.

Complete the manual evaluation form.

Creating an active learning environment

A: Establishing a productive training environment

- Choose a venue that is big enough to carry out the exercises; that is quiet, with good lighting and ventilation, and with tables and chairs arranged so everyone can see one another. Provide lunch and coffee breaks.

- Promote an atmosphere of mutual respect. Encourage experience-sharing. Allow adequate time for questions and the sharing of lessons learnt, and apply the principles of adult learning.

- Before the start of every training session, set out rules regarding mutual respect, management of discussions and timekeeping.

- Promote participation by creating committees, for example, for documenting and presenting the learning from each day at the opening of training on the following day.

- Encourage creativity in how the learning is presented.

- Use entertainment to maintain enthusiasm and energy throughout the training (humorous exercises, riddles and games).

- Build self-confidence by using exercises such as *Ahlan wa Sahlan* or *Mouhakat* at the beginning of each day.

*Ahlans wa Sahlan* is a warm-up exercise for participants to help to assess their mood and enthusiasm for the training day ahead.

*Mouhakat* (Simulation) is an exercise that can be used in the mornings for about 15 to 20 minutes and encourages participants to get to know each other on a deeper and more meaningful level. This exercise gradually builds their confidence and their self-esteem, and allows them to discover their likes and dislikes, their values and what aggravates them. The facilitator can adapt this exercise to the topic of the day.

**Examples of Ahlan wa Sahlan and Mouhakat exercises to start the day**

Ask participants to:

- express their feelings at the start of the day through a simple expression or word

- nominate one participant to demonstrate a gesture or body stance that will mimic or express what they perceive to be the feelings of another participant just by looking at them. Ask the group to guess what feeling they are trying to express, and ask the person they are imitating if they got it right

- talk about their state of mind using the vocabulary of a “weather man” presenting the weather forecast on TV – a happy mood will be presented as a shining day while a sadder mood will be a day with clouds and rain.
B: Building relationships through ice-breakers at the beginning of the workshop

These exercises give each participant a chance to talk about themselves and their tendencies, likes and dislikes, and experiences. Participants should be encouraged to express themselves freely.

Examples

Throw a ball, and whoever catches it has to introduce themselves and then pass the ball on until everyone has had a turn.

- Make up two groups. The facilitator writes the name of each person from the first group on a separate piece of paper and folds it. They then ask each participant from the second group to choose a piece of paper and introduce themselves to the person named on it.
- Form an inner and outer circle and play some music. Those in the outer circle walk around to the sound of music until it stops. Then they introduce themselves to the person facing them in the inner circle. Repeat the exercise a few times.
- Participants sit in small groups and introduce themselves to each other. Each group is given a name or title and draws their interests on a piece of paper. They then present themselves and their interests to another small group.

C: Personal skills

The facilitator should be someone who is:

- well versed in the topics they want to present and capable of managing a training workshop
- competent in using active learning methods and techniques so as to engage participants and promote learning
- able to communicate in front of a new group of people and to use language tailored to the group
- confident and committed.

They should:

- understand their specific duties
- respect the customs and traditions of the group they are working with
- have no preconceived opinions, or at least be able to acknowledge their own prejudices and opinions and not let them interfere with participants’ learning
- be able to analyse, negotiate and give constructive feedback
- accept being assessed and be objective in their reporting of the training experience.

As a facilitator, you should be mentally prepared for your sessions. Before starting, ask yourself:

- Am I ready to undertake this assignment?
- Do I respect the various groups I have to train?
- Do I have all the technical information relevant to the topics of the workshop?
- Am I open to seeking assistance from experts in the field?

The facilitator should aim to:

- build mutual trust among participants
- create a positive learning environment
encourage group work  
set the workshop rules  
emphasise the importance of active listening  
encourage participants to list their expectations from the training workshop and compare them to the workshop’s objectives.

Preparing for the session
- Prepare the theoretical content associated with the exercises.
- Read the exercises and the theoretical content, and prepare the relevant resources.
- Keep the manual handy for quick reference.
- Refer to the toolkit and other references in preparation for questions.
- Practise the tools and sessions ahead of the session.
- Prepare the materials needed for the exercises.
- Note down observations, questions and participant feedback.
- Have photocopies of the annexes, pictures, cards, etc.

Guest speakers
It can be helpful to invite guest speakers to training courses as they can provide insights and share experience that can be valuable to participants. Ensure that the speaker understands the objectives of the training and the expected outcomes well in advance. It is also useful to share a short biography of the speaker before they start to speak.

Running the session
Although you will encounter all sorts of questions and situations, it is important to allow participants to ask questions and freely express themselves as this will enhance the sessions’ productivity. Prepare yourself for times when you may experience:
- a lack of participation in the discussions  
- sarcasm and unnecessary jokes from some of the participants when discussing certain topics.

Get familiar with the active learning methods and training materials, and make sure you understand how to use the manual.

D: Active learning approaches based on adult learning principles
As we have already discussed, for participants to be active rather than passive learners the training must be participatory, interactive and based on adult learning principles.

It is important for the trainer using the information in this manual to apply adult learning principles to how they conduct the training.

The active learning methods and techniques used in this manual to facilitate the sessions include:

Brainstorming
Ask a question or present an idea about a subject that could raise strong feelings or that could lead to the expression of a number of viewpoints. This allows you to present the general idea and to determine participants’ capacity and analytical skills before going into details. All ideas are accepted and written down: there are no right or wrong answers – although it would be useful at the end of the training to check whether anyone has changed their view as a result of the training.
**Role-playing**

When doing role-plays, encourage the use of real-life scenarios that could be based on participants’ own painful and personal situations, although these do not have to be acknowledged openly. By using imaginary characters, participants can present challenging or taboo subjects. Props can help participants to get into character.

Participants should reflect on the challenges faced by the characters in their role-play and come up with solutions. Through this, they are enabled to reflect on their own attitudes, prejudices and areas where they may need to develop their skills further. You could also ask the other participants to discuss what they observe in the role-play and try to predict what might happen before the end of the performance.

**Case studies**

As facilitator, prepare stories in advance of the training that reflect the reality of working with MSM in their own context. The stories should be presented to the group with questions for participants. When preparing the stories, consider having an introduction, a number of characters, a plot and an open-ended conclusion. Participants should be able to:

- relate to the circumstances of the characters
- suggest what can be done to support them
- name the key issues and challenges raised in the story
- identify the obstacles and think of solutions suitable for the particular culture, needs and capabilities of the characters.

**Group work and storytelling**

Some exercises require working in groups of four to six. It is often easier to discuss sensitive or challenging issues in small groups.

Approaches to working in small groups can include:

- asking a small group to discuss a sensitive issue and then presenting the content of the discussion to the larger group
- introducing a topic in the large group that is relevant to working with MSM through outreach activities, and that may be controversial or challenging to some participants; e.g. an MSM not using condoms or an MSM being made homeless as a result of family rejection
- first discussing an issue briefly in the large group, then asking all the groups to discuss the same issue, and finally feeding back a summary of the discussion to the larger group.

**Illustrations and wall journals**

Ask participants to illustrate issues or topics, rather than simply relying on discussions. Getting images from newspapers or magazines can be a useful way of stimulating thought. Participants could also draw images or a symbol to represent an issue. Similarly, the facilitator could prepare wall journals with questions or brief exercises that could be analysed in different ways. Participants can walk around individually or in groups and write down their answers.

**The “buzz” technique**

Ask participants to discuss a question in pairs or to gather as many answers as possible to a particular complex question. They may move around the room to collect the answers or sit opposite one another. Encourage participants to move around, and to express themselves quickly and effectively. The discussion is over once the “buzz” of conversation stops.
The cards brainstorming method
Give the participants cards with questions written on them related to the training and ask them to think how they would answer. You could create a competition among participants to answer as many questions as possible, or give out different cards to each participant.

Discussion and debate
Choose topics with conflicting points of view and ask participants to stand or sit facing each other to discuss them. They should observe certain rules such as listening to each other and not repeating arguments. This encourages everyone to express their thoughts, as well as to think about how others think and feel about an issue. It is an effective way of learning from each other, as well as a way of trying to influence others. Discussions could be around common expressions about MSM, or how society thinks about a particular issue related to the subject of the session.

An alternative approach could be to choose a belief or attitude for participants to debate with each other based on their own experience and observations. Ask participants to back up their arguments for the belief or attitude with either scientific facts, common beliefs or tradition.

If working in small groups, the group may choose one person to represent them in the debate or have each person in the group present a different section of the discussion. This may generate some chaos – and some strong feeling. As facilitator, you must pay attention and ensure that the session is lively and enthusiastic, while at the same time making sure that participants remain respectful of each other.

Short presentation
Prepare a short presentation with pictures/illustrations to summarise the content. People’s attention span is usually no more than 20 minutes, so make your presentation 10–15 minutes long.

E: Dealing with different personalities
Understanding the different characters in the group and learning how to deal with them will enable you to run an active training session where all participants can be engaged. The table on the next page presents the types of personalities and sub-personalities that facilitators can encounter during training.

General advice
- Listen and correct misconceptions by providing scientific information to counter myths.
- Encourage everyone, especially those who do not speak much, to participate and to ask questions.
- Rephrase ideas for those who do not easily comprehend in depth and try not to complicate matters.
- Do not be afraid to show conflicting aspects of the topic and allow discussion.
- Avoid evaluating participants’ attitudes, values and beliefs, and instead respect their cultural backgrounds and help them understand the content of the sessions.
<table>
<thead>
<tr>
<th>PERSONALITY</th>
<th>CHARACTERISTICS</th>
<th>HOW TO DEAL WITH THIS MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inquirer</td>
<td>May want to embarrass you</td>
<td>Let participants answer him</td>
</tr>
<tr>
<td>(asks a lot of questions)</td>
<td>Is pleased when his answer matches yours</td>
<td>Do not take sides</td>
</tr>
<tr>
<td></td>
<td>Seeks your approval</td>
<td></td>
</tr>
<tr>
<td>Troublemaker</td>
<td>He wants to hurt the feelings of others, or</td>
<td>Focus on the positive</td>
</tr>
<tr>
<td></td>
<td>Has valid issues that he complains about</td>
<td>Keep him on track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Get participants to give their opinion when he causes trouble</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss with him further outside of the session</td>
</tr>
<tr>
<td>Non-conformist/</td>
<td>Enjoys objecting for the sake of it, possibly because he is dealing with some</td>
<td>Try to direct his attention to the main topic and ask his opinion</td>
</tr>
<tr>
<td>critic</td>
<td>personal problems or finds it difficult to discuss the issue</td>
<td>Show respect for his personal experience and explain your position to the group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain what he does not understand</td>
</tr>
<tr>
<td>Opinionated</td>
<td>Refuses to listen to you or to the participants</td>
<td>Encourage the group to debate with him and avoid taking anything personally</td>
</tr>
<tr>
<td></td>
<td>Thinks he does not need to learn anything new</td>
<td>Explain to him that he has to consider the opinions of the rest of the group, and you can then discuss his point of view</td>
</tr>
<tr>
<td>“Know-it-all” expert</td>
<td>Wants to impose his opinion</td>
<td>Interrupt his interactions by asking him direct questions</td>
</tr>
<tr>
<td></td>
<td>May be more knowledgeable or just wants to talk</td>
<td>Raise the confidence of participants so he is not in control (e.g. Say, “What you are saying is interesting but let’s ask what the others think”)</td>
</tr>
<tr>
<td>Quiet one</td>
<td>Indifferent</td>
<td>Address him personally</td>
</tr>
<tr>
<td></td>
<td>Thinks that he is either above or below what is being discussed</td>
<td>Remember his name</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask his opinion</td>
</tr>
<tr>
<td>Affable/supporter</td>
<td>You do not need to convince him, he is always on your side</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Great helper in debates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask for his input</td>
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<tr>
<td></td>
<td></td>
<td>Address him frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thank him</td>
</tr>
<tr>
<td>Talkative</td>
<td>Talks about everything except the topic being discussed</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Interrupt him (e.g. Say, “Don’t you think we have drifted away from the topic?”)</td>
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<tr>
<td></td>
<td></td>
<td>Look at your watch and gesture to hint that he has gone on for too long</td>
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<tr>
<td></td>
<td></td>
<td>Suggest he continues the discussion in the break</td>
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<tr>
<td>Shy</td>
<td>Has his own point of view but finds it hard to express it</td>
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<tr>
<td></td>
<td></td>
<td>Ask him easy questions</td>
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<td></td>
<td></td>
<td>Support him</td>
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<tr>
<td></td>
<td></td>
<td>Raise his self-confidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Give attention to his valuable input</td>
</tr>
<tr>
<td>Obstinate</td>
<td>Always goes back to the same ideas</td>
<td></td>
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<tr>
<td></td>
<td>Talks non-stop</td>
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<tr>
<td></td>
<td>Is insensitive</td>
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<tr>
<td></td>
<td></td>
<td>Be patient with him</td>
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<tr>
<td></td>
<td></td>
<td>Let the group ignore him</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promise that you will discuss his issues privately</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apologise about the limited time for further discussion</td>
</tr>
</tbody>
</table>
F: Tips for the facilitator

Respect participants’ privacy and appreciate what they have to say. Write down their ideas, understand their needs and time all discussions.

<table>
<thead>
<tr>
<th>PERSONALITY</th>
<th>CHARACTERISTICS</th>
<th>HOW TO DEAL WITH THIS MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distracted</td>
<td>■ Unfocused</td>
<td>■ Go back to the topic</td>
</tr>
<tr>
<td></td>
<td>■ Has difficulty following</td>
<td>■ Make use of the new ideas</td>
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<tr>
<td></td>
<td></td>
<td>■ Try to understand him</td>
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<tr>
<td></td>
<td></td>
<td>■ Treat him gently</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Tell him your will ask for a summary of what has been discussed at the end of the session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Keep sessions short and focused</td>
</tr>
<tr>
<td>Arrogant</td>
<td>■ Treats others with a superior attitude</td>
<td>■ Do not criticise him</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ When he is at fault, say, “Yes ... but ...”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Acknowledge his point of view and encourage him to acknowledge others</td>
</tr>
</tbody>
</table>

Sample set of ground rules

■ Everyone participates
■ Each participant is important in the training and his input is essential
■ All ideas are accepted and respected
■ Effective listening
■ Respect allocated time
■ Try not to deviate from the core subject
■ Maintain confidentiality about the subjects and ideas being presented
■ Turn off cell phones

Sample preliminary session

Exercise: *Ahlan wa Sahlan* or Check-in (10 minutes)

Expectations of participants (first day only) (10 minutes)

Ground rules (first day only) (10 minutes)

Pre-evaluation form (10 minutes)

Use the training manual to help you to:

■ develop an outline of each session
■ select the necessary resources
■ choose an *Ahlan Wa Sahlan* exercise with which to start the session
■ summarise the key learning and discussions from previous sessions
■ encourage participation
■ be systematic in presenting the topics
■ provide documentation
complete a pre- and post-evaluation form
write the training report for the person who requires it (e.g. the funder, your manager, participants).

After the session, check that you have presented all the prepared subjects and assess the level of participation.

G: Evaluation
Self-assessment
- Did you perform your role appropriately?
- What did and did not work, and what were the reasons? What could you improve?

The learning environment
The exercises are an essential part of the training and facilitation.
- Did you keep the momentum going throughout the training?
- Did you pace the sessions to the capacity of participants?
- Did you explain the exercises clearly so participants were able to follow the instructions? If not, what would you do next time to correct this?
- Did you provide enough time for participants to discuss?
- Did you listen to their input and needs?

Ask all participants to evaluate the topics, the exercises, the methods and the training atmosphere.

Pre- and post-assessment forms
There are a series of closed questions for each session that you can use to help you to assess any changes in the level of participants’ knowledge or attitude changes.

Ask participants to fill out an anonymous questionnaire using the individual code that you should have provided to them at the beginning of the training. This enables each participant, and you, to compare the pre- and post-training results.

If you only wish to measure the group performance as a whole, it is not necessary for them to include their code on the form.

Results
- Ask participants to fill out a form at the beginning and end of the workshop.
- Give each participant a code (e.g. 1/A to 20/N) to use on their form. Ask them to keep it until the end of the session and use the same symbol again on their post-evaluation form.
- Where the form is filled out in small groups, use a group symbol and use the same one again for the post-evaluation form. Results can also be compared in this way.

Daily evaluation form
These are simple questions to find out what participants have learnt and gained, and what most impressed them.
Module evaluation
Participants fill out the form at the end of each module with complete objectivity. This can be done at group or individual level. Alternatively, ask questions, or ask participants to raise their hands to indicate whether they agree or disagree with the question. You could also ask them to stand on one side of the room or the other to show whether they are for or against. Evaluation should be expressed freely and without pressure. The main aim is purely educational as well as to improve future training.

Report writing for each module and lessons learnt
At the end of each module, review some of the exercises and modify them as necessary, noting any changes in the module report. This helps you, as facilitator, to monitor and analyse your own competence, and can provide direction for any area that needs improvement.

Make sure you have read *Time to shift from awareness to commitment: NGO MSM project orientation manual* before you start this module.
Module 1: Core Knowledge

Overall timing
21 hours 35 minutes

Objectives
This module covers the core knowledge necessary for people undertaking outreach with MSM:

- Issues related to biology, sex and identity (and common misconceptions)
- Characteristics of MSM, including sexual practices
- Policies and other factors affecting MSM
- The impact of stigma and discrimination
- Basic knowledge about STIs, HIV and prevention
- Issues related to sex work and drug use
- Characteristics and attitudinal issues related to peer educators

<table>
<thead>
<tr>
<th>SESSIONS IN MODULE 1</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: Sexual practices among MSM – facts versus cultures</td>
<td>2 hours 40 minutes</td>
</tr>
<tr>
<td>Session 2: MSM in their social, health, cultural, religious and legal context</td>
<td>1 hour 40 minutes</td>
</tr>
<tr>
<td>Session 3: Challenges facing the MSM population</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>Session 4: Stigma, discrimination and vulnerability</td>
<td>2 hours</td>
</tr>
<tr>
<td>Session 5: Overcoming the challenges to accessing this population</td>
<td>1 hour</td>
</tr>
<tr>
<td>Session 6: The male and female reproductive systems</td>
<td>2 hours</td>
</tr>
<tr>
<td>Session 7: HIV and other STIs</td>
<td>3 hours</td>
</tr>
<tr>
<td>Session 8: Sexual practices and preventing HIV and other STIs</td>
<td>1 hour</td>
</tr>
<tr>
<td>Session 9: False beliefs about STIs</td>
<td>1 hour</td>
</tr>
<tr>
<td>Session 10: Drugs and prevention</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>Session 11: Sex work</td>
<td>1 hour</td>
</tr>
<tr>
<td>Session 12: Health education and harm reduction in the field</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>Session 13: The peer educator</td>
<td>1 hour</td>
</tr>
<tr>
<td>Session 14: Attitudes and beliefs</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>
Session 1

Sexual practices among MSM – facts versus cultures

Overview
This session allows participants to discuss sexual relationships among MSM, express their concerns, and talk about what they already know about the subject.

Participants may need some clarification about common misconceptions related to MSM. Your role is to give them the opportunity to ask questions, so preparation is crucial. If you lack confidence, you may wish to invite an expert to facilitate this first session.

Don’t hesitate to go into detail. Allow participants to talk about what they know and what they think they know about MSM, including subgroups.

Remember, this is just the beginning of the training workshop, and there will be many more opportunities to dispel myths and misconceptions related to sexual orientation, and chances for you to correct any negative attitudes.

Activity: Understanding the MSM population – creating a life-like story

Step 1: Preparing the stories (30 minutes)
1. Ask participants to think about a man who has sexual relationships with other men.
2. Draw an image of the man in middle of a large sheet of paper and give him an identity: name, age, sexual orientation, social status, friends, family, type of work, culture, country, region, etc. Describe his life, needs and sexual partners. Note any risky behaviours he may have, such as drug use or sex work. Also discuss the relationships between him, his family, peers and partners.

All this information will enable other participants to identify the challenges he faces and those barriers that may be encountered in reaching him.

Participants could use symbols and colours to indicate the quality and strength of relationships he has with each person and the level of risk he may have from his lifestyle.

Step 2: Sharing MSM profiles (30 minutes)
3. Ask each participant to share the profile of their imaginary MSM and encourage questions. During the discussions, the facilitator may identify discriminatory attitudes. If other participants do not challenge them during the discussions, they need to be noted down and addressed later in the training.
Step 3: Explaining terms associated with MSM (30 minutes)

4. Ask participants a question related to terms associated with MSM, such as:
   ■ What does [term] mean to you?

5. Affirm correct answers and correct misunderstandings by sharing the correct answer.
   Terms to be discussed can include those related to biological identity, homosexuality, gender identity, sexual orientation, gender/social roles, transgender people and transsexuals (Annex 1).

Step 4: Kinsey scale (20 minutes)

6. Introduce participants to the Kinsey scale, explaining that it was developed to help to describe actual human experience and behaviours rather than a simplistic understanding of human sexuality as either heterosexual or homosexual. Share the scale with participants and encourage them to discuss their reaction to the scale (Annex 2).

Step 5: Klein Sexual Orientation Grid (20 minutes)

7. The Klein Sexual Orientation Grid is a different approach to helping to describe human sexual experience. Using the account of it in Annex 3, explain to the group why it was developed and distribute copies of it. If there is sufficient time, encourage participants to fill in the form and/or ask them to complete it later.

8. You could ask them later to share their feelings about the scale. It is important to explain to participants that they have the right to keep personal information confidential and should only share information if they feel comfortable to do so.

Step 6: Misconceptions (30 minutes)

9. Discuss the beliefs provided in Annex 4. Present each common misconception to the group and investigate what the group thinks about it. Correct the misconceptions using the information in Annex 4.

10. Talk about how sexual minorities are particularly affected by these misconceptions.
    This introduces participants to MSM identity without going into too much detail, thereby setting the scene for the next exercise.

---

**Hassan is a 22-year-old MSM**
When Hassan was young he liked to dress in girls’ clothing. In his teens he began to think of himself as female. His school friends used to tease him that he looked more beautiful than a woman. After trying to change him, his parents gave up and chased him out of the house. He moved to the city where he met a taxi driver called Anis, a 28-year-old MSM. They fell in love, developed a strong sexual relationship and moved in together.

**Aymen is a 40-year-old married man**
People sometimes gossip that Aymen has “effeminate gestures”, but everyone sees him as a happily married man. In reality, he loves to have sex with men in secret, and often meets with male sex workers. One of his regular friends is Salim. Salim only has sex with men for money. He is sexually attracted to women, and in the future hopes to get married to his girlfriend.
Annex 1: Understanding MSM

Why use the term “men who have sex with men”?“Men who have sex with men” (MSM) is a concept developed in public health to describe sexual behaviour between men. It is a label used to describe behaviour and not identity. While some men who have sex with men will define themselves as homosexual/gay or bisexual, many will not because it does not reflect their perception of their own identity. For instance, sex between men can take place in single-sex only environments such as prisons and the military, and those men who have sex with other men in that context will do so because their preferred sexual partner, a woman, is unavailable. Likewise, some married men may have sex with other men while still enjoying active and satisfying sexual relations with their wives. Other married men may prefer to have sex with men but for family and societal reasons will live in a traditional heterosexual marriage.

What is sex?
It is important also to understand what kind of sexual behaviour is covered by the term “sex”. Some people think that only penetration (anal or vaginal) constitutes sex, whereas others define sex as a catch-all term for any activity that results in sexual pleasure and orgasm; for example, mutual masturbation, oral sex and sensual massage. Not all men who have sex with other men have or enjoy penetrative sex.

Among those who do have anal sex, some are only active (the person who penetrates), some are only passive (the person who is receptive) and some men are versatile (sometimes they are receptive and sometimes they are the active partner).

When it comes to developing HIV prevention guidance and support, it is important for programmers to know how local MSM define sex and what are common sexual practices.

This distinction between behaviour and identity is particularly important in the MENA region, where sexual identity is differently understood from many European and Western-based countries. For instance, scholars* have argued that there is no concept of homosexuality within Arab history despite many descriptions of sexual expression between men, and between older and younger men/boys, in poetry and literature. While there are a number of countries within the region that have a recognised homosexual (gay) community, in other countries sexual behaviour between men will be much more hidden and secret.

The reality is that despite protestation and denial by some, historical and contemporary evidence shows that sex between men has existed throughout history and in all civilisations. Within the MENA region, it is referred to in Arab stories, novels, poems and songs, and it exists among all age groups, social classes, educational backgrounds, marital statuses, races, colours, nationalities and ethnicities.

Biological sex, gender identity and sexual orientation
To deepen our understanding of human sexual behaviour and its association with HIV risk, it is important to understand how biology, gender and identity interact as they refer to MSM. Definitions are not always straightforward, and yet understanding them is vital to inform a basis for and development of meaningful HIV prevention and care services.

Our biological sex refers to our physical biology at birth defined by our genitalia. Predominantly, the human race is born either female or male, with a small percentage (between 0.1% and 1.6%) who have ambiguous genitalia or both. These people are normally described as “intersex”.

<table>
<thead>
<tr>
<th>The spectrum of human biology and anatomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
</tr>
<tr>
<td>--------</td>
</tr>
</tbody>
</table>

Intersex
Historically, people who are intersex were known as hermaphrodite. Most were assigned a gender identity (male/female) by doctors and/or family, and sometimes underwent surgery to make their genitalia match their assigned gender identity. Empirical evidence has shown that children born intersex often suffered greatly from being assigned an identity that did not necessarily match how they felt about themselves. Over recent years, many people who are intersex have come to define themselves as a third sex and do not want to be assigned a male or female identity. They do not feel that they need to be changed in any way from how they were born.

* El-Rouayheb K (2009), Before homosexuality in the Arab–Islamic world, 1500–1800, University of Chicago Press.
There are also a number of people who from the earliest age feel that their genitalia do not reflect how they experience their gender; i.e. someone with female genitalia may feel that they are a man and vice versa. People who feel this way are known as transsexual.

Our gender identity refers to the way that we outwardly express ourselves in how we dress, behave and identify. Normally this is heavily informed and framed by cultural and social norms. Feminine identity is associated with being a woman and masculine identity is associated with being a man. In reality, this is not so defined and there are women who may display characteristics that would be commonly described as masculine and vice versa.

However, if a man expresses traits traditionally associated with femininity, this does not necessarily mean that he is homosexual, and a woman who expresses traits traditionally associated with masculinity is not necessarily a lesbian. In fact, gender norms are changing and evolving, and this is demonstrated by what is acceptable now for men and women regarding clothes, hairstyles, professions and so on compared to what was acceptable in the past.

The term transgender describes someone who dresses, acts as and wishes to be (or is) recognised the opposite sex to their biological sex at birth. It includes those people who identify as transsexual and transvestite.

A transsexual is someone who feels they are in the wrong biological body and wants to change it – or has changed it through hormone treatment and sometimes surgery. This is known as gender reassignment. Once a person has gone through gender reassignment, they often identify as the other sex from the one they were born as. However, changing their body does not mean that they necessarily change their sexual orientation. Therefore, someone who was a biological man who loves women prior to reassignment will continue to love women post reassignment, and vice versa.

A transvestite is someone who dresses and makes themselves appear outwardly as the opposite gender. It does not mean that a man who dresses as a woman wants to have sex with men, or vice versa. There can be many reasons why people dress as the opposite sex, including for enjoyment, relaxation, sexual pleasure, sex work, entertainment work (dancer, singer) or sometimes for ritual purposes.

Sexual orientation refers to sexual attraction; i.e. who arouses our sexual feelings and who we want to express our sexual feelings with through sexual and other forms of intimacy.

The spectrum of sexual orientation

<table>
<thead>
<tr>
<th>Heterosexual</th>
<th>Bisexual</th>
<th>Homosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Someone who is heterosexual seeks sexual intimacy with someone of the opposite sex.
- Someone who is homosexual seeks intimacy with someone of the same sex.
- Someone who is bisexual seeks intimacy with both men and women.

Over a lifetime, people may not feel they are so clearly defined by these labels. Who they primarily have sex with when they are young may be different from who they have sex with as they get older.
Annex 2: The Kinsey scale

In 1948 the American scientist Alfred Kinsey developed a scale system to help to classify the spectrum of human sexual orientation. He devised this because his research had suggested that sexual orientation is more subtle than is indicated by the heterosexual–bisexual–homosexual continuum. For instance, men may be predominantly heterosexual but have occasional sexual contact with other men and not define themselves as bisexual. He developed a six-point scale that people can use to position themselves along the spectrum from heterosexual to homosexual. The rating is what the person themselves thinks best reflects their experience.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Exclusively heterosexual</td>
</tr>
<tr>
<td>1</td>
<td>Predominantly heterosexual, only incidentally homosexual</td>
</tr>
<tr>
<td>2</td>
<td>Predominantly heterosexual, but more than incidentally homosexual</td>
</tr>
<tr>
<td>3</td>
<td>Equally heterosexual and homosexual</td>
</tr>
<tr>
<td>4</td>
<td>Predominantly homosexual, but more than incidentally heterosexual</td>
</tr>
<tr>
<td>5</td>
<td>Predominantly homosexual, only incidentally heterosexual</td>
</tr>
<tr>
<td>6</td>
<td>Exclusively homosexual</td>
</tr>
<tr>
<td>X</td>
<td>No socio-sexual contacts or reactions</td>
</tr>
</tbody>
</table>
Annex 3: The Klein Sexual Orientation Grid

Researchers, while fully acknowledging Kinsey’s pioneering research, have observed that his scale does not take into consideration issues such as how orientation can change throughout a person’s lifetime and also how a person expresses their sexual orientation emotionally and socially rather than just sexually. In 1978, Fritz Klein developed a more refined tool called the Klein Sexual Orientation Grid (KSOG) that takes into consideration other factors that may relate to sexual orientation, such as a person’s fantasy life, emotional attraction and their own self-identification.

The KSOG uses a seven-point scale to assess seven different dimensions of sexuality at three different points in an individual’s life: past (from early adolescence up to one year ago), present (within the last 12 months), and ideal (what you would choose if it were completely your choice). To complete the grid, the person uses the scoring guidance that is given after the grid.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>PAST (UP TO LAST YEAR)</th>
<th>PRESENT (LAST 12 MONTHS)</th>
<th>IDEAL (IF YOU HAD A CHOICE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Sexual attraction. To whom are you sexually attracted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Sexual behaviour. With whom have you had sex?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Sexual fantasies. About whom are your sexual fantasies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Emotional preference. Who do you feel more drawn to or close to emotionally?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Social preference. Which gender do you socialise with?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Lifestyle preference. In which community do you like to spend your time? In which do you feel most comfortable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Self-identification. How do you label or identify yourself?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scale to measure variables.** Starting with the past, individuals choose a number that most corresponds to their situation based on the guidance scale below. The process is then repeated for the “present” and “ideal” boxes, bearing in mind that there are no right or wrong numbers.

**Scale to measure variables A, B, C, D and E of the KSOG**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>other sex only</td>
<td>other sex mostly</td>
<td>other sex somewhat more</td>
<td>both sexes equally</td>
<td>same sex somewhat more</td>
<td>same sex mostly</td>
<td>same sex only</td>
</tr>
</tbody>
</table>

**Scale to measure variables F and G of the KSOG**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>heterosexual only</td>
<td>heterosexual mostly</td>
<td>heterosexual somewhat more</td>
<td>heterosexual/homosexual equally</td>
<td>homosexual somewhat more</td>
<td>homosexual mostly</td>
<td>homosexual only</td>
</tr>
</tbody>
</table>
Annex 4: Correcting common misconceptions

Use Annex 3 to back up the clarifications in this section. It also would be helpful for facilitators to become familiar with the content of the NGO MSM project orientation manual, as the information there will help you to address some of the common misconceptions about MSM.

<table>
<thead>
<tr>
<th>MISCONCEPTIONS</th>
<th>CLARIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is homosexuality a disease or deviant behaviour?</td>
<td>Homosexuality is simply one sexual orientation; heterosexuality (men and women) is another. It is not a disease, nor is it abnormal or deviant behaviour. It exists in all societies.</td>
</tr>
<tr>
<td>The behaviour of MSM is against our traditions, customs and local culture. How can we accept them?</td>
<td>It is true that sexual activities among people of the same sex are considered to be deviant in some societies, and many MSM face harassment and discrimination in communities where it is thought to be against local customs and cultures. However, customs and culture change with new learning and knowledge. As people begin to accept that homosexuality is not a disease or a choice, attitudes will slowly change. Likewise, both national and international laws across the world protect the rights of MSM and consider discrimination towards MSM to be a crime. This is not true in all countries, but there is a shift across the world towards a growing international consensus regarding the acceptance of MSM.</td>
</tr>
<tr>
<td>What are the reasons that make someone engage in a sexual relationship with another person of the same sex?</td>
<td>There are no reasons – just as there are no reasons for someone wanting to have a sexual relationship with someone of the opposite sex or for having different sexual fantasies. Please see the section What influences or helps to explain sexual orientation in Chapter 2 of the NGO MSM project orientation manual.</td>
</tr>
<tr>
<td>Is homosexuality just a phase that goes away?</td>
<td>For most people, sexual orientation is not something that changes, even if the way they express their sexuality changes over a lifetime. For instance, a person may be bisexual but only have sex with a person of the opposite sex, or a man who is homosexual may live in a heterosexual marriage because of local customs. For some people, accepting their sexual orientation may be so difficult that they will suppress it until they feel they are ready to express it, and this can sometimes be in later life.</td>
</tr>
<tr>
<td>Is there a cure for homosexuality?</td>
<td>Homosexuality not a disease, so there is no “cure”.</td>
</tr>
<tr>
<td>It is wrong for a person to be homosexual or bisexual?</td>
<td>We cannot classify the person as “wrong” and “right” in the same way as we cannot say that it is wrong for someone to be heterosexual.</td>
</tr>
</tbody>
</table>
Session 2

Time
1 hour 40 minutes

Objectives
At the end of this session, participants will be able to:
- describe the social (family, community, peers), health, cultural, religious and legal contexts of MSM
- discuss common myths, misconceptions, prejudices and negative attitudes about MSM
- discuss the impact of these on MSM and their families
- identify existing laws and policies regarding MSM and which of them are actually applied in everyday life.

You will need
- Flipchart, large sheets of paper, Post-it notes and masking tape
- List of questions and attitudes relating to the steps in the exercise
- Handouts (one per participant) of:
  - Annex 5: Taking a holistic and multi-sectoral approach to working with MSM
  - Annex 6: Perceptions about homosexuality

Overview
This session explores the reality of the lives of MSM.
Encourage everyone to participate and share real-life experiences. Be mindful that this may include negative attitudes they have experienced from family and close friends, or experiences of threats, rejections, abuse, prosecution and even prison.

Each of the four steps of this session tackles a different topic. It may be useful to reiterate some of the challenges brought up in Session 1.

Activity: Correcting misconceptions about MSM environments

Step 1: Designing a holistic and multi-sectoral approach (15 minutes)
1. Use Annex 5 to explain the link between the individual and their environment. Ask your group to give examples of the relationship between MSM and their immediate environment (e.g. family, community), as well as their wider context (e.g. the media, law, religious values and leadership).

Step 2: Group work (25 minutes)
2. Brainstorm the idea that any intervention with MSM should start with a better understanding of the environment that has the most significant impact on their lives and how that connects to HIV prevention.
3. Ask them to divide into working groups and identify the challenges that affect this target group. Ask each group to discuss the range of attitudes of a particular group of people or institutions towards MSM:
   - Group 1: Parents (towards a son having sexual relationships with men)
   - Group 2: Society in general (work, educational institutions, health and social services)
   - Group 3: Religious leaders
   - Group 4: Media
   - Group 5: Legal systems and government
4. Ask each group to present their work back to the main group for discussion, raising questions such as:
   - What are the misconceptions that your group or institution often displays about this population?
   - What are their attitudes towards this group?
   - Give examples of common attitudes and prejudices towards them? What might be the reasons behind these beliefs and attitudes?
5. Discuss the difference between existing policies (if applicable) and unjust and unfair community practices not based on law. Ask for real-life examples.

6. Sum up by reiterating how myths, misconceptions and prejudices reinforce negative attitudes towards MSM.

Step 3: Ideas on Post-it notes (30 minutes)

7. Ask the group to write on Post-it notes common negative attitudes expressed by different sections of society that peer educators will have to confront while undertaking their work. Then stick them on to the following sheets:
   - **Sheet 1:** from parents
   - **Sheet 2:** from the local environment (law, media, religious leaders, community)
   - **Sheet 3:** from a sexual partner of an MSM
   - **Sheet 4:** addressed to the parents of the MSM group
   - **Sheet 5:** from the legal system or as a result of misinterpretation of policies

8. Then stick the sheets on to the wall panels.

9. Ask participants to walk around the room to read all the comments on the different sheets, or ask each participant to read out their comment as they stick their Post-it note to the sheets of paper.

Step 4: Discussion and comments (30 minutes)

10. Conclude the session by reinforcing the learning about the negative impact of policies based on myths and misconceptions. Explain how important it is for peer educators and programme planners to understand the contextual factors affecting MSM, and to address their impact in outreach programmes.

   It would also be useful for participants to reflect on the differences between how policies, laws and doctrines are defined and the actual day-to-day realities of how those policies, laws and doctrines are implemented or observed.
Bassem is a 32-year-old student and peer educator with ATL in Tunisia

“I now feel that with the group that I joined we are stronger. There is this feeling of belonging that I have and which is very important, now that we are a strong and solid group and we can stand up for our rights.”

Mahjoubi from ATL

“The greatest success of this programme according to me is the fact that MSM who were mobilised on the ground have become peer educators, trainers, activists, have founded NGOs working for MSM rights and, above all, skilled programme managers.”

Jamil is a peer educator with SIDC in Lebanon

“This prevention and mobilisation work with the community and key actors in the HIV response has led to deep changes. Now if, for example, an effeminate gay man presents himself to any service, he won’t be turned down. There is still a lot of work to do. However I believe that we have made great strides.

This work boosts my self-confidence; I became more confident to address sensitive topics. I learned from this experience to deal with information related to HIV and to communicate them to others. I was afraid that people discover my positive status and I was reluctant to participate in the outreach work, but this work transforms me positively.”
Annex 5: Taking a holistic and multi-sectoral approach to working with MSM

Like all human beings, MSM live in a context that includes the stage they are at in their own life and beliefs, as well as the beliefs of their family and loved ones, social and religious beliefs, cultural norms, national laws, public attitudes and the media. Sometimes, HIV prevention programmes only focus on the risks associated with sexual behaviour, and do not situate that behaviour holistically in the context of the person’s whole life to understand all the factors that influence it. At the individual level, it is important that people working on MSM outreach programmes approach MSM holistically as human beings, not just people who may be at risk of being infected with HIV.

Likewise, addressing the complex needs of MSM in any society demands a multi-sectoral response, as the health and wellbeing of MSM is dependent on many different factors and not just health. These include issues related to education; social norms; religious values, norms and the public attitudes of religious leaders; the behaviour of the police and the position of MSM within the national legal system; as well as the portrayal of MSM in the media.

Programme planners and policymakers involved in intervention programmes for the MSM population must take into account all the needs of the target group. We cannot expect someone to look after his health, to protect himself and to maintain a risk-free quality of life unless his basic needs are being met: from food, shelter and clothing through to safety, love and a sense of belonging.

Such basic needs may be at risk when MSM are threatened and expelled from their homes because of their behaviour, or experience discrimination because of their sexual orientation and gender identity.

Any interventions should therefore:

- take into account the group’s lifestyle and gender-related issues
- consider the impact on the lives of this target group
- be effective and adopt both a holistic and multi-sectoral approach to prevention, care and treatment
- focus on the context and underlying influencing risky behaviours in order to promote behavioural change and reduce potential harm
- strengthen and diversify services and preventive actions, and facilitate their access.
Annex 6: Perceptions about homosexuality

Culture is a set of habits, traditions, values, beliefs and rituals adopted by a group of people over a period of time. People sharing the same culture tend to perceive things and behave in similar ways. Generally, individuals who conform to a society’s cultural values are judged positively, while those who do not share the same values are judged negatively. We tend to marginalise those who do not “fit in”.

However, since cultures across the world are all very different and all cultures tend to evolve over time, how is it sensible to consider one culture to be better than another? Talking about MSM – whether about homosexuality or issues related to sex – is still offensive and distasteful for many people in MENA communities. These attitudes are further reinforced by false beliefs about “unacceptable” sexual behaviour and preconceptions about MSM: e.g. that all homosexuals are also paedophiles, or are predatory or spread disease. Despite the overwhelming evidence that this is not true, these kinds of prejudices can prevent individuals from discussing their own situation openly, except in places where they feel comfortable and safe. It also contributes to some MSM having strong feelings of guilt and shame that can affect their mental health and wellbeing.

<table>
<thead>
<tr>
<th>FALSE BELIEFS AND MISCONCEPTIONS ABOUT GAYS AND LESBIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no gays or lesbians in the Arab world/the Middle East/North Africa</td>
</tr>
<tr>
<td>Sexual orientation is a choice</td>
</tr>
<tr>
<td>Sex between men is a sexual deviation</td>
</tr>
<tr>
<td>Sex between men is an infection that can be stopped</td>
</tr>
<tr>
<td>Homosexuals act as they do because they do not have any morals</td>
</tr>
<tr>
<td>Sexual orientation can be changed and therefore homosexuals can be changed too</td>
</tr>
<tr>
<td>Homosexuals are effeminate and lesbians have masculine traits</td>
</tr>
<tr>
<td>Homosexuals are paedophiles who lure children</td>
</tr>
<tr>
<td>Homosexuality is a mental illness caused by a mental disorder</td>
</tr>
<tr>
<td>Gay men rape children</td>
</tr>
<tr>
<td>A man becomes homosexual when he starts hating women</td>
</tr>
<tr>
<td>A girl becomes a lesbian when she starts hating men</td>
</tr>
<tr>
<td>Homosexuals are cursed by God and that is why they got HIV/AIDS</td>
</tr>
<tr>
<td>Homosexuals have strong urges for sex</td>
</tr>
<tr>
<td>Homosexuals cannot commit to long-term relationships</td>
</tr>
<tr>
<td>Homosexuals do not have values and ethics</td>
</tr>
<tr>
<td>Homosexuals are heretics</td>
</tr>
<tr>
<td>Homosexuality is the reason behind the spread of HIV/AIDS</td>
</tr>
<tr>
<td>Homosexuals are all alike and share the same hobbies and interests</td>
</tr>
</tbody>
</table>
Session 3

Time
1 hour 30 minutes

Objectives
At the end of this session, participants will be able to:
- determine the impact of negative behaviours and the problems they create in the lives of those affected, their partners and their families
- classify the challenges faced by this population according to their seriousness, frequency and ways to deal with them.

You will need
- Large sheets of paper, coloured markers, coloured cards, masking tape
- A drawing of the Problem Tree
- Handouts (one per participant) of:
  Annex 7: The Problem Tree

Challenges facing the MSM population

Overview
This exercise is pivotal to the training workshop and you can use it to develop related activities. It may take more time than planned: use your own judgment based on the flow and the quality of the discussions.

Make sure that the discussion is objective and remains on track. Keep the Problem Tree illustration hanging up on the wall throughout the workshop. If you are conducting this session together with the programme planners, it is important to base the programme strategies on this exercise.

Activity: The different problems and their impact on the lives of MSM

Step 1: Preparing the Problem Tree (30 minutes)
1. Draw a tree (Annex 7) and ask participants to put on the trunk the kind of problems (forms) faced by MSM.
2. Ask participants to think about the underlying causes of these problems based on earlier exercises (e.g. legal, religious, society and media). Place these causes at the level of the roots. Then on the branches they should place the effects of these challenges, drawing on previous discussions about the environment, law, community, media and religious leaders. At the end of the exercise, display the drawing with the result of their analysis.

Step 2: Identify challenges (30 minutes)
3. Split the group into three and ask them to list 10 challenges faced by the MSM population. Ask the first group to prioritise these in order of seriousness, the second in order of frequency and the third in order of both seriousness and frequency. Give them examples to start with.

Step 3: Presentation and discussion (30 minutes)
4. Ask participants to share their findings and discuss:
   - What are the types of challenges that you listed?
   - What sexual health problems occur among MSM and not among other groups? Why?
   - What are the reasons that make some sexual health problems risky (dangerous) among MSM and not others?
   - Are these problems the same for all MSM? Do they differ and why?
   - Is the degree of severity the same among MSM? Do they differ and why?
   - Is it important for this group of men to recognise these sexual health problems that may affect them? Why?
Annex 7: The Problem Tree

The Problem Tree: examples of the forms, causes and effects of stigma from the MENA stigma training workshop

**Causes:** judgments; blaming; lack of confidence in own sexuality; conservative religious beliefs; fear of infection; ignorance; poverty; belief in myths; moral judgments.

**Forms:** being chased from home; not welcomed at the clinic; rejected by family; finger-pointing; name-calling; being attacked; violence; losing your job; mistreated by police; blackmail; loss of inheritance; devalued.

**Effects:** isolation; loss of dignity; viewed as an object; suicide; depression; loneliness; going into hiding; increased HIV infections; increased risk-taking; breakdown of family relations; low self-esteem; loss of family honour.

---

### About Vulnerability and Needs: Summary of Findings of PCA Workshop in Rabat

<table>
<thead>
<tr>
<th>MSM Sexual Health Problems</th>
<th>Increase in the Rate of STI and HIV Infection Among MSM in Rabat</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immediate causes</strong></td>
<td>■ No use of condom and lubricants among MSM</td>
</tr>
<tr>
<td></td>
<td>■ Lack of health service provision (condoms, lubricants, testing, consultation) adapted to MSM needs</td>
</tr>
<tr>
<td><strong>Individual factors</strong></td>
<td>■ Lack of knowledge about STIs</td>
</tr>
<tr>
<td></td>
<td>■ Lack of knowledge about HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>■ Belief in recovery from AIDS</td>
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<td></td>
<td>■ Rape</td>
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<td></td>
<td>■ Ignorance</td>
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<td></td>
<td>■ Not using of condom with intimate partners</td>
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<td></td>
<td>■ Limited education</td>
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<td></td>
<td>■ Self-medication</td>
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<td></td>
<td>■ Fear related to disclosure of HIV status</td>
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<td></td>
<td>■ Perception of homosexuality as a mental illness</td>
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<td></td>
<td>■ Discrimination against HIV-positive MSM by peers</td>
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<tr>
<td></td>
<td>■ Discrimination against HIV-positive MSM by other MSM</td>
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<tr>
<td><strong>Vulnerabilities related to services</strong></td>
<td>■ Location of health services in poor neighbourhoods</td>
</tr>
<tr>
<td></td>
<td>■ Remoteness of institutions/centres offering sexual health services for MSM</td>
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<tr>
<td></td>
<td>■ Lack of informal sources of sexual health services</td>
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<tr>
<td></td>
<td>■ Condom and lubricant shortages</td>
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<tr>
<td></td>
<td>■ Lack of quality health services for MSM</td>
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<tr>
<td></td>
<td>■ Lack of provision of condoms and lubricant</td>
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<tr>
<td></td>
<td>■ Afraid to identify himself as having an STI or HIV</td>
</tr>
<tr>
<td></td>
<td>■ Stigma and discrimination by healthcare workers</td>
</tr>
<tr>
<td></td>
<td>■ Fear of heterosexual doctors</td>
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<tr>
<td></td>
<td>■ Lack of psychological support</td>
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<tr>
<td><strong>Vulnerabilities related to social context</strong></td>
<td>■ Sexual exploitation</td>
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<tr>
<td></td>
<td>■ Hatred</td>
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<tr>
<td></td>
<td>■ Resentment of the family towards MSM</td>
</tr>
<tr>
<td></td>
<td>■ Resentment of heterosexuals toward MSM</td>
</tr>
<tr>
<td></td>
<td>■ Failure to respect the right to benefit from public health services</td>
</tr>
</tbody>
</table>
Session 4

Time
2 hours

Objectives
At the end of this session, participants will be able to:
- analyse the impact of stigma and discrimination on the lives and rights of MSM and on the health of society in general
- understand homophobia and other stigmatising terms
- analyse the link between vulnerability and risk-taking, and the nature of the target group in the intervention programme
- identify terminology associated with stigma and discrimination.

You will need
- Paper, markers, masking tape
- Camera
- Handouts (one per participant) of:
  - Annex 8: Stigma and discrimination
  - Annex 9: Increased risks and vulnerability

Stigma, discrimination and vulnerability

Overview
This exercise is very sensitive as it asks participants to share personal experiences. Encourage them to talk about situations resulting from stigma and discrimination, but set out ground rules regarding respect and privacy.

Activity: My knowledge helps me to “move” and to “face”

Step 1: Group work (1 hour)
1. Organise four groups, each to discuss one of the following categories of MSM:
   - gay
   - bisexual
   - transgender
   - sex worker who uses drugs.
   These are suggested groups, however there are other possible categories and risk factors within the diverse MSM community. The facilitator may choose other groups to highlight risks and vulnerabilities depending on the specific context of the workshop.

2. Ask them to imagine a day in the life of their subject. Ask them to prepare a scenario with real-life scenes or cartoon-like storyboards. Imagine the places their subject frequents and what they do in those places. Discuss what behaviours and words others may use to describe them. Think about how these might affect them and how they might react to the different situations they encounter.

Step 2: Presentation of group work (30 minutes)
3. Ask each of the groups to present their stories in turn to the large group.

Step 3: Discussion and summary (30 minutes)
4. End with a discussion about how stigma and discrimination can lead to risky behaviour. Explain the difference between risky behaviour and vulnerability. Risky behaviours are actions that the person does that increase their risk of HIV transmission or being infected with an STI, whereas vulnerability is a set of factors – personal and non-personal – outside of the control of the person, limiting their capacity to protect themselves.

5. Discuss the impact of stigma and discrimination, and ask the group to define homophobia. Explain how individuals who have not yet come to terms with their sexuality (“come out of the closet”) may display homophobic attitudes towards themselves (self-stigma) and others. Ask participants to share examples of people who have taken their lives, or attempted to take their lives, as a result of labelling and homophobia.
Annex 8: Stigma and discrimination

Stigma
Stigma is a set of negative beliefs that a society or group holds about an individual or group of people.

Types of stigma
- Society’s stigmatisation of MSM
- Self-stigmatisation by MSM themselves
- Using derogatory terms when referring to homosexuals, such as deviant, abnormal, diseased, spreads diseases, faithless, not a real man

Discrimination
Discrimination is unjust and destructive behaviour adopted by a person, community, institution or state towards people because of their affiliation or their possible association with a certain group.

Types of discrimination
- Refuse admittance to or expulsion from an educational institution
- Expulsion from work
- Failure to respect the privacy and confidentiality of others
- Denying health, psychological or social care services

Stigma and discrimination against this group is found around the world and is a violation of the human rights not only of MSM but also their families and communities. It can prevent individuals from accessing information and services, which contributes to the spread of HIV and engagement in risky behaviours.

Attitudes that have a negative impact on the affected individual

Heterosexism
This is an ideology that considers relationships between people of the opposite sex as the norm and superior. It denies and stigmatises any behaviour, identity, relationship or society that is not heterosexual. It considers that homosexuality should remain concealed and, if present, should be condemned.

Homophobia
Homophobia presents itself as strongly negative feelings and rejection of the behaviour, way of thinking and lifestyle of individual lesbian, gay, bisexual, transgendered and intersex (LGBTI) people, as well as the wider LGBTI community. These feelings and prejudices are often expressed through extreme anger, resentment, violence, threat of expulsion, persecution, condemnation and even killing. Homophobia is often rooted in traditions, cultures and, sometimes, religious doctrine.

Internalised homophobia
Society’s perception of homosexuality can often cause gay men/lesbians to have negative feelings about their own sexual orientation, resulting in feelings of anxiety, fear and disgust. Internalised homophobia can have a negative impact on a person’s health and social relationships:

<table>
<thead>
<tr>
<th>PSYCHOLOGICAL CONSEQUENCES OF HOMOPHOBIA</th>
<th>SOCIAL IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guilt</td>
<td>Loss of friends</td>
</tr>
<tr>
<td>A crisis of identity</td>
<td>Risky behaviours (addiction/unsafe sex)</td>
</tr>
<tr>
<td>Lack of self-esteem, self-loathing or inflated self-image</td>
<td>Fewer chances for self-fulfilment</td>
</tr>
<tr>
<td>Self-destructive behaviour: risky sexual relationships, drug abuse</td>
<td>Lower productivity and fewer employment opportunities</td>
</tr>
<tr>
<td>Poor body image</td>
<td>Poor communication with close relations</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Limiting social activities and relationships to gay/lesbian groups</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Insecurity</td>
<td></td>
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<tr>
<td>Confusing sexual behaviour with love</td>
<td></td>
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<tr>
<td>Loneliness and isolation</td>
<td></td>
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<tr>
<td>Suicidal thoughts and feelings, sometimes resulting in suicide</td>
<td></td>
</tr>
</tbody>
</table>
Annex 9: Increased risks and vulnerability

MSM are considered to be one of the populations most at risk of getting HIV and other STIs. In many countries, some MSM have sexual relations with women or get married, and this contributes to the spread of the virus among the general population. Feeling vulnerable and the experience of being stigmatised and discriminated against can sometimes diminish a person’s capacity to reduce the risk of getting HIV by practising safer sex.

This group’s vulnerability is usually physical and is linked to the nature of the sexual relationship:

■ Unprotected anal sex carries a much higher risk of HIV transmission than vaginal sex due to biological factors. The receptive (passive) partner is more at risk of HIV transmission than the active partner, although partners may exchange positions.

■ Unprotected sexual relationships with multiple partners increase the risk of exposure to HIV and other STIs.

■ Certain methods of rectal douching prior to sexual intercourse can inflame the anal mucous and make it more prone to infections. Only tepid water should be used.

■ Oral sex is considered less harmful than anal sex, although it is not risk free, particularly if there are sores in the mouth or if there is gum disease. It is advisable to reduce risk by using a condom and avoid ejaculation into the mouth.

■ Using psychotropic substances and drugs, steroids, hallucinogens or alcohol raises the risk of unprotected sex.

■ Exchanging or sharing needles carries a high risk of HIV, and hepatitis B and C transmission.

■ Sharing sniffing tools can increase the risk of hepatitis C transmission.

■ Regular condom use among sex workers varies and can be influenced by many factors, including the sex worker experiencing sexual violence, not using condoms with regular partners, clients paying more money to have unprotected sex, and drug use that may reduce a person’s perception of risk and the likelihood of condoms being used all the time.

Stigma, discrimination and punitive laws all contribute to reducing the chance of MSM seeking necessary help and health and other services. Past bad experiences with health service providers refusing treatment also influences uptake. For instance, unsympathetic healthcare services can lead to transsexuals taking hormones or undergoing costly sex reassignment surgery without appropriate medical and psychological support and expertise.

Risk factors that increase the vulnerability of this group

■ Being young and sexually active

■ Having multiple sexual partners

■ Being poor or in financial need

■ Difficulty in accessing various health services

■ Sex in exchange for money or drugs (i.e. both formal and informal sex work)

■ Verbal and physical abuse

■ Stigma and discrimination

■ Low level of education

■ Lack of appropriate preventive and therapeutic healthcare services

UNAIDS classifies MSM as a “key population” (those most likely to be exposed to HIV or to transmit HIV). While this label affords this group a pivotal role in prevention and awareness processes, it does not lessen the risk factors.
Annex 10: Examples from stigma training workshops in Beirut and Tunisia

Beirut

**Waiting area:** Patients gossip about other patients while sitting on the bench. Stigma is directed towards people they suspect have HIV. They give hostile looks about the way you dress and walk.

**University campus:** In the library people won’t sit next to you if they know you are an MSM. There is gossip and isolation in the hostels. Lecturers make homophobic comments in front of students.

**In the barracks:** Being told to act like a “real man”. Being segregated if people suspect you are homosexual. Drinking too much when you get isolated.

Tunisia

**School and university:** Malicious gossiping; contempt; need to hide sexuality; rejection; reluctance to be in the same class as MSM; isolation; physical attacks; beatings; verbal attacks; hurtful and shocking words shouted at MSM; intolerance.

**Cafés, bars and nightclubs:** Violence; MSM are victims of beatings and injuries; denied access to nightclubs and bars; insulted when we try to enter; fingers pointed at us wherever we go because of the way we are dressed; contempt; sometimes insulted by the same people who would like to get involved with us; yelling; some people are reluctant to greet us or even to sit next to us; sometimes sex workers are the ones who gossip about us; aggressive looks.

**Family:** Assumptions; malicious words about us; rejection; isolation; denigration; lack of respect; hostile looks; contempt; insults; violence; brutalisation; giving us women’s work; repercussions on other family members; mothers get blamed for son’s behaviour.

**Mosque or church:** Gossiping; prejudice; banning; taboo (sex is taboo in religious and/or traditional families); punishment; exclusion; puritanism; haram (not allowed by religion); guilt; inciting intolerance; accusing gay men of being sinners; judgments about immoral behaviour.

**Clinic:** Received in an unfriendly way (looks, gestures) at reception; rejection – we feel like we are not wanted in the clinic; overprotection; our sickness is not taken care of by health workers; we are kept waiting or given another appointment; contemptuous looks by health workers; we are examined with disdain and contempt; bitter words about how we are dressed; we are asked to come another day; some medical doctors do not accept MSM in their clinics; treated like we have a psychological condition that can be cured.
Session 5

Time
1 hour

Objectives
At the end of this session, participants will be able to:
■ map out and analyse the challenges and opportunities in reaching MSM
■ discuss human rights and public health approaches
■ list the rights and responsibilities of MSM.

You will need
■ Flipchart, large sheets of paper, markers, masking tape
■ Handouts (one per participant) of:
  Annex 11: The human rights approach
  Annex 12: Specific rights and responsibilities of MSM
  Annex 13: The public health approach

Overview
This session is about exploring the factors that can help or hinder peer educators from reaching MSM. It also explores the role of others in reaching MSM to ensure they get the services they need.

The session also introduces participants to human rights and public health approaches.

Activity: Benefits of human rights and public health approaches

Step 1: Discussion (15 minutes)
1. Begin the discussion by asking:
   ■ What challenges do you experience in accessing MSM?
   ■ Who and what make it difficult to reach MSM?
   ■ Who and what can help you to reach MSM?

   Write down responses on the flipchart and reiterate that while it is difficult to reach this group, it is crucial to give MSM support in light of the many problems they experience.

2. Then ask: What are the implications for individuals and wider society of not reaching MSM with the services they need?

   Summarise responses on a large sheet of paper for all to see.

Step 2: Questions and answers (30 minutes)
3. Encourage participants to raise any remaining questions and invite the group to help you to answer them.

Step 3: Collecting ideas (15 minutes)
4. Using the challenges identified on the Problem Tree, ask:
   ■ What are the common responses of MSM to the challenges identified?

   Brainstorm answers in plenary and write them on the flipchart.

5. Write down four questions, each on a different sheet of paper (see below). Then form four groups and ask the groups to move from sheet to sheet, writing their responses to:
   ■ Who are the actors who can address the needs of MSM?
   ■ What are the types of services that need to be offered to MSM?
   ■ What are the facilitating factors that could help MSM gain access to the services they need?
   ■ What are the challenges in the community likely to obstruct access by MSM to the assistance they need?

6. At the end of the exercise, list existing challenges and supportive factors, and highlight the importance of interventions for this group using human rights and public health approaches, giving examples.
Annex 11: The human rights approach

When discussing effective and efficient responses to HIV and AIDS, United Nations agencies and international organisations emphasise the importance of using approaches that are based on:

- human rights
- accurate scientific evidence.

They also recommend adopting a participatory approach to ensure the full participation of those infected and affected by HIV and AIDS, as well as decision-makers and those working on gender equality.

Human rights principles

The concept of “human rights” refers to the universal and fundamental rights to which every human being is entitled, without distinction. The human rights approach is based on involvement, freedom and accountability.

Countries signed up to the Universal Declaration of Human Rights are responsible for promoting and protecting the rights of their citizens, who in turn have a responsibility to protect others. In reality, human rights are not always enforced or respected by national governments.

Adopting a human rights approach to the HIV response in a systematic and deliberate way helps to promote access to prevention, care, treatment and support. This means using this approach when planning, implementing, evaluating and monitoring programmes and policies.

The basic principles of the human rights approach include:

- Every human being is entitled to universal rights with no exception.
- There is no distinction – all human rights are of equal value.
- All rights are closely interlinked. The right to health does not override the right to privacy; the link between sexual violence and HIV/AIDS is a violation of the right to liberty and security.
- Equality and non-discrimination – equal rights to all, with priority given to the vulnerable and most at risk.
- Participation and inclusion – strengthening the capacity of target groups and those most at risk will enable them to participate in the improvement of their health (including decision-making, planning and implementation of programmes and activities, and access to training).
- Accountability and the rule of law – since nations and officials are responsible for the promotion and observance of human rights, the individual has a duty to hold the authorities accountable for this.

Human rights principles related to HIV/AIDS include:

- Non-discrimination
- Confidentiality and privacy
- Health – the right to access quality available services
- Education
- The right to work in a discrimination-free environment

In communities where MSM behaviour is regarded as “undesirable” or “offensive”, taking an explicit human rights approach can limit resistance to the provision of services. This is because the human rights approach stresses the importance of the unalienable rights of all human beings, and combined with the public health approach, situates the provision of services for MSM within a wider understanding of the impact on society of not providing those services (see Annex 13).
Anex 12: Specific rights and responsibilities of MSM

Wellbeing: physical, social, psychological, and relationships
The right to enjoy good health and an infection-free life, together with a positive self-image. Basic needs (food, shelter, clothing, education, work) are met, alongside spiritual, psychological and social needs.

The right to maintain sexual health
This includes behaviour and practices necessary to enjoy healthy sexual relations, a healthy body free from STIs, and access to relevant information and services. This brings with it a responsibility to respect the health of others and not subject them to violence or sexual exploitation.

The right to reproductive health
This was defined at the International Conference on Population and Development (Cairo, 1994) as a state of complete wellbeing of the reproductive system and its functions (physical, psychological and social) and not merely the absence of disability or disease.

The right to acceptance of sexuality and social roles or gender
Helping MSM to feel comfortable, safe and confident can help to ward off risks and unhealthy behaviours, and will enable them to make informed decisions free from social pressures. To achieve this, they need support and acceptance in order to be able to address the challenges facing them and to access the information and services they need.

The right to information/education
This concerns access to comprehensive, up-to-date, accurate, appropriate and unambiguous information on health issues. This kind of awareness-raising material should be simple, attractively packaged and available in health centres.

The right to access services
Services have to be available and accessible at reasonable prices and in the right places. To achieve this, they should be free from exclusion derived from gender-based stigma, sex, social status, ethnicity, race, nationality and sexual orientation.

The right to safe services
Safe services require service providers with skills in preventive information and an ability to combine theoretical knowledge with practical know-how. They should also be able to identify and manage the complications associated with this group, be they physical or psychological.

The right to privacy and confidentiality
The right to privacy and confidentiality while receiving services also includes confidentiality of medical records.

The right to continuity of care
The right to continuity of services, supplies, follow-up and referral.

The right to dignity and freedom of speech
The right to be treated with respect and understanding of personal circumstances. Service providers should ensure friendly services and encourage users to express themselves and their views freely, particularly if the service provider holds divergent views.

The right to make informed decisions
Decisions should be made with an understanding of all the available options and their repercussions. An individual who is reluctant to take a particular decision is free to do so, but should be made aware of the possible consequences for their health.

The right to develop skills and attitudes
Building up life skills can help to foster:
- social responsibility – advocating for rights while not accepting stigma and discrimination
- ability to analyse the consequences of actions and to distinguish between contradictory messages (what was learnt as a child versus changing social attitudes)
- leadership and entrepreneurial skills (adopting positive and healthy attitudes)
- a healthy lifestyle (acquiring new healthy habits and making suitable choices).

Responsibilities of men who have sex with men
- Self-protection and protection of others.
- Acquiring life skills (decision-making and facing peer pressure), good behaviours and effective communication with others.
- Improving self-confidence, planning and analytical thinking; being responsible and not feeling frustrated when failing.
- Staying away from verbal and physical violence and abuse to oneself and to others.
- Adopting healthy social and sexual behaviour and using preventive measures when needed.
- Having regular check-ups, especially if engaging in unprotected sex; accessing relevant information and getting immunisation against certain types of STIs (hepatitis B, syphilis).
Annex 13: The public health approach

The World Health Organization (WHO) defines public health as all organised measures used to prevent disease, promote health, and prolong life among the general population. It aims to address the determinants of ill health and disease, and create conditions in which people can be healthy and thrive, not just be free from disease. Public health efforts are focused on entire populations and communities rather than on individual patients. A public health approach recognises that we are all interdependent, and that the health or lack of health of one person can affect the health of another.

The three main public health functions are:

- Assessing and monitoring the health of communities and populations at risk to identify health problems and priorities.
- Formulating public policies designed to solve identified local and national health problems and priorities.
- Ensuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

Some of the main areas of public health interventions include vaccination campaigns, such as for polio; safer workplace policies; control of infectious diseases, such as tuberculosis and HIV. They also include addressing the enormous increase in non-communicable diseases such as cardiac disease and obesity. STIs and HIV are communicable diseases and require a public health response to manage them effectively.

In the MENA region, those most at risk of HIV and other STIs are sex workers, people who inject drugs, MSM and their sexual partners – people who are often marginalised by society and consequently can experience a greater deal of isolation and discrimination. As a result, members of these key populations are often reluctant to seek medical support and services as they fear being discriminated against. For these reasons, they can also be difficult to reach.

In this context, if medical and social services focused only on each individual living with HIV or an STI, it would be impossible to address some of the underlying factors that make MSM and other key populations particularly vulnerable to STIs and HIV.

Therefore, while a human rights approach is essential to protect the rights of every individual MSM, the public health approach complements it by trying to address the key factors that render a community vulnerable to infection and disease. In the response to HIV, human rights and public health intertwine to ensure that effective measures are taken to reduce the burden of HIV infection in communities through:

- MSM-friendly STI and HIV counselling and testing services
- providing access to quality and tailored education and information, particularly oriented towards young people at risk
- ensuring access to quality condoms and lubricants
- monitoring the dynamics of HIV infection through surveillance and analysis of data to inform planning (the kinds of questions this work seeks to answer are: Who is infected? How many? Where? How? What are the factors that contribute to vulnerability and risk?)
- ensuring that there are public policies in place to provide an enabling environment for responding to the public health threat of HIV. This includes ensuring that the human rights of those at risk of infection and those living with HIV are fully respected and upheld, and that discrimination is confronted and managed
- key population user-friendly services and effective outreach prevention, care and support services, with particular access to young people at risk.
Session 6

The male and female reproductive systems

Overview

This session helps participants to develop a good understanding of the male and female reproductive systems. The session can be quite sensitive, so encourage everyone to participate even if they feel a little embarrassed or shy at times. This is essential information that they need to know. If they are embarrassed while talking about sexuality in training, then they will really struggle to do outreach work with MSM. An ability to discuss issues related to sex and sexuality is a prerequisite for anyone wanting to work in this area.

If for any reason participants are reluctant to discuss the female reproductive system, remind them that some MSM have female sexual partners, so it is important to understand the female body and reproductive health system.

Activity: Functions of the male and female reproductive systems

Step 1: Naming the different parts (45 minutes)

1. Divide participants into two groups: one to draw the male reproductive system and one to draw the female reproductive system. Give each group a list describing the functions of each part (Annexes 14 and 15) and ask them to place it next to the appropriate anatomical part.

Step 2: Presenting the drawings (15 minutes)

2. Then ask the two groups to present their drawings to the big group.

Step 3: Discussion and corrections (1 hour)

3. Bring out the prepared drawings of the male and female reproductive systems (Annex 16) and compare them to what was produced by the group. Are there any differences?
   You could ask further questions about how the body works (physiology), such as:
   - What are the two main ingredients of semen and where are they produced?
   - What fluid can leak from the penis before ejaculation? Does this fluid present a risk for HIV transmission?
   - What are common names in the local language for semen?
   - What factors can cause a man to lose or fail to maintain an erection?
   - What factors may limit a woman’s enjoyment of sexual stimulation and intercourse?

4. Use Annex 16 to help to correct misinformation.
Annex 14: Cards explaining the functions of the female reproductive system

Refer to this table to prepare the cards, ensuring that the size of the card is appropriate for the size of the drawing.

<table>
<thead>
<tr>
<th>THE FEMALE REPRODUCTIVE ORGANS</th>
<th>THEIR FUNCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovaries</td>
<td>Located in the lower part of the abdomen and responsible for producing eggs and secreting hormones.</td>
</tr>
<tr>
<td>Fallopian tube</td>
<td>The tube that carries the egg to the uterus (womb). Where the sperm meets the egg (fertilisation).</td>
</tr>
<tr>
<td>Uterus or womb</td>
<td>Where the fertilised ovum becomes an embryo and develops into a foetus (also called conception).</td>
</tr>
<tr>
<td>Pubis</td>
<td>The area above the genitals covered with hair.</td>
</tr>
<tr>
<td>Labia majora</td>
<td>Protects the internal genitalia.</td>
</tr>
<tr>
<td>Labia minora</td>
<td>Located inside the labia majora and covers the openings of the urethra and the vagina.</td>
</tr>
<tr>
<td>Clitoris</td>
<td>Located between the labia minora, it gives a feeling of sexual excitement and pleasure when stimulated and contributes to female orgasm.</td>
</tr>
<tr>
<td>Urethra</td>
<td>The canal through which urine is discharged from the bladder.</td>
</tr>
<tr>
<td>Vagina</td>
<td>The opening leading to the cervix where penetration takes place during intercourse. It is an elastic, muscular canal that connects the vaginal opening to the cervix. It is lined with a thin membrane of tissue that is able to expand. The Bartholin glands located beside the vaginal opening produce a fluid (mucus) secretion that acts as a lubricant during intercourse.</td>
</tr>
<tr>
<td>Cervix</td>
<td>The band of tissue protecting the opening of the uterus.</td>
</tr>
<tr>
<td>Hymen</td>
<td>The hymen is a thin piece of tissue covering the opening of the vagina where menstrual blood is released. It usually tears during the first attempt at sexual intercourse, or it may be soft and pliable so no tearing occurs. Breaking the hymen is commonly associated with the loss of virginity in a girl or woman. However, the hymen can also break without penetration or loss of virginity.</td>
</tr>
</tbody>
</table>
Annex 15: Cards explaining the functions of the male reproductive system

Refer to this table to prepare the cards, ensuring that the size of the card is appropriate for the size of the drawing.

<table>
<thead>
<tr>
<th>THE MALE REPRODUCTIVE ORGANS</th>
<th>THEIR FUNCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vas deferens</td>
<td>Transports mature sperm to the ejaculatory duct in preparation for ejaculation.</td>
</tr>
<tr>
<td>Prostate gland</td>
<td>Produces fluid to nourish sperm and help transport it via the ejaculatory duct. Stimulation of the prostate can be very enjoyable for both heterosexual and homosexual men. Stimulation leads to the production of prostatic fluid. The prostate can be stimulated by gently rubbing the prostate gland with a finger, penis or sex toy inside the rectum.</td>
</tr>
<tr>
<td>Testicles (or testes)</td>
<td>Responsible for making testosterone (the primary male sex hormone) and for producing sperm.</td>
</tr>
<tr>
<td>Ejaculatory duct</td>
<td>A tube that connect the vas deferens to the urethra and passes through the prostate gland.</td>
</tr>
<tr>
<td>Urethra</td>
<td>The tube that carries urine from the bladder to outside of the body. In males, it has the additional function of ejaculating semen when the man reaches orgasm. When the penis is erect during sex, the flow of urine is blocked from the urethra, allowing only semen to be ejaculated at orgasm.</td>
</tr>
<tr>
<td>Penis</td>
<td>The penis is an external sexual organ made up of the shaft, glans penis and foreskin. It allows the transport of urine and sperm. It reaches its full size during puberty, around the ages of 14 to 17. With stimulation, it becomes engorged with blood and erect, which facilitates penetration into either the vagina or rectum during sexual intercourse.</td>
</tr>
<tr>
<td>Glans</td>
<td>This is the bulbous area at the head of the penis and is made from the same tissue as the female clitoris. It is highly sensitive and can contribute to much sexual pleasure.</td>
</tr>
<tr>
<td>Foreskin</td>
<td>The skin at the top of the penis that covers and protects the glans. This is removed during circumcision.</td>
</tr>
<tr>
<td>Scrotum</td>
<td>The loose pouch-like sac of skin that hangs behind and below the penis. It contains the testes and controls their temperature.</td>
</tr>
</tbody>
</table>
Annex 16: Anatomy of the female and male reproductive systems

Female reproductive system

- Fallopian tube
- Ovary
- Pubis
- Uterus or womb
- Cervix
- Vagina
- Labia (majora and minora) and clitoris

Male reproductive system

- Bladder
- Urethra
- Penis
- Foreskin
- Glans
- Scrotum
- Testes
- Prostate gland
- Vas deferens
Annex 17: Puberty and the functions of the reproductive system

Puberty for boys and girls starts in their early teens and the physical changes happen quickly. It is the process of physical change by which a child’s body matures into an adult body.

The physical changes that happen during puberty are caused by hormones. In girls, puberty starts around the ages of 10 or 11 and is complete by 15 or 16. It is marked by the time a girl starts to ovulate and have periods, which often occurs around the ages of 12 to 13 but can happen sooner or later.

For boys, puberty begins around the ages of 11 to 12 and sexual maturity happens around 16 to 17. During this time, a boy will ejaculate semen for the first time and this normally happens around the age of 13 but can also happen sooner or later. First ejaculation can often happen during sleep and these are commonly known as “wet dreams”.

Puberty can be a very challenging time for both boys and girls as their bodies go through so many changes and the surge of hormones can affect their mood. The body shape of both boys and girls changes, and boys’ voices lower. It is often a very sensitive time in a person’s life, and without education, guidance and support it can be difficult for some young people to navigate. The physical changes and the hormonal release in puberty can have a strong impact on self-esteem, mood and social interaction.

It is important to understand the following about boys:

- **Erections** are the process of the penis filling with blood caused by sexual arousal.
- **Wet dreams** are ejaculation during sleep – a completely normal experience and nothing to worry about.
- **Ejaculation** is the release of semen from the erect penis.
- **Semen** – from puberty, sperm is produced in the testicles under the influence of hormones from the pituitary gland. The sperm comes out through the vas deferens and is transported by the fluid produced by the prostate gland until it reaches the urethra and comes out of the body.
- **Masturbation** is fondling and rubbing the genitals in order to reach orgasm.
HIV and other STIs

Overview

In this session participants are asked to talk about their understanding and beliefs about how STIs are transmitted. The first part of the session contains exercises to enable participants to share their existing knowledge. Following that, you as the facilitator will be able to correct any misinformation.

You will need to encourage full participation in this exercise.

Please refer to the supporting documents before you start, and remember to assess participants’ reading and writing skills so that you can adjust exercises accordingly (replacing the writing with pictures if necessary or doing both).

Activity: HIV, STIs, transmission, prevention measures and access to services

Step 1: Wall journal exercise (1 hour)
1. Pin up wall panels related to the topic (Annex 19).
2. Take pages from magazines, cut them in half and mix them up. Ask participants to pick a half-page randomly, then to mingle and find the person holding the other half of the magazine page. This person will be their partner for this exercise. This exercise works for up to 20 people. If you have more, organise them into threes instead of pairs. If you have less than 20, choose a fewer number of questions but ensure that by the end of the session you have covered all the information.
3. Ask each pair to go to one of the wall panels and write their answers to the questions on the sheet using Post-it notes.

Step 2: Giving the correct answers (2 hours)
4. Once everyone is back in their seats, go to each board and read out the answers. Ask the group whether they think each answer is right or wrong and then correct any misinformation.
Annex 18: HIV, STIs, prevention, treatment and referral

**What are STIs?**

STIs are a group of infections caused by bacteria, viruses and fungi that get transmitted during intimate sexual relations. They include syphilis, gonorrhoea, chlamydia, herpes simplex virus, genital warts, chancroid, inflammation of the urethra (urethritis) and pubic lice.

STIs affect both men and women, and can cause a great deal of suffering in people’s lives. Sometimes a person can become infected with an STI and be unaware of it as they may have no symptoms in the early stage. This can lead to secondary complications that may cause severe health problems. Without treatment, the person can also infect other sexual partners as they are unaware themselves of the infection. A person may also have multiple infections.

Those infections that are caused by bacteria (gonorrhoea, chlamydia, syphilis) can be treated with antibiotics. It is essential that any sexual partner be treated at the same time to avoid recurrence of the infection. It is also essential that the person complete the whole course of antibiotics they are prescribed, as if they do not resistance can develop. Treatment-resistant STIs are becoming increasingly common.

Viral infections – herpes, genital warts, hepatitis B and HIV – cannot be cured with antibiotics. Genital warts can be removed with ointment and cryotherapy (freezing) but they can recur as the virus stays in the body and can reactivate at any time. Herpes is a chronic condition that causes painful sores at the site where the person was infected, and these can recur at regular intervals. The sores can be inside the vagina, anal canal and mouth or the skin around the genitals and mouth. Treatment with antiviral drugs such as acyclovir can suppress the virus and reduce the frequency of outbreaks of painful sores.

Hepatitis B infection can be symptomatic or without symptoms. Some treatments are available, such as antiviral drugs, but it is a chronic infection that can cause lasting damage to the liver. Thankfully, there is a vaccine that can prevent people getting infected with hepatitis B, and all MSM should be advised to get it.

**Means of transmission**

Some STIs are commonly transmitted during sexual intercourse – vaginal, anal and oral. Infections transmitted this way include gonorrhoea, syphilis, and chlamydia, as well as hepatitis B, genital warts and herpes. Some, such as genital warts, herpes, pubic lice and syphilis, can also be transmitted without sexual intercourse (vaginal, anal or oral) during close skin-to-skin physical contact.

HIV is primarily transmitted during vaginal or anal sex and very rarely during oral sex. HIV can also be transmitted from a mother to her baby during pregnancy, delivery and through breastfeeding. With the right support and treatment, women can reduce their risk of transmitting HIV to their baby to almost no risk. HIV can also be transmitted when people who inject drugs share injecting equipment that contains small amounts of HIV-infected blood. Lastly, a person receiving a blood transfusion can be infected if the blood being transfused was not adequately tested for HIV. Thankfully, with correct screening of donor blood for HIV, the risk of being infected with HIV from a blood transfusion is negligible.

**Common STI symptoms (for men and women)**

- Burning sensation during urination
- Smelly, coloured secretions and discharge from the sexual organs
- Pain in the lower abdomen
- Ulcers and painful sores on the genitals or mouth.
- Sores or ulcers caused by syphilis are generally not painful. Sores or ulcers caused by herpes can be very painful
- Itchiness around the genital and perianal area
- Fever – either a high fever or a low-grade fever
- Pain during sexual intercourse
- Skin rashes

**Remember:** Some people infected with an STI may have no symptoms but can still pass the infection on to a sexual partner.

**Complications of untreated STIs (for men and women)**

- Infertility, particularly in women
- Irreversible damage to vital organs in the body (heart, brain, nervous system, liver)
- Miscarriage or ectopic pregnancy (women)
- Cervical cancer (women)
- Death – HIV, syphilis and hepatitis B

**Prevention approaches**

- Wearing the male condom for penetrative sex offers important protection against STIs despite the fact that it does not give complete protection against sexual infections (because the condom does not cover the whole genital area that is prone to infection).
- The female condom does cover the external female genitalia. It can also be left in place for a few hours if the couple wants to have sexual intercourse more than once. It can also be used for anal intercourse.
### SOME FALSE BELIEFS AND MISCONCEPTIONS ABOUT STIs

<table>
<thead>
<tr>
<th>False Belief</th>
<th>Not true:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only women get STIs</td>
<td>both men and women can be infected with STIs.</td>
</tr>
<tr>
<td>Having sexual intercourse with an underage girl cannot transmit an STI</td>
<td>infection is transmitted through intercourse with an infected person, regardless of age, sex and colour. Sex with an underage girl can cause lasting damage to the girl as she is still developing physically and emotionally. In most countries, it is also illegal.</td>
</tr>
<tr>
<td>The use of contraception will protect a woman from STIs</td>
<td>hormonal contraceptives offer no protection against STIs. However, the female condom is very effective at reducing the risk of infection as it not only protects the vaginal wall but also the external genitalia. The male condom also offers some protection against STI transmission.</td>
</tr>
<tr>
<td>Herbal therapy is the best remedy for STIs</td>
<td>there is no evidence about their effectiveness, whereas there are tried and tested treatments that health professionals can prescribe to treat STIs (see the information above).</td>
</tr>
<tr>
<td>Good hygiene is the best prevention for STIs</td>
<td>cleanliness is important but it does not protect from STIs.</td>
</tr>
<tr>
<td>Cleanliness heals infections</td>
<td>however, at the early stage in syphilis when it common to have a painless ulcer called a chancre or when sores are present from herpes, cleanliness can prevent the sores/ulcer from getting secondarily infected with bacteria that can cause more pain.</td>
</tr>
</tbody>
</table>

- Reducing the number of sexual partners reduces the risk of being exposed to someone who is infected with an STI.
- Avoid having sex during the period when a person is being treated for an STI and make sure that all sexual partners of someone diagnosed with an STI get examined and treated.
- It is important not to share razors and injecting equipment.

**Treatment**

- If someone suspects that they have an STI, they must seek medical help to get screened and treated. Remember, untreated STIs can lead to serious consequences, so getting early treatment is essential to protect health and wellbeing.
- MSM peer educators or peers within the MSM community may know of healthcare services and workers who are particularly friendly and welcoming to MSM and who also know how best to examine and treat them. It is not common for men who only have sex with women to have swabs taken from their throat or anus, but for MSM who have had oral and/or anal sex, this is very important.
- Ensure that all treatments are taken as prescribed otherwise the infection can recur.
- Attending STI services with a sexual partner is ideal as both can be treated at the same time. However this is not always possible, particularly when sex was with a casual partner. The commitment of both partners is important for treatment success.
- STIs can be passed from a mother to her baby and therefore pregnant women and their partners should be tested for STIs such as syphilis. Women and their partners/husbands should also be offered HIV testing.
- Where a woman is living with HIV and is pregnant, she will need specialised support and treatment to minimise the risk of HIV transmission to the baby.
- If a person suspects they have pubic lice, they should avoid sharing bed linen, towels or clothing until they have been fully treated.

**What is HIV?**

HIV is the abbreviation for **human immunodeficiency virus**. HIV attacks the immune system of the body and its functions. As a result, the immune system becomes weakened and unable to fight infections, and this includes normal bacteria that usually live quietly in the body without causing any problem to their host. With time, the body develops opportunistic infections (bacteria and other germs that take advantage of the opportunity offered by a weakened immune system to infect the body) and cancers that without treatment can cause death.
What is AIDS?
AIDS is the abbreviation for acquired immune deficiency syndrome. Acquired means it is caused by infection and comes from outside of the body. Immune deficiency means the infection causes the immune system to weaken and not perform its normal functions. Syndrome means that HIV does not cause one illness but rather a collection of different infections, cancers and illnesses.

With advances in treatment, most infections and illnesses caused by HIV can be successfully treated if diagnosed early and the correct therapy is available. Most importantly, ensuring that the person who has illnesses caused by HIV is prescribed and takes antiretroviral treatment (ART) is essential to restoring them to health. ART suppresses HIV and thereby stops it from weakening the immune system. ART allows the body to recover its normal immune function. Without treatment or ART, the person with AIDS will die.

Where does the virus live inside the body?
HIV can be found in all the body fluids listed in the box below. However, it is only the fluids in bold letters in the box that have sufficient quantity of HIV to enable the transmission of HIV to another person through unprotected sex, blood transfusion, sharing injecting equipment or from a mother to her baby. It is not possible to get HIV from being in contact with the sweat, tears, saliva or urine of a person living with HIV.

<table>
<thead>
<tr>
<th>Blood</th>
<th>Tears</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semen</td>
<td>Urine</td>
</tr>
<tr>
<td>Breastmilk</td>
<td>Sweat</td>
</tr>
<tr>
<td>Vaginal fluid</td>
<td>Saliva</td>
</tr>
</tbody>
</table>

What happens when the virus enters the body?
Once HIV invades the body, among other things it starts to destroy the white blood cells that help to protect us from infections and some cancers. The particular white blood cells that HIV targets are known as T lymphocytes or CD4 cells. As HIV begins to replicate and multiply, it destroys more CD4 cells and weakens the immune system.

Does the virus survive outside of the body?
HIV does not survive for outside of the body for a long time. For instance, it only survives for 45 minutes in open air and for 15 minutes at a temperature of 60 degrees.

How can HIV be transmitted?
The table on page 48 provides a summary of the different ways that HIV can be transmitted and the ways that it cannot.

The stages of HIV infection
Stage 1: Seroconversion About three to six weeks after infection, many people develop flu-like symptoms (fever, swollen glands, sore throat, rash, muscle and joint aches and pains, fatigue, and headache). This is because HIV is rapidly multiplying in the body and the immune system has not yet produced antibodies to fight the infection.

The amount of HIV in the blood is called the HIV viral load. When the viral load is very high, there is a high risk of HIV transmission, whereas when the viral load is low, the chances of HIV transmission are much lower. During the period of seroconversion, the viral load is very high. In fact, many people get infected during this time from a person who does not know they are infected with HIV.

If the person tests for HIV during the first two or three weeks after possible infection, it is highly likely that the result will come back negative even if the person is actually infected with HIV. This is because the HIV test most commonly used for screening looks for antibodies to HIV and not HIV itself. Until the body has produced antibodies, the result of this particular test will come back negative.

After infection, the body starts to produce antibodies to HIV within four weeks. If a person tests for HIV at this stage it is likely that the test will pick up the presence of HIV antibodies and the test will be positive for HIV. Usually it is advised to wait for four weeks after the time when infection might have occurred to take the HIV antibody test. At this point, research suggests that 95% of HIV infections will be picked up by the test. If a person tests at four weeks and is found to be HIV negative, they will still need to repeat the test at four months as in some people antibodies will not be produced until after four weeks.

Stage 2: The asymptomatic or latency period Post initial infection, the body is normally able to suppress HIV because it still has a strong immune system. During this time, a person can feel well and have few or no health problems that may indicate infection with HIV. Asymptomatic means that they are without symptoms. If the person has not tested for HIV, it is likely that they will not know that they are infected. This stage could last anywhere between three and
HIV IS TRANSMITTED THROUGH

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insect bites?</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Unprotected penetrative sex with someone infected with HIV?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Sharing eating and cooking utensils?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Breathing?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>From an untreated infected pregnant mother to the foetus/baby during pregnancy, delivery and during breastfeeding?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion with blood infected with HIV?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Coughing?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Hugging?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>French kissing?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Kissing on the cheek?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Sharing underwear?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Masturbation?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Being tattooed with unsterilised equipment infected with HIV?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Sharing unsterilised injecting equipment and related paraphernalia?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Daily life: shaking hands, sharing food and drink in public places?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>The use of clean and sterilised surgical instruments?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Mutual masturbation and non-penetrative sexual stimulation?</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

Annex 18: HIV, STIs, prevention, treatment and referral

Ten years. Slowly during this time HIV is destroying the immune system to the point where it begins to destroy the body’s natural defences. By the end of the asymptomatic period, the viral load increases and the person begins to have illnesses caused as a result of a weakened immune system.

Stage 3: AIDS By this stage the patient shows clinical symptoms and develops life-threatening illnesses that can include opportunistic infections and cancers. Without ART, this stage can last between a few months and several years. However, if ART is started as soon as symptoms occur, it is highly probable that the medication will help lower the viral load and this will allow the immune system to recover. Without treatment, the person living with AIDS will die.

Who should get tested and the benefits of early diagnosis?

- Anyone who would like to know their HIV status
- Anyone who thinks they may have been exposed to HIV through unprotected sex
- A person who injects drugs who has shared needles and syringes
- A person in prison who has been exposed to HIV through unprotected sex with another inmate or who is the victim of sexual violence
- Anyone who has been sexually violated and raped. This should happen at the time of the rape and then again three months later
- Anyone wishing to have unprotected sex with a new sexual partner, either because they are getting married, want to start a family and have children, or because they are in a long-term monogamous relationship
- Someone who is about to undergo major medical procedures, such as surgery, dialysis or treatments for cancer
- Children born to an infected pregnant mother. In these circumstances, it is normal to wait for up to 10 to 12 months before doing the antibody test as a baby’s immune system is not well developed and it can take many months for antibodies to develop. If feasible, it is better to do an antigen test, which tests for the virus itself, as this can be performed much earlier.
Early diagnosis with HIV has many benefits. Not least, it means that the person living with HIV can get ongoing support and health screening from healthcare workers, and early signs of immune damage can be treated. Research has clearly shown the benefits of starting ART before a person gets sick. A person living with HIV on ART is expected to have a nearly normal life span, yet sadly many people still die from being infected with HIV because they were not diagnosed or diagnosed too late, or ART was not available to them.

Although there are many benefits from knowing your HIV status, the reality of getting an HIV diagnosis is not easy, and it can take time and a lot of support from family, loved ones and friends to come to terms with living with HIV.

**Voluntary counselling and testing (VCT)** Research has also shown that the way someone finds out that they are infected has an impact on how they are later able to manage and deal with being HIV positive. Prior to being tested, a person needs to understand what they are doing, what the test will and won’t tell them, and know what support might be available to them if they test positive. Even for the person who tests negative, being tested for HIV can affect their subsequent behaviour and often leads them to not want to repeat the situation that led them to be tested in the first place. It is for all these reasons that it is recommended that a person undergoing the test is given the opportunity to talk through their concerns and find out the information they need to know during a pre-test counselling discussion. VCT is performed by people trained to provide support throughout the testing process.

**The different types of tests**

**Antibody tests** The most common HIV tests look for HIV antibodies in the body rather than looking for HIV itself. The ELISA (enzyme-linked immunosorbent assay), the rapid test and the Western blot all detect HIV antibodies in the blood.

**Antigen tests** Antigen tests test blood for HIV itself and not just antibodies. Therefore, they can be used shortly after infection (between one to three weeks) rather than wait a couple of months for antibodies to develop. The PCR (polymerase chain reaction) technique, for example, detects the genetic material of HIV itself and can identify HIV in the blood within two to three weeks of infection.

**Antiretroviral therapy (ART) to prevent infection**

**Combination antiretroviral treatment** can be used both pre exposure and post exposure to prevent HIV infection.

**Pre-exposure prophylaxis (PrEP)** is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (tenofovir and emtricitabine) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injecting drug use, these medicines can work to keep the virus from establishing a permanent infection.

When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%. PrEP is much less effective if it is not taken consistently.

PrEP is a powerful HIV prevention tool and can be combined with condoms and other prevention methods to provide even greater protection than when used alone. But people who use PrEP must commit to taking the drug every day and seeing their healthcare provider for follow-up every three months."

**Post-exposure prophylaxis (PEP)** is when a person who is not living with HIV fears they have been exposed to HIV and wants to prevent infection. ART must be taken within 72 hours of the exposure and taken for three months. If a person has had unprotected sex and fears they may have been infected with HIV, waiting two to three months before testing for HIV antibodies can be agony. Research has shown that it is possible to reduce the risk of a person who has been exposed to the virus by treating the person with ART. In many countries, ART is also usually offered to victims of sexual assault immediately following the rape to try to prevent them becoming infected with HIV. Unless the rapist is known or arrested and tested for HIV, it is normally impossible to know whether they were infected with HIV. Therefore it is better to treat all victims with ART to minimise risk.

**Is there a cure or a vaccine and how is HIV treated?**

Currently, no preventative vaccine exists to lower the risk of an uninfected person becoming infected with HIV, nor is there a cure. However, ART is a very effective at suppressing the virus. As a result of the
viral suppression HIV viral load is reduced, and when it is at undetectable levels, the risk of the person transmitting HIV to a sexual partner is extremely low. With effective ART, a person living with HIV can expect to have a near normal life expectancy.

However, ART is not without problems:

- The combination of drugs that make up ART all have different side effects and some of them are potentially dangerous. Regular monitoring by healthcare workers is essential to ensure that a person can continue on ART for as long as they need it.
- If ART is not taken every day as prescribed, resistance can develop and it will cease to be effective. Adherence to any medication can be challenging and this is also the case with ART. Sometimes people also have to hide the medication from their family and loved ones, and this can impact on their ability to take ART consistently.
- Another challenge is the cost. In many countries, first- and second-line ART is provided free of charge, but this is not the case in all countries. The MENA region is one of the least-served regions in terms of access to ART.

Apart from ART, good nutrition and paying attention to psychological and spiritual needs is also essential for health and wellbeing.

**The link between HIV and STIs**

- The majority of HIV infections globally are transmitted sexually – HIV is an STI.
- The ways that HIV and STIs are transmitted are similar in many respects, and the ways to prevent them are also similar.
- The presence of wounds and sores on the genitals as a result of an STI increases the risk of HIV transmission.
- Having multiple sexual partners increases the risk of exposure to HIV and other STIs.
- There is a high correlation, or relationship, between people being infected with syphilis and also being infected with HIV.

<table>
<thead>
<tr>
<th>FALSE BELIEFS</th>
<th>ANSWERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A sexual relationship with an underage girl or boy cures AIDS</td>
<td>Having a relationship with an underage girl or boy does not cure nor protect against HIV. HIV does not discriminate against age, sex, etc. The only treatment is ART</td>
</tr>
<tr>
<td>AIDS does not exist in our society</td>
<td>All countries have HIV cases</td>
</tr>
<tr>
<td>The only way to get HIV is through sexual relationships between men</td>
<td>Any unprotected sexual relationship with a partner living with HIV is risky, whether between people of the same sex or opposite sex</td>
</tr>
<tr>
<td>Prevention is possible by avoiding sexual penetration or interrupted penetration (withdrawal before ejaculation)</td>
<td>Any contact of the genitals or actual penetration in the vagina or anus without ejaculation is risky. Oral sex is also risky, especially when ejaculating in the mouth or if there are sores in the mouth</td>
</tr>
</tbody>
</table>
Annex 19: Wall journals

Sheet 1: List the names of all the STIs that you have heard of. Group them into STIs caused by bacteria and those caused by viruses

Sheet 2: How can you tell (whether you are a male or female) if you have been infected with STIs? What are the symptoms?

Sheet 3: True or false – ways of transmitting STIs

<table>
<thead>
<tr>
<th>STIs ARE TRANSMITTED THROUGH …</th>
<th>TRUE</th>
<th>FALSE</th>
<th>WHICH STIs CAN BE TRANSMITTED THIS WAY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected sexual intercourse with an HIV-positive person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being exposed to HIV-infected blood through a blood transfusion or sharing injecting equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unprotected oral sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual masturbation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sneezing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing sheets/towels and underwear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother-to-child HIV transmission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being treated with unsterilised surgical instruments that were used immediately after treating someone living with HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet seats</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sheet 4: What are the long-term consequences of untreated STIs and HIV? How can you prevent these long-term consequences developing?

Sheet 5: True or false – beliefs related to STIs

<table>
<thead>
<tr>
<th>COMMON BELIEFS</th>
<th>TRUE</th>
<th>FALSE</th>
<th>WHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections affect only women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanliness heals infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A high level of genital hygiene is the best prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herbal therapy is one way of treating STIs effectively</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sexual intercourse with an underage girl is risk-free from getting an STI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The use of contraception will protect a women from sexual infections</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sheet 6: What is the usual treatment for STIs caused by bacteria? What is the usual treatment for STIs caused by viruses?

Sheet 7: What is AIDS? Put these words in the right order:
- syndrome
- acquired
- immune
- deficiency

Sheet 8: What is HIV? Put these words in the right order:
- deficiency
- virus
- human
- immuno
Sheet 9: HIV and AIDS symptoms Place the right word in the right box:

<table>
<thead>
<tr>
<th>The appearance of</th>
<th>Severe</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Opportunistic

Nightly

- infections
- sweats and fatigue
- lymphatic glands
- temperature
- diarrhoea

Sheet 10: An MSM thinks he may be at risk of HIV infection through unprotected sex with a person of unknown HIV status. What HIV prevention options might be available to him? What tests might he need to have and when?

Sheet 11: False beliefs

<table>
<thead>
<tr>
<th>FALSE BELIEFS</th>
<th>TRUE</th>
<th>FALSE</th>
<th>WHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having sexual intercourse with an underage girl is a cure for HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS does not exist in our society</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV can only be transmitted between MSM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV infection can be prevented if there is no penetrative sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawing the penis before ejaculation is a safe way of limiting the risk of HIV transmission</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sheet 12: List a few local places where you can go to test for HIV or other STIs, and put a tick next to the ones that are MSM-friendly.
Session 8

Time
1 hour

Objectives
At the end of this session, participants will be able to:
■ have a good understanding of the range of sexual practices enjoyed by MSM and assess them in terms of their risk of HIV and STI transmission
■ outline STI prevention strategies.

You will need
■ Flipchart, large sheets of paper, coloured markers (red, orange, green), masking tape
■ Flyers
■ A drawing of the male anatomy
■ Handouts (one per participant) on:
  Annex 20: Examples and classification of common sexual practices

Sexual practices and preventing HIV and other STIs

Overview
Some people may find the next exercise a little embarrassing if it is hard for them to discuss sexual behaviour and practices. It is important to address this issue in the training. It is essential that peer educators working with MSM are able to talk about sexual practices in detail if they are going to be effective in discussing a person’s risk of HIV or other STIs and in assessing their current behaviour against the risk the practice may involve.

Humour and laughter can really help this session flow. Remember, it is important to not judge or castigate others for the kinds of sex they enjoy so long as it is not harming another person.

Activity: Sexual practices among MSM and associated risks

Step 1: Identifying the male erogenous zones (30 minutes)
1. Ask participants to draw the outline of a man, including the face, nipples and genitals. Ask them to mark on it the erogenous zones across the whole body. Ask them if erogenous zones are just the genitals or other parts of the body too.
2. Ask them to list the sexual practices that they know that MSM enjoy. What are the most common? What practices do people think bring the most amount of pleasure? What might be considered more of a fetish? Are there any practices that some people feel ashamed about enjoying?

Sexual pleasure is not just about anal or oral sex. It can include many other things: hugging; caressing the head, chest and ears; kissing on the lips or neck; licking and biting the nipples; licking the thigh, testicles, head of the penis and anus (rimming). They may add other practices.

Step 2: Presentation of drawings and discussion (30 minutes)
3. Get the participants to share their lists and indicate on one drawing whether the practice is risky or not risky by classifying each practice as follows:
   Red dot = high risk
   Orange dot = low risk
   Green dot = no risk
4. Get them to add other practices for discussion. Refer to Annex 20, which lists these practices.
5. Round up the session by correcting any false information, and allow participants to discuss where they originally got their information from about sex, their sexual life, the age when they started experimenting and so on. Focus on the scientific information, and explain that these workshops are the best place to obtain accurate information for them to use later in the outreach programme.

Reiterate the importance of condom use in preparation for the next session.
Annex 20: Examples and classification of common sexual practices

<table>
<thead>
<tr>
<th>SEXUAL PRACTICES</th>
<th>RISKY OR NOT RISKY (IN TERMS OF HIV AND STIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal sex without using a condom</td>
<td>High risk</td>
</tr>
<tr>
<td>Active partner (the person who penetrates/the “top”) having unprotected sex with another male</td>
<td>Medium-to-high risk</td>
</tr>
<tr>
<td>Passive partner (receptive, the “bottom”) having unprotected sex with another male</td>
<td>High risk</td>
</tr>
<tr>
<td>Active and passive man using protection during sex</td>
<td>Low risk</td>
</tr>
<tr>
<td>Unprotected penetrative sex within a group encounter (orgy)</td>
<td>High risk</td>
</tr>
<tr>
<td>Licking the genitals of the sexual partner</td>
<td>Not risky for HIV transmission</td>
</tr>
<tr>
<td>Swallowing the semen of the sexual partner</td>
<td>Risky but better to swallow immediately than leave in the mouth as the stomach acid destroys the virus. Any sores or gum disease in the mouth increases risk</td>
</tr>
<tr>
<td>Licking the anus of the sexual partner then washing the mouth with soap and water</td>
<td>Not risky for HIV transmission but risk of hepatitis A, genital warts and herpes</td>
</tr>
<tr>
<td>Inserting finger into the anus of the sexual partner</td>
<td>Not risky unless there are sores on the finger and bleeding</td>
</tr>
<tr>
<td>Use condoms every time for anal or vaginal intercourse</td>
<td>Low risk for HIV transmission if used properly, and there are no tears and the condom does not come off. Male condoms do not necessarily protect a person from infections transmitted through skin-to-skin contact; e.g. herpes, warts, syphilis and genital lice</td>
</tr>
<tr>
<td>Use condoms most of the time</td>
<td>High risk</td>
</tr>
<tr>
<td>Ejaculates inside partner without using a condom</td>
<td>High risk</td>
</tr>
<tr>
<td>Unprotected penetrative sex but no ejaculation</td>
<td>High risk</td>
</tr>
<tr>
<td>A head massage</td>
<td>No risk</td>
</tr>
<tr>
<td>Caressing/sucking and playing with nipples</td>
<td>No risk</td>
</tr>
<tr>
<td>Ejaculating on the body of the partner</td>
<td>No risk</td>
</tr>
</tbody>
</table>

**Condom advice**

- Use a condom with a valid use-by date, with water-based lubricant.
- Keep it away from sunlight and high temperatures, and do not put it in the back pocket of your pants or in your wallet.
- Use the condom throughout intercourse.
- Use a water-based lubricant to cut down friction and reduce the risk of damage to the lining of the anal canal.
- Use a new condom when changing sexual positions.
- Hold on to the condom while withdrawing to prevent leakage of semen.
- The condom should be used only once. Tie a knot in it, and wrap it in tissue and dispose of it in the bin **not** the toilet.
- Wash the penis with water and soap.
- If you suspect an infection, immediately contact a doctor. You may be eligible to take ART to reduce the risk of HIV transmission.
Session 9

Time
1 hour

Objective
At the end of this session, participants will be able to:
- compile, discuss and provide accurate information about HIV and other STIs.

You will need
- Flipchart, large sheets of paper, markers
- Handout (one per participant) of:
  Annex 21: List of misconceptions about STIs with the correct answers

False beliefs about STIs

Overview
This session encourages participants to identify and discuss common myths about STIs, what they are, and what is true and false. Make sure that plenty of time is left for discussion.

Activity: Possible or impossible?

Step 1: Collect and list the information (20 minutes)
1. Ask participants to go into small groups to discuss common beliefs about STIs in their local communities (it could be about diagnosis, methods of transfer and/or treatment).

Step 2: Discussion and corrections (40 minutes)
2. Then ask them to discuss the accuracy of this information within their groups. Following this, each group should share their findings with the larger group. You as facilitator should be able to correct any remaining misconceptions (Annex 21).
Annex 21: List of misconceptions about STIs with the correct answers

<table>
<thead>
<tr>
<th>MISCONCEPTION</th>
<th>CORRECT INFORMATION</th>
</tr>
</thead>
</table>
| STIs affect MSM because they have unnatural sex | Statistically, MSM have a higher prevalence of STIs than the general population because:  
- anal sex is much more risky than vaginal sex, particularly for the passive partner  
- they may have a number of casual sexual partners while also having a long-term partner  
- some relationships are considered “open”; i.e. the partners have agreed they can have sex with other men (open relationships often have rules like agreeing that they will only have anal sex with each other)  
- maintaining the use of condoms over a long time can be challenging, particularly in long-term relationships  
- stigma and discrimination make it more likely that they will not get appropriate education and support, or access to condoms and lubricants  
- low uptake of HIV testing results in higher levels of HIV and other STIs, and vice versa (research suggests that there is a relationship between HIV testing and the level of HIV and other STIs). |
| Passive sexual partner is less at risk | Not true: in fact they are more at risk. However, talking about the percentage of risk is unhelpful in real life. It is always preferable to have safer sex regardless of whether the person is an active or passive partner. |
| A sexual relationship between an adult and an underage girl or boy is not risky for HIV and other STIs | Not true: unprotected sex is always risky if you are infected with STIs, regardless of age and social or economic status. Older people having sex with underage girls and boys can have a devastating impact on the young person’s life and can be considered child abuse. |
| Herbal therapy is the best treatment for STIs | Not true: people with STIs should seek medical help to receive treatment that has been scientifically tested and known to work. |
| Cleanliness after sex is the best prevention | Not true: Cleanliness is very important but does not protect from STIs. |
| The presence of haemorrhoids increases the risk of HIV and other STIs among MSM | True: it does increase risk if unprotected sex occurs and there is bleeding. |
Session 10

Time
1 hour 30 minutes

Objective
At the end of this session, participants will be able to:
■ consolidate/update their knowledge about drug use
■ make the link between drug use and HIV and other STIs.

You will need
■ Flipchart, large sheets of papers, markers
■ List of questions for the exercise
■ Handout (one per participant) on:
  Annex 22: Drug use and the risks of HIV and other STIs

Drugs and prevention

Overview
This session has some useful information about drugs and drug taking, so it should be of particular relevance and interest to participants. You may want to invite a specialist in this field to present the session if you do not think you have sufficient experience to train participants about drug use, HIV and MSM.

This is an important subject to understand as participants are highly likely to come across MSM who use drugs and may be at increased risk of HIV as a result of their drug use.

It is useful to share any national and local data about drug use patterns among the population in general and MSM in particular, if known.

Research facts about the country where the workshop is taking place and focus on the type of drugs used locally by MSM. However, this should not prevent you from also listing all types of drugs, their effects and associated risks.

Activity: Drug use and prevention

Step 1: Q & A (30 minutes)
1. Start off with the following questions:
   ■ Why do we need to talk about drugs?
   ■ What is the link between drug use and HIV/AIDS?
   ■ What do you know about MSM and drug use?
   ■ What kind of drugs do MSM use?

Step 2: Brainstorming, group work and information correction (30 minutes)
2. Initiate a brainstorming session by talking about the different types of drugs and their effects. Then get everyone into small groups to talk about the effects of different drugs (Annex 22).

Step 3: Discussion, Q & A and information correction (Annex 22) (30 minutes)
3. Ask the group to discuss:
   ■ the reasons why people use drugs, including alcohol
   ■ the difference between recreational drug use and drug addiction
   ■ the different ways of taking drugs, such as smoking, drinking, eating, injecting
   ■ risks associated with drug use, such as behavioural inhibition, infection, overdose, HIV
   ■ what treatments are available for opiate addiction, such as maintenance therapy (medically supervised opiate treatment).
Example

Nabil is 20 years old and studying foreign languages at the university

Nabil loved modelling and enjoyed dressing up in the latest fashion. Nabil’s mother died when he was young, and he lived with his father, Mohammed, and grandmother, Fatima. Fatima did not approve of the way Nabil looked and dressed. She was always criticising him and worrying about what their neighbours might think. One day when Nabil came home with a new hairstyle, Fatima shouted at Mohammed, saying he needed to control his son. He was bringing dishonour to the family because he acted and dressed in a feminine way. Mohammed told Nabil that he needed to change the way he looked or he would have to leave home.

The situation deteriorated and Nabil decided to move in with a friend. He started to spend more time in bars but he didn’t have a job to pay for his lifestyle. One day Nabil agreed to have sex with a man in exchange for money. He began to sell sex more and more in order to pay for his studies and living costs, since his family no longer supported him. He also started drinking more because clients bought him drinks as they got to know him. Nabil started to miss classes and knew that he was getting into trouble. He missed his family but was scared to return home. He did not know how to get out of his situation.
Annex 22: Drug use and the risks of HIV and other STIs

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>Natural or manufactured substances that affect the brain and nervous system as they interact with the functions of the human body, affecting the senses, reactions and behaviour. They can be used for medical purposes and recreation.</td>
</tr>
<tr>
<td>Drug tolerance</td>
<td>When a person’s reaction to a drug is progressively reduced, requiring an increase in concentration of the drug to achieve the desired effect. Someone who has a high tolerance can take amounts that would kill a person who has not been previously exposed to the drug.</td>
</tr>
<tr>
<td>Drug use</td>
<td>The intermittent use of substances, not necessarily for medical purposes.</td>
</tr>
<tr>
<td>Drug dependency/addiction</td>
<td>A disorder that occurs when a person needs alcohol or a drug to function normally. Abruptly stopping the substance leads to withdrawal symptoms. Addiction means that a person has a strong urge to use the substance and cannot stop, even if they want to.</td>
</tr>
<tr>
<td>Overdose</td>
<td>The act of taking a dose of alcohol or drug resulting in adverse reactions, ranging from mania, hysteria and coma to death.</td>
</tr>
</tbody>
</table>

Types of drugs

**Hallucinogens, tranquillisers and stimulants**

**Hallucinogens** are drugs that induce hallucination and produce changes in perception, thought and feelings. Reactions may vary from person to person, ranging from extreme joy to extreme terror. LSD (“acid”) is a commonly used hallucinogen. Hashish (cannabis) is one of the most widely used recreational drugs that can also be a hallucinogen in its purest form.

**Tranquillisers** are drugs to reduce tension or anxiety. They can have a sedative effect and can lead to dependence with long-term use.

**Opioids** are painkilling drugs derived from opium poppies (morphine, heroin, methadone, codeine). They can create a feeling of intense euphoria and wellbeing. They also lead to addiction. Side effects include sedation, respiratory depression, severe withdrawal, development of tolerance, and dependence issues.

**Stimulants** increase the activity of the brain and the nervous system, and give a feeling of euphoria, weaken the appetite, alleviate fatigue and intensify heart rate (which increases blood pressure). Stimulants include nicotine, caffeine, cocaine, amphetamines and ecstasy pills.

**Alcohol** in low doses can lead to a feeling of euphoria, stimulation and lowered inhibition. In high doses it can lead to drowsiness, slurred speech, emotional volatility, impaired memory, sexual dysfunction and loss of consciousness. Side effects include addiction, depression, liver and heart disease, and overdose.

<table>
<thead>
<tr>
<th>Recreational drugs</th>
<th>Physical side effects</th>
<th>Associated risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Recreational drugs” is a term used for substances that are often used in entertainment venues such as nightclubs, bars and dancehalls (raves). These drugs are illegal, but use has increased among young people:</td>
<td>- Dehydration  &lt;br&gt; - Increase in body temperature  &lt;br&gt; - Strong feelings of anxiety or fear  &lt;br&gt; - Unexpected negative consequences when interacting with other drugs (especially alcohol)  &lt;br&gt; - May also lead to behavioural disinhibition, which means doing things – often risky – that they would not do if they were not taking the drug.</td>
<td>- Recreational drugs often contain unknown ingredients.  &lt;br&gt; - Pills may all look the same yet have different ingredients and effects (stimulating, hallucinogenic etc.). Users may confuse one with another, miscalculate doses or simply ignore what they are ingesting.  &lt;br&gt; - The negative effects of mixing drugs – because stimulants raise the heart rate and blood pressure, this may lead to problems with the heart and the respiratory system (unlike sedatives, where there is a decrease in heart rate and blood pressure).</td>
</tr>
<tr>
<td>Cocaine  &lt;br&gt; Ecstasy  &lt;br&gt; GHB  &lt;br&gt; Medicine  &lt;br&gt; Poppers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recreational drugs often contain unknown ingredients. Pills may all look the same yet have different ingredients and effects (stimulating, hallucinogenic etc.). Users may confuse one with another, miscalculate doses or simply ignore what they are ingesting. The negative effects of mixing drugs – because stimulants raise the heart rate and blood pressure, this may lead to problems with the heart and the respiratory system (unlike sedatives, where there is a decrease in heart rate and blood pressure).
## Types of Recreational Drugs, Their Effects and Ways to Reduce Harm

<table>
<thead>
<tr>
<th>TYPE</th>
<th>SIDE EFFECTS</th>
<th>HARM REDUCTION MEASURES</th>
</tr>
</thead>
</table>
| Cocaine   | **Cocaine** is a stimulant that is usually in the form of a white powder that is sniffed or snorted. Although users feel energised after using the drug, its negative effects include loss of appetite and feelings of anxiety and discomfort. Cocaine users can also use injecting drugs and take sexual risks that they would not do if they did not use cocaine.  
Studies on cocaine users have shown that they have a higher prevalence of HIV largely related to other behaviours – needle sharing, unprotected sex, sex work – and while sniffing powder is not a risk for HIV, other behaviours are. | **Use your own tools and make sure they are clean**  
Use the snorting method and prepare your own snorting tools:  
- a piece of plastic sheeting, mirror, straw or bank note  
- a clean card for cracking the substance  
- use either a straw or a rolled-up bank note (that hasn’t been used by someone else)  
- use a new bank note or straw for every session                                                                                                                                                                                                                                                                                                        |
| Ecstasy pills | **Ecstasy** pills have an energising and hallucinatory effect.  
Side effects include increased heart rate, blood pressure, anxiety, nausea and blurred vision.  
Use can lead to dehydration and collapse. | **Use only one type and avoid mixing different drugs.**  
**Refrain from using different methods in the same session (sniffing, inhaling, injecting), whether for the same drug or several types.**  
**Refrain from mixing the drug with alcohol, as this could lead to loss of motor coordination and collapse, disorientation, and loss of consciousness.**  
**Avoid reducing the effects of one type of drug by using another.**  
**Always keep hydrated while using ecstasy. Drink 500ml to a litre while out dancing.**  
**Use a condom during sexual intercourse.**                                                                                                                                                                                                                                                                                               |
| GHB       | **GHB** is a sedative and is often used as a liquid even though it is available in powder form. It is also known as the “date rape drug” and is often added to alcoholic drinks to increase its impact. This can cause collapse and loss of consciousness.  
**GHB** rape victims are usually unable to consciously consent to sexual acts and often do not remember the act or the offender.  
Some people use GHB voluntarily.  
Consuming GHB and alcohol can result in sudden loss of consciousness, difficulty in breathing and, in some cases, death. | **Hold on to your drink at parties and make sure it is in fact alcohol.**  
**Should you experience any strange symptoms, stop drinking alcohol and drink plenty of water instead.**                                                                                                                                                                                                                                  |
| Medication | In several MENA countries, medicines such as Tramal, Rivotril, Cemo, Valium, Neocodeine, Xanax are sometimes sold without prescription and used during parties.  
When they are combined with alcohol, misuse of these medicines that are sold over the counter can be very dangerous and lead to health problems, including overdose and death. |                                                                                                                                                                                                                                                                                                                                                                        |
Ways to use drugs

There are different ways of using drugs according to their type: smoking, inhaling, sniffing, chewing, swallowing and injecting.

Why do people use recreational drugs?

- Their friends are doing it and they don’t want to feel left out or not be cool.
- They want to experience “euphoria”.
- Experimentation, being rebellious and taking risks.
- Belief that it increases sexual prowess.
- It makes them feel more relaxed; they can forget their worries and escape from harsh realities.
- A desire to participate, such as at parties.

The risks associated with drug use, and their health, social and legal implications

Drugs may be prescribed to alleviate pain or to treat mental, neurological or psychological illnesses. However, when a drug is not used for medical reasons, and without supervision and/or prescription – and particularly if it is mixed with alcohol or with other drugs – it can lead to chronic health and social problems, as well as to addiction, overdose and death.

People who use drugs are exposed to risks and may experience problems with their community, parents or workplace. This can lead to isolation and marginalisation, and (depending on the type of drug) to prosecution. In addition, drug use can lead to increased risk of HIV infection, viral hepatitis B and C, cancer, ulcers, distress, coma and overdose. In summary:

- **Physical dependency** – the interaction of the body with the drug, so that when without the drug, the person can experience mental and physical dysfunction, accompanied by pain in all parts of the body, muscle spasms, vomiting, diahphae and deficiency symptoms.
- **Psychological dependency** – the person having an irresistible craving to find the substance, with a strong desire to relive previous enjoyable sensations. Side effects may include anxiety, stress, depression and withdrawal symptoms.
- **Long-term health problems** – major organ disease (liver, heart, kidneys, lungs); psychological complications; dependency and addiction; infection around injection sites.
- **Long-term social problems**, when not controlled – family and relationship disruption; dependency leading to financial problems, crime and sex work; inability to work.

The link between HIV and drugs

- The HIV virus remains alive in blood contained in syringes for up to four weeks. Sharing contaminated needles among people who inject drugs exposes them to HIV infection and hepatitis B and C.
- Just a small amount of blood in tools such as injection needles can transmit the virus.
- Stimulant drugs affect personal behaviour during sexual relationships; people who use drugs expose themselves to the risk of HIV transmission through unprotected sex and by sharing needles or other injecting tools.
Recreational drugs are mostly stimulants and their use can increase the risk of STIs:

- The sense of euphoria caused by these drugs dampens the perception of risk or harm, and diminishes the instinct for self-protection, as well as the ability to use condoms correctly when having sex.

Increased sexual arousal can also lead to a decrease in the perception of risky behaviour.

---

### Prevention during sexual relations under the influence drugs

- Try to avoid penetrative sex when high on drugs.
- Keep condoms and lubes with you at all times.

### Prevention while injecting drugs

- Make sure you always use a new/clean needle and syringe. Never share needles and syringes!
- Wash your hands before and after injecting.
- Make sure you know the side effects of the drug and don’t mix more than one type per session.
- Tend to any wounds and ulcers, especially if there is blood and you are using sharp tools.
- Dispose of used needles responsibly.
- If addicted to drugs and/or alcohol, seek medical help. Substitution therapy may be available to keep you stable and help you live with your drug use in a way that does not affect your mental, physical health and wellbeing in such a damaging way as when it is uncontrolled.

### Getting treatment

- Admit that you have a problem and need help.
- Decide to take action today and not tomorrow.
- Visit local centres that specialise in harm reduction.

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### Treatments for people who use drugs

The global response to drug use is guided by the principles of harm reduction.

Harm reduction is an evidence-based approach that aims to reduce the adverse health, social and economic consequences of drug use for individuals who use drugs, their families and their communities. It is a pragmatic approach to health comprised of interventions that address harms like HIV transmission, hepatitis C transmission, overdose and unsafe injecting. The approach is guided by both public health and human rights principles.

People who have become dependent and/or addicted to drugs and alcohol have several options about managing their situation. These can include undertaking a process of withdrawal and then remaining abstinent from drugs or alcohol; trying to control their drug use and limit the potential harms associated with them; and for people addicted to opiate drugs such as morphine, heroin and other opioid-derived drugs, a treatment option called substitution or replacement therapy. Whatever the approach, it is important to consider the following stages:

- **Stage 1:** understand whether the person themselves sees drug use as being a potential problem in their lives. A person’s current perception will influence the approach. Those who want to reduce or stop their drug use will need to be referred for support and treatment. For those who do not want to change, it is important to raise awareness of the risks – physical, mental, social – associated with drug use, addiction and the wider impact it can have on their own life and the lives of their loved ones.

- **Stage 2:** those who would like to become drug and/or alcohol free may need to register to be part of a rehabilitation and detoxification programme. This process can take anywhere between six months to three years depending on the individual. Detoxification is often started and supervised within a hospital or a specialised centre. The medical treatment involves eliminating physical dependence and can take between five days and three weeks. There are many approaches to rehabilitation, including behavioural therapy programmes as an inpatient or an outpatient. Some of these approaches adopt client-focused therapy, motivational interviewing and becoming a lifelong member of a 12-step programme.

- **Stage 3:** for those people who are addicted to opiate-based drugs and feel they cannot go down the abstinence approach, there is a medically supervised programme called opiate substitution or replacement therapy. This involves the person taking a daily dose of an opiate substance such as methadone or buprenorphine prescribed by a doctor. This treatment can control cravings and the destructive behaviours that can accompany drug use. Most people on this treatment are able to maintain work and remain sober. As the therapy is given at predictable times, and at a dose level that will not cause harm, people on this therapy often live quite normal lives and others would never guess that they have ever been dependent on drugs. However, drug replacement or maintenance therapy is not available in all countries, and in some countries it is illegal despite being fully supported by WHO.
Session 11

Sex work

Overview
This session is about MSM and sex work. It is an important subject for peer educators, particularly in relation to HIV and other STIs.

The session aims to help to dispel myths and correct misconceptions.

It is important to refer to statistics about local experience of sex work, MSM and HIV, if they exist.

Activity: Concepts related to commercial sex and MSM

Step 1: Brainstorming (20 minutes)
1. Start the session by asking participants to brainstorm their understanding of sex work. Who does it? When? How? With whom?

Step 2: Group work (20 minutes)
2. Divide participants into three groups and ask them to stand facing a large sheet of paper on the wall with questions on it taken from Annex 23.

   In Part 1 of the exercise, the groups must answer “Yes” to every question, even if they are not convinced the answer should be a “yes”. This is in order to reflect the common beliefs of local communities.

3. In Part 2 of the exercise, the groups move to another sheet and this time answer “No”, backing up their answers with evidence.

Step 3: Reading the answers and discussion (20 minutes)
4. In the big group, spend five minutes asking each group to share their answers to Part 1 of the exercise. Then spend 10 minutes sharing the answers to Part 2. Spend the last five minutes answering any remaining questions or concerns about sex work and MSM.

You will need
- Flipchart and large sheets of paper
- Handout (one per participant) on:
  Annex 23: MSM and sex work – Q&A

Objective
At the end of this session, participants will be able to:
- analyse their attitudes toward sex work and any related misconceptions.

Time
1 hour
## Annex 23: MSM and sex work – Q&A

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>ANSWERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all MSM sex workers?</td>
<td>Of course not. Sexual orientation and sex between men does not constitute sex work. Sex work is an exchange of money, commodities or services for sex; i.e. one person is selling a service (sex) and the other person is buying it.</td>
</tr>
<tr>
<td>Would a person offering money/gifts for sex always entice an MSM to have sex with them?</td>
<td>This would be the same answer if the person were heterosexual; i.e. most people do not sell sex for money or gifts, but some do. Some who sell sex are MSM, whereas others are heterosexual men and women. There can be formal sex work as well as informal sex work. For instance, some young people will have sex with older people for items such as cell phones and luxury goods, and this is known as transactional sex.</td>
</tr>
<tr>
<td>A homosexual is usually unable to commit to one sexual partner</td>
<td>Commitment to one sexual partner is a personal choice regardless of sexual orientation or sexual behaviour. Some MSM choose to live in “open” relationships, where they have a primary partner but the couple has an agreement that they may have sex with other people. In reality, in some parts of the world like the MENA region, it is difficult for two men to set up home together and be known as a couple. Having to constantly hide who they are and who they love can put a strain on any relationship.</td>
</tr>
</tbody>
</table>
Session 12

Objectives
At the end of this session, participants will be able to:
■ understand the concept of outreach programming and how to develop it based on a public health approach
■ define health, health education and its components
■ identify risk reduction approaches
■ explain the importance of peer education and participatory approaches.

Overview
This session contains information about peer outreach and health education. You will need to adapt it so that it is at an appropriate level for your group. This technical information is central to the training, so you must make sure that participants understand it all. Allow time for questions and answers, as this exercise is a preparatory session for subsequent sessions.

Activity: Outreach programming and health education

Step 1: The wall journal exercise (20 minutes)
1. Distribute the following concepts, each written on a small sheet of paper:
   - health
   - health education
   - risk reduction
   - behavioural change
   - peer education

2. Distribute the following list of descriptive terms and ask the participants to discuss their understanding of the words and then place the words beside the appropriate corresponding word from the first list. Participants may find that they use a word or phrase more than once. Words to discuss:
   - inner peace
   - physical wellbeing
   - social relationships
   - information
   - skills
   - attitudes
   - values
   - renewed enthusiasm
   - resources
   - balancing benefits and risks
   - long term
   - continuity
   - risk
   - similar characteristics
   - similar age
   - mutual understanding
   - creativity
   - participation
   - necessity
   - better future.

Step 2: Summary and correction of information (1 hour 10 minutes)
3. Once this exercise is complete (and displayed on a large sheet of paper on the wall), make any necessary amendments and then summarise the definitions of “health” and “health education”. Then explain the process of behavioural change and the elements that support it. Discuss the issue of harm reduction.

4. You should end by summarising the definitions of “health”, “health education” and “peer education”, and the importance of adopting a participatory approach.
Annex 24: Peer health education based on public health principles

WHO in its constitution of 1946 defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” When we are considering outreach work with MSM in the area of HIV and STI prevention, this holistic understanding of health is extremely important in guiding the nature and focus of any interventions.

Peer education is an approach that employs people of a similar age with similar characteristics to the target group to go out and meet MSM in places where they socialise and live, and provide health and social support. Peer educators who are well trained and supervised can often be extremely effective at building the trust and confidence of MSM. With that trust, they are able to provide MSM-specific health education, active encouragement and support for behaviour change, psychosocial support to those who need it, as well as be trusted providers of condoms and condom-safe lubricant. Peer educators can provide their services to individual MSM as well as to small groups.

It is essential that peer educators are seen to be practising what they preach and remain professional at all times. Those who do not will no longer be taken seriously. Therefore, it is imperative that organisations running peer outreach services provide their peer educators with regular supervision and an opportunity to discuss and share any personal concerns about their own behaviour or challenges, and get the support they might also need.

MSM in the MENA region often live in challenging circumstances, where their rights are neither protected by the laws of the country nor by the communities in which they live. Any outreach programme focused on behaviour change must take into consideration the impact of the context where MSM live on their behaviour, sense of self, and mental and social wellbeing. That is why HIV programmes working with MSM generally provide direct support to MSM, as well as undertake initiatives to help change negative social norms about MSM into something more positive and welcoming. Therefore, peer education programmes working with MSM must fully endorse and promote the basic human rights of MSM, including their right to self-determination.

As part of helping to create a more welcoming and enabling environment, peer educators can be very effective at trying to address some of the issues of stigma and discrimination experienced by many MSM. They can do this by actively working with and supporting healthcare workers, religious and community leaders, and law enforcement agents to be less discriminatory and more supportive of the human rights and the health and social support needs of this population.

It is essential that peer educators get to know local service providers and work with them to provide sensitive and quality health and support services. Peer educators can only do so much, and one of their most important roles is to identify the needs of their clients and, where necessary, make effective referrals to service providers, and then support the client with any follow up.

Peer educators and peer education programmes are a means of ensuring the social inclusion of MSM in society. MSM are often marginalised and treated with contempt as well as intimidation and violence. As a result, they can feel isolated and fearful. By providing sympathetic, compassionate and respectful peer education programmes, MSM can feel respected, that their needs are valid, and that they are deserving of respect from others as well as themselves. Therefore, peer education approaches can help to transform lives.

Peer educators can play a number of roles. Core functions will include:

- providing correct information on health issues such as HIV and other STIs, risk behaviours and prevention
- distributing condoms, lubricants, clean needles and syringes, and other injecting equipment
- providing some direct health services such as VCT, adherence support for HIV-positive men taking ART, and psychosocial support
- facilitating referral – one of the most important roles of a peer educator is to ensure that their clients are referred to the services they need. Peer educators need to follow up any referral to ensure that the person was able to access the service and received appropriate and sympathetic treatment and/or services. Services could include HIV testing, STI diagnosis and treatment, and HIV treatment and psychological support. Sometimes a peer educator will accompany the person to a service provider, particularly if they feel nervous or embarrassed about seeking help.
Annex 24: Peer health education based on public health principles

### DEFINITIONS OF COMMON TERMS RELATED TO HEALTH AND PEER EDUCATION

<table>
<thead>
<tr>
<th>TERMS</th>
<th>COMPONENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>A sense of psychological and physical wellbeing</td>
</tr>
<tr>
<td>Health education</td>
<td>Any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes. (WHO)</td>
</tr>
<tr>
<td>Behaviour change</td>
<td>A process of addressing knowledge, attitudes and practices associated with a particular behaviour in order to change it. For example, exploring and understanding the level of knowledge, attitudes and practice of someone having unprotected sex to help them change their behaviour to practise safer sex.</td>
</tr>
<tr>
<td>Peer education</td>
<td>Teaching and sharing of information by people who have similar characteristics to the target group, such as age, culture, social status and life experiences.</td>
</tr>
<tr>
<td>Risk reduction</td>
<td>A process of identifying the risks associated with HIV and other STIs and implementing measures to limit the risk of transmission. These can include direct measures such as condom use, reducing number of sexual partners or only practising safer sex, as well as efforts that address the context of where MSM live and operate; e.g. to make sex work safer by ensuring that all sex workers are protected from violence and have access to condoms and lubricants at all times.</td>
</tr>
</tbody>
</table>

Annex 25: Risk reduction

One of the best-known HIV prevention approaches is the ABC approach: abstinence, be faithful and/or use a condom. In reality, for most people abstinence is not really an option.

MSM are at a higher risk of HIV and other STIs for a number of reasons:

- They have a higher level of exposure to HIV and other STIs because there is a higher prevalence of these infections among MSM than among the general population.
- Some sexual practices such as anal sex carry a higher risk of infection than others.
- Some MSM have not had access to sex education and prevention advice that is relevant to their own lives.
- Maintaining safer sex can be challenging. For instance, a recent study in Lebanon found that over half of MSM surveyed and targeted in an intervention programme between 2007 and 2011 were not using condoms in their sexual relations. Most stated that condoms interfered with their enjoyment of sex and reduced their sexual pleasure. Despite the increased risk of HIV and other STIs, they preferred to take the risk and have a higher level of sexual enjoyment.

Risk reduction is an approach to behaviour change that acknowledges that it is not possible to reduce all risks unless someone becomes totally abstinent. Since this is the case, risk reduction approaches encourage people to reduce their risk of exposure to HIV and other STIs by adopting evidence-based and scientifically validated prevention approaches. These include reducing the number of sexual partners; using condoms and condom-safe lubricant for anal sex; getting STIs treated early; getting tested for HIV and starting ART early to keep HIV viral load low; and limiting the use of alcohol and recreational drugs to reduce the risk of behavioural disinhibition.
Session 13

The peer educator

Overview
This exercise provides programme planners and field supervisors with a set of core characteristics that will be useful for selecting peer educators.

Activity: The role and characteristics of the peer educator

Step 1: The drawings (15 minutes)
1. Draw an image of a peer educator and ask each participant to provide characteristics that they feel are important for them to be successful; e.g. knowledge, values, attitudes and skills.

Step 2: Presentation (45 minutes)
2. Ask each participant to read out loud the characteristics they have chosen and explain why. Ask the rest of the group if they agree with each characteristic. If not, why not?
3. Once all the participants have shared their characteristics, review the information and add any further characteristics from Annex 26 if they did not come up in the discussions.

You will need
- Large sheets of paper, coloured markers, masking tape
- Handout (one per participant) on: Annex 26: Characteristics of the peer educator
Walid, 31, is a student who is single and defines himself as MSM. He is a peer educator with SIDC and Helem in Lebanon

“I am a peer educator in the project and I benefited from all the trainings in terms of information, approaches for conducting peer education, planning my field work and, overall, I benefited from the field work and the practical aspects. I was able to put in practice the theoretical information I learned.

In my position as a PE [peer educator], what has changed is that I met other groups and communities who are different from the people I knew and I have learned how to work with approaches adapted to each of those groups. The way of working, of speaking, the content of the information destined to street youth are different from those used with young people in bars and nightclubs. I am no longer limited in using one single method or approach.

It is during my work on the street that I could feel the difference between the populations I meet with, and I started using two different methods or approaches. This was very important because it makes my interventions more useful and increases my self-confidence and my trust in the quality of the information I am providing. And when I feel that the people I am talking to accept easily, ask more questions and are interested in the issue, this makes my work more significant and more useful.”

Bassem, 32, is a student and peer educator with ATL in Tunisia

“Today, I feel responsible for [my] sexual behaviours. I am aware of the importance of prevention and of the risks faced by our community, starting with the high risks of HIV infection since we have a concentrated epidemic in our community.”
Annex 26: Characteristics of the peer educator

Peer educators may themselves belong to the target group, and may share some similar characteristics, such as age, social status, culture, religion and experience of being “different” from the dominant norm. This “insider knowledge” means that peer educators often know how and where to reach the target group, and what is the best way to approach them.

Training develops their capabilities and enables them to transfer their skills and knowledge into a health education and promotion context. Their role is to access the group and provide them with educational resources and accurate information about HIV and AIDS. They help MSM to develop an accurate sense of their own risks of acquiring HIV and other STIs by sharing their knowledge on the link between sexual and other behaviours and STIs and HIV. The peer educator promotes prevention by discussing risk and distributing condoms, lubricants, clean needles/syringes and injecting equipment when needed; providing basic health services in the street (whenever possible); and referring MSM to appropriate services such as VCT and STI screening, STI and HIV treatment and counselling, and services for people living with HIV.

Not all fieldworkers will be peers, but those who are not need to demonstrate a positive regard and respect for MSM and not be embarrassed about discussing intimate details about sex between two men. In fact, some MSM may prefer to be contacted by someone who is sympathetic but is not necessarily MSM themselves. In some situations, it may be much easier and safer for peer educators not to be identified as MSM.

Whether the fieldworker is a peer educator or not, he should meet the criteria in the table below. These characteristics are enhanced and developed with appropriate training and self-development.

The success of any outreach programme also requires community mobilisation, and this is best achieved by adopting a participatory approach. Organisations wishing to start a programme should involve the target group at all stages. This will strengthen relationships between MSM and the programme, and over time with the community in general, helping to reduce stigma and discrimination.

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### Characteristics of the Peer Educator

<table>
<thead>
<tr>
<th>Core Characteristics</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged over 18*</td>
<td>Able to communicate in the “language” of the target group and simplify technical information</td>
</tr>
<tr>
<td>Known and respected by peers</td>
<td>Good listener</td>
</tr>
<tr>
<td>Respects and values other people</td>
<td>Able to make decisions</td>
</tr>
<tr>
<td>Honest</td>
<td>Able to work and operate in places where MSM gather regardless of practices and beliefs. These places can be dangerous</td>
</tr>
<tr>
<td>Mature and able to keep information confidential</td>
<td>Innovative, suggest new and realistic strategies for supporting behaviour change</td>
</tr>
<tr>
<td>Adaptable</td>
<td>Responsible and well organised</td>
</tr>
<tr>
<td>Welcomes feedback and wants to grow and improve</td>
<td></td>
</tr>
</tbody>
</table>

**Knowledge**

- Has a good understanding of:
  - HIV and other STIs – what they are, how they are transmitted, treatment and prevention
  - the impact of the social and economic context on behaviour
  - drug use, HIV and MSM
  - sex work, HIV and MSM
- Has a good understanding of issues related to gender, sexual orientation and identity
- Is familiar with available local resources

**Attitudes**

- Understands and respects the values and principles of the target groups
- Advocates for their rights and for human rights in general
- Believes in the work he is doing and its importance
- Strives to be free from prejudice and actively works against any discrimination towards MSM
- Available to work in the evenings and weekends

* Programme planners should review local policies relating to street intervention when defining an age range for peer educators. It is best to choose over-18s but this doesn’t prevent working with under-18s. This younger group, who may be sexually active, can receive personal awareness sessions, and can be asked to cooperate in bringing their peers for awareness or to be referred to services (especially if there are special protocols for counselling), voluntary testing and information, education and communication material distribution. Programme planners should work within local health policies and, if necessary, get parents’ consent, as this is a sensitive moral issue.
Session 14

Attitudes and beliefs

Overview
This interesting exercise may cause some agitation, so remind everyone about the workshop rules on respecting each other’s opinion. Encourage constructive and evidence-based criticism, and let everyone express their views.

You may not get through the whole list of attitudes (Annex 27), so choose those you find appropriate and leave the rest for discussion throughout the training.

Listen to participants’ points of view. Take notes and focus on any attitudes that need clarification or encouragement. Do not take sides, but gear the discussion towards the more positive attitudes without imposing them.

Encourage effective listening, as this exercise is a test of participants’ openness and effective listening skills.

Activity: For or against

Step 1: Individual exercise (15 minutes)
1. Hand out copies of Annex 27, and ask participants to fill it in individually (without consulting each other), ticking the appropriate box for each answer.

Step 2: Group exercise (30 minutes)
2. Once they have finished, ask participants to stand facing each other holding their sheets and explain the reasons behind the choices they made (for or against). Those who opted for an “against” answer have to stand in the middle and explain their position.
Annex 27: List of attitudes

<table>
<thead>
<tr>
<th>ATTITUDES</th>
<th>FOR</th>
<th>AGAINST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distributing free condoms to MSM will encourage them to engage in same-sex practices</td>
<td>No, MSM have sex in the same way as men who have sex with women, but they have less access to information and condoms. Free condoms not only reduce the risk of HIV and other STIs for MSM, but also for all of society.</td>
<td></td>
</tr>
<tr>
<td>Giving free condoms to those under 16 will encourage them to engage in same-sex practices</td>
<td>Encouraging young people to delay having sex is important as research shows that the earlier you start having sex has some influence on the number of sexual partners over a lifetime. The more sexual partners you have, the more likely you are to get exposed to HIV. The reality is that young people do have sex and get exposed to infection when they do not use condoms. Distributing condoms provides an opportunity for health education and also to find out from the young person whether they are experiencing any problems or have any questions about intimacy, sex and sexuality.</td>
<td></td>
</tr>
<tr>
<td>Encouraging MSM to talk about who they are and their lives can help reduce their exposure to risks</td>
<td>Yes, because they feel they are accepted so that builds their trust with a peer educator and encourages them to ask questions. As they open up, their self-esteem will grow as they realise that they are accepted and respected. Increased self-esteem can lead to less risk taking and increased use of condoms.</td>
<td></td>
</tr>
<tr>
<td>The best way to reduce harm from STIs is to ban/outlaw sexual relationships among MSM</td>
<td>Firstly, banning something doesn’t mean that it will not happen. Secondly, stopping consenting adults from expressing their sexuality is contrary to human rights. MSM are just like heterosexual men and women in needing to express their sexuality and enjoy sex. What they need is the knowledge and guidance to be able to do it safely and enjoyably.</td>
<td></td>
</tr>
<tr>
<td>People living with HIV and with an undetectable viral load and a high CD4 count can have unprotected sex</td>
<td>Although having an undetectable viral load means the risk of HIV transmission is very low, HIV transmission is still possible. There are spikes in the level of circulating virus during times of illness and stress, and it is not feasible to do the level of screening necessary to observe the changes in viral load. Therefore, it is advisable to continue using condoms.</td>
<td></td>
</tr>
<tr>
<td>Encouraging MSM not to mix drugs will reduce their risk of overdose</td>
<td>Yes, it is never a good idea to mix drugs but it is also possible to overdose on just one drug.</td>
<td></td>
</tr>
<tr>
<td>Encouraging MSM to reduce their alcohol intake before sex will help them to use condoms</td>
<td>Yes. Even small amounts of alcohol can lead to disinhibition, meaning that people are less likely to use condoms.</td>
<td></td>
</tr>
<tr>
<td>Distributing condoms to MSM will encourage them to have multiple sex partners</td>
<td>This has nothing to do with the use of condoms. However, a condom will provide protection to those who want to have multiple sex partners.</td>
<td></td>
</tr>
</tbody>
</table>
About the International HIV/AIDS Alliance

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

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

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

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MODULE 2
SKILLS DEVELOPMENT

TRAINING MANUAL FOR MSM PEER EDUCATORS
Acknowledgements

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

This orientation manual was written by John Howson and Nadia Badran. Simone Salem, on behalf of UNAIDS, and Manuel Couffignal, on behalf of the Alliance, revised and completed the report. Special thanks to Eltayeb Elamin from UNAIDS RST MENA, who provided critical feedback during the writing process.

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We sincerely thank the associations that organised and facilitated local workshops in April 2014 to review the toolkit: APCS in Algeria, AMSED in Morocco, ATL in Tunisia and SIDC in Lebanon. We are also grateful to the stakeholders who participated in these local workshops and provided valuable comments and input: ASCS, Association de Lutte contre le SIDA (ALCS) and OPALS-Fes in Morocco, Helem, Oui Pour la Vie, Lemsic and Lebmash in Lebanon, Arken and Damj in Tunisia, and Green Tea and AIDES-Algérie in Algeria.

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The MENA programme’s partner associations

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

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All the quotes in this manual have been collected from MSM living in different countries of the region. We believe they are representative of the regional context and reality, hence have chosen mostly to omit the specific countries where they were collected.
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MODULE 2
SKILLS DEVELOPMENT
Overall timing
28 hours 35 minutes

Objectives
In this module, participants learn and practise the skills necessary to work with their clients to promote and encourage behaviour change. This will include exploring their own attitudes and beliefs in order to reflect on how these may influence their work with clients, both positively and negatively. Specifically, they will:

- discuss the various stages of behaviour change
- improve communication skills related to sexual risk behaviours and the use of condoms and condom-safe lubricants
- practise communication
- analyse potential challenges and how to overcome them
- learn negotiation and life skills
- discuss the different personalities they may encounter in their work and learn how to deal with them
- develop positive attitudes free from stigma and discrimination
- role play an educational session on behaviour change.

<table>
<thead>
<tr>
<th>SESSIONS IN MODULE 2</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: Sexual risk behaviour and risk reduction</td>
<td>4 hours</td>
</tr>
<tr>
<td>Session 2: Risk reduction</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>Session 3: Safer sex</td>
<td>2 hours 15 minutes</td>
</tr>
<tr>
<td>Session 4: Identifying the components of outreach interventions</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>Session 5: Communication skills</td>
<td>3 hours 20 minutes</td>
</tr>
<tr>
<td>Session 6: Communication during outreach</td>
<td>1 hour</td>
</tr>
<tr>
<td>Session 7: Life skills</td>
<td>3 hours 30 minutes</td>
</tr>
<tr>
<td>Session 8: Self-esteem</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>Session 9: Interacting with different personalities in the field</td>
<td>2 hours</td>
</tr>
<tr>
<td>Session 10: Developing non-discriminatory attitudes and behaviours towards MSM</td>
<td>2 hours 30 minutes</td>
</tr>
<tr>
<td>Session 11: Educational and motivational messages in the field</td>
<td>3 hours 15 minutes</td>
</tr>
<tr>
<td>Session 12: Importance of the outreach programme and influencing decision-makers</td>
<td>2 hours 15 minutes</td>
</tr>
</tbody>
</table>
Session 1

Sexual risk behaviour and risk reduction

Overview
This session conveys simple scientific information through practical examples. The exercises in parts 1 and 2 provide the theoretical framework for addressing the process of behaviour change. This framework will support participants’ understanding and provide a reference source to help them retain the information.

The session consists of two parts:
- **Part 1. Risk alert**
- **Part 2. Stages in behaviour change and factors influencing them**

Activity: Part 1. Risk alert

**Step 1: Drawing (40 minutes)**
1. Divide participants into six groups (preferably four to six per group). Draw six boxes on a large sheet of paper. Tell them this imagined scenario involves a young MSM.
2. Give each group a blank sheet of paper and ask them to draw six boxes. Explain that the last box represents unprotected penetrative sex. Ask participants to go back, step by step, into each of the five previous boxes and list the circumstances (using key words, cartoon drawings or symbols) that could have led this young man to Box 6 (i.e. to have unprotected sex).
3. After 20 minutes, ask participants to discuss the learning from this exercise (10 minutes) and the importance of talking about the risk continuum (10 minutes).

**Step 2: List of risks (30 minutes)**
4. Ask the small groups to draw three boxes on the other side of their paper. Ask them to list:
   - Box 1: HIV and other sexually transmitted infection (STI) risks faced by MSM
   - Box 2: Factors that might prevent them from protecting themselves from HIV and other STIs
   - Box 3: What they can do to reduce their risk of becoming infected or transmitting HIV or STIs

Part 2. Stages in behaviour change and factors influencing them

**Step 1: Presentation and discussion of stages of behaviour change (30 minutes)**
5. Present and explain each of the six stages of behaviour change, using the pre-prepared sheet (Annex 1). Ask if there are any questions that need clarifying. Invite discussion of the points presented.
Step 2: Exercise to identify behaviours applying to each stage
(1 hour 20 minutes)

6. Take six sheets of paper and write a different stage of behaviour change as a heading on each. Put these on the walls as wall panels.

7. Give each small group a set of Post-it notes. Ask them to write examples of behaviour that correspond to each stage (one example per Post-it). Ask them to stick their Post-its on the appropriate sheet. Remind them to refer back to the diagram they developed in Step 2 of Part 1 to identify behaviours.

8. Present the list of examples of behaviours applying to each stage using the pre-prepared sheet (Annex 2). Ask groups to make any amendments required to their Post-its.

9. Ask groups to review the final version and positioning of all the Post-its. Check for any inaccuracies and correct these. Invite general discussion, queries or challenges to points listed.

Step 3: Factors that influence movement between stages of behaviour change
(1 hour)

10. Assign one working group to each wall panel.

11. Ask the groups for panels one to four to discuss and write on their wall panel the resources, attitudes and skills that are needed to enable individual MSM to progress to the next stage.

12. Ask the group for panel five to discuss and write on their panel the resources, attitudes and skills needed to enable individual MSM to sustain the behaviour changes that have brought them to this stage.

13. Ask the group for panel six to discuss and write on their panel the resources, attitudes and skills needed to support MSM in this stage and enable them to move again to a different stage. Remind all groups to refer to their diagram for Step 2 of Part 1.

14. After 20 minutes, invite groups to view each other’s panels (10 minutes in total). Invite comments, questions and general discussion. Check the points listed for feasibility and relevance. Clarify any queries, and amend any errors and misconceptions (30 minutes).
Annex 1: The stages of behaviour change

Any outreach work with MSM has to start with an assessment of an individual’s risk behaviour and an understanding of whether the person considers their behaviour to be risky; i.e. their perception of risk. An understanding of the behaviour change process will help peer educators to discuss with the client where they are on the behaviour change continuum, assess their particular needs and possibilities, and support them to make positive changes.

The following behaviour change theory is based on the Transtheoretical model of behaviour change, which assesses an individual’s readiness to act on a new healthier behaviour, and provides strategies or processes of change to guide the individual through the stages of change to action and maintenance of this new behaviour. James O Prochaska of the University of Rhode Island and colleagues developed this model at the end of the 1970s, and they subsequently refined the model on the basis of research that they published in peer-reviewed journals.

The six stages of behaviour change:

- **Stage 1: Pre-contemplation**
- **Stage 2: Contemplation/awareness and acceptance**
- **Stage 3: Preparation for change**
- **Stage 4: Action**
- **Stage 5: Maintenance**
- **Stage 6: Relapse**

The characteristic features of each stage are described below.

**Stage 1: Pre-contemplation**

The person:

- has no intention of changing behaviour
- is not aware of the negative consequences of the risk behaviours
- is aware of the negative consequences but is not willing to change
- is in denial of the risks and negative consequences
- is unwilling to discuss their risk behaviour with others.

Individuals in this stage need to become aware of the risks associated with, and possible consequences of, their present behaviours. Conversations should be backed up with concrete evidence as far as possible. Various initiatives such as mass media awareness campaigns have a role to play in this regard, alongside the efforts of the peer educator.

**Stage 2: Contemplation/awareness and acceptance**

At various points in this stage, the person:

- is aware of the immediate dangers of their risk behaviour but is hesitant and reluctant to make changes
- declares their intention to change but lacks a clear strategy to do so
- is aware of the health risks of their present behaviour and its causes, and is willing to analyse their situation and discuss it
- finally declares their willingness to implement change.

Those at this stage need help to consider the pros and cons of engaging in harmful or risk behaviours, the choices available to them and potential challenges. They can start thinking of a suitable action plan that will help them move into the next stage.

**Stage 3: Preparation for change**

The person:

- gives definite indications of their willingness to change
- makes decisions about the changes that are possible for them
- develops an action plan for the near future (e.g. for the next six months)
- is willing to consult specialists for support to better implement their action plan
- realises that the changes identified are good and meet their particular needs.

Motivation and capacity-building are needed at this stage to help the person to develop their decision-making skills, face external pressures and learn how to adjust to their new behaviour. Assistance is also needed in developing an action plan, and in knowing about and accessing available referral and support services that will help them to implement their action plan. It is important to develop SMART (specific, measurable, achievable, realistic and time-scaled) objectives for implementation, taking into consideration the time constraints and available resources.

**Stage 4: Action**

The person is:

- willing and able to adopt the new behaviour, taking small positive steps to reach the desired goal
- willing and able to call upon service providers for support, share achievements so far and discuss what still needs to be done.
Annex 1: The stages of behaviour change

This is a critical stage, as it is tempting to regress to previous stages. So individuals need all the support and encouragement they can get to appreciate the achievements of their small, and perhaps slow, steps. Support, recognition and rewards help, as does focusing on how to overcome potential challenges.

**Stage 5: Maintenance**

At this stage:
- change becomes an integral part of the individual's life (a way of life)
- the person draws on resources and tools, and takes steps to avoid regressing to old habits and previous stages
- the person can see the benefits of the new behaviour
- the person encourages others to follow suit
- the person participates in a follow-up plan and in outreach and referral programmes.

At this stage, individuals need ongoing support, both from peer educators and through accessing referral services, in relation to the skills and attitudes needed to sustain their changed behaviour. They are also ready to share their experiences with peers and take an active role in raising awareness. They have become experts in the field and can be of assistance to others.

**Stage 6: Relapse**

Setbacks are normal and part of the process. It is important to understand that setbacks are expected and that help is available, no matter how total the relapse. What is important is working out the reasons for the relapse, and a strategy to help prevent it happening again.

Individuals at this stage may find themselves alone in facing the challenges and lose enthusiasm. The option to revert to earlier behaviours is still present and change itself is scary, taking the individual into unknown territory. Personal and psychological factors may add to the situation, such as deeply rooted self-stigmatisation, which may resurface and prevent the individual from looking after himself.
### Annex 2: List of behaviours applying to each behaviour-change stage

<table>
<thead>
<tr>
<th>STAGES</th>
<th>BEHAVIOUR</th>
</tr>
</thead>
</table>
| **Pre-contemplation**               | - A sex worker never uses condoms with clients in the Turkish baths/Haman and during massage  
- A young man engages in sexual relationships without using a condom. He think that choosing his partners from an affluent social class will protect him from HIV and STIs  
- A married man engages in MSM penetrative sex without using condoms  
- A man who uses drugs has unprotected sex with men for money to get drugs |
| **Contemplation/awareness and acceptance** | - An MSM reads a publication on HIV, reflects on his behaviour and thinks he may have exposed himself to risk of infection  
- A man who injects drugs learns about someone with HIV and realises that he may be at risk  
- A sex worker finds out about an association that distributes free condoms  
- A transsexual learns that using “poppers” during sexual activities can reduce a person’s awareness of the sexual risks they may be taking  
- An MSM in a steady relationship for nine months hears about an HIV test centre and wants to suggest to his partner that they should consider getting tested  
- A young MSM hears about hepatitis B and that there is a vaccination to prevent people from getting infected, and wants to know more about how he can protect himself |
| **Preparation for change**           | - A sex worker decides to start using condoms with his clients  
- An MSM decides to use condoms in all future relationships  
- A man who injects drugs who sells sex from time to time in order to buy drugs decides to use condoms and not to share his injecting equipment with others  
- A married man who has same-sex sexual relationships decides to buy condoms and use them  
- A married man decides to use condoms while having sex with his wife until he gets tested for HIV, and always with other sexual partners  
- An MSM who recognises that he takes risks while taking recreational drugs decides not to take them when attending a party |
| **Action**                          | - An MSM always uses condoms for penetrative sex  
- A sex worker takes advantage of peer educators’ weekly visits to obtain a supply of condoms  
- A man who injects drugs refuses to share his injecting equipment with others and always carries clean needles and syringes on him  
- A sex worker refuses to have sexual relations without the use of a condom, even in massage parlours |
| **Maintenance**                     | - An MSM has an accurate perception of his own HIV risk and practises safer sex  
- An MSM has an HIV test every three months  
- An MSM has used condoms consistently for the last four months in all sexual activities  
- An MSM challenges his sex work clients when they refuse to use condoms and convinces them of their benefits  
- An MSM uses condoms consistently and advises his friends to use them as well |
| **Relapse**                         | - An MSM abandons his earlier strategy to always use condoms  
- An MSM gets himself referred to support services by the peer educator but does not show up for his appointment  
- An MSM is persuaded by peers to revert to his riskier behaviours  
- An MSM is persuaded by financial enhancements from clients to have penetrative sex without a condom  
- Withdrawal of funding for sexual health and drug use referral services make it difficult for an individual to access supplies of condoms or clean needles and syringes, and rather than try to find another source decides to abandon using condoms |
Session 2

Time
1 hour 30 minutes

Objective
At the end of this session, participants will be able to:
■ better understand the kinds of situations encountered by MSM and the factors affecting decisions they make.

You will need
■ A means of timing one-minute intervals
■ A large sheet of paper taped to a nearby wall/stand, masking tape
■ One or more sets of five cards, each with a different question and accompanying multiple-choice answers (Annex 3). The overall number of cards required will be half the number of participants

Risk reduction

Overview
This session seeks to help participants to better understand the factors influencing potential risk reduction decisions made by MSM.

The exercise for this session is geared towards having participants choose answers. But it is important that you, as facilitator, allow enough time for discussion, and that you correct misinformation and fill any gaps in participants’ understanding.

It is also important to make clear that for most of the questions there may not be a single correct answer, as individual choices may vary depending on particular circumstances.

Activity: Choose and take action

Step 1: The buzz exercise (30 minutes)
1. You will need an even number of participants for this exercise.
2. Ask participants to sit in two rows of five, facing each other. If there are more than 10 participants, set up multiple sets of two rows of five.
3. Give each participant in the first row one of the five Q&A cards. Instruct them to read the question and the multiple-choice answers to the person sitting opposite them.
4. Instruct the person sitting opposite them to choose one answer, and note their choice. After one minute, ask everyone in the respondents’ row to stand up and move one chair to their right. The person who had been at the end of the row now moves to the beginning.
5. Those asking the questions remain in their original chairs. They now put the same question to the respondent newly seated opposite them. This process is repeated until respondents have been asked and replied to all five questions.

Step 2: Sharing and discussion (60 minutes)
6. At the end of the exercise, ask the team with the Q&A cards to display these on the sheet of paper for all to see. Ask one participant to read out the first question and accompanying answers. Ask those in the respondents’ row to share what they chose as their reply and why. Invite general discussion of the choices made. Pay particular attention to areas of contention or disagreement between participants, and to any choices that were excluded by all.
7. Explore what participants believe would be the consequences of the various choices listed for each question. Correct any inaccurate or unrealistic answers. Where relevant, inform participants, with practical details, of the options that are in fact available to MSM, and what are and are not used in practice.
Annex 3: Q&A cards

What do you think MSM might do when they think they may have an STI?
- Nothing
- I do not know
- They go to the pharmacist
- They tell their parents
- They tell a friend
- Other (specify)

An MSM has become infected with an STI and wants to confide in someone. What sort of person would he choose?
- Someone who is trustworthy
- A peer
- A doctor
- Someone who knows how to keep a secret
- Someone from his family
- Someone who is already infected with an STI
- His sexual partner(s)
- Other (specify)

What advice would you give to a young MSM if he became infected with an STI?
- Tell your parents
- Tell a friend
- Tell a mature person who you trust
- Go to the doctor
- I do not know
- Other (specify)

Would a man who is open about his sexual orientation face the same risks as a man who conceals it?
- No, because being open means he can seek advice on protective measures and get prompt treatment for STIs
- No, because he can better deal with cultural and peer expectations to have girlfriends and get married
- Yes, because he will still face the same pressures from society to have girlfriends and get married, and to keep his MSM activities hidden
- Yes, because judgmental health professionals will make it harder for him to access appropriate services
- Other (specify)

What do you think are the reasons why a young man or woman might avoid disclosing that they have an STI?
- Fear
- Shame
- Does not see any risk
- I do not know
- Other (specify)

An MSM has become infected with an STI and wants to confide in someone. What sort of person would he choose?
- Someone who is trustworthy
- A peer
- A doctor
- Someone who knows how to keep a secret
- Someone from his family
- Someone who is already infected with an STI
- His sexual partner(s)
- Other (specify)
Session 3

Time
2 hours 15 minutes

Objective
At the end of this session, participants will be able to:
■ ■ demonstrate the proper use of condoms
■ ■ discuss the explanations people give for not using condoms, and find alternative and convincing arguments to counter these explanations
■ ■ talk about condom-safe lubricants and where they can be purchased from
■ ■ discuss information related to the use of lubricants
■ ■ discuss various other sexual practices apart from anal sex.

You will need
■ ■ Flipchart, large sheets of paper, markers, masking tape
■ ■ Male condoms (one per participant and a few spares)
■ ■ A condom-safe lubricant sachet for each participant (if available) or other condom-safe lubricant
■ ■ Handouts (one copy per participant) of:
  - Annex 4: General information about the male condom
  - Annex 5: How to use the male condom
  - Annex 6: Information about lubricants
  - Annex 7: Excuses and counter-excuses
  - Annex 8: Safer sex without condoms

Safer sex

Overview
This session enables participants to ensure accuracy in their understanding of the variety of safer sex options, and their effectiveness and limitations. It also helps them to develop their skills and confidence in discussing and demonstrating the use of condoms.

Activity: Safer behaviour and the use of condoms and lubricants

Step 1: Presentation on the male condom (30 minutes)
1. Begin by talking about condoms and their use-by date, trying to supply information that may be new and fun for participants. Move on to condom standards available on the market and how to safeguard them until use.

Step 2: Demonstration on the correct use of condoms (30 minutes)
2. Demonstrate condom use involving a mock-up penis (alternatively, the demonstration can be done on a cucumber, a banana or the finger of one of the participants).
3. Remind participants that demonstrations cannot take place in the street, but only in a private home or a Turkish bath/Haman. The important thing is to provide educational material illustrating the use of condoms during the street intervention.

Note: it might be a good idea to explain about the female condom and its use even though it is not widely available in the MENA region. Do what you think is suitable for the situation. And don’t forget that some MSM may also have sex with female partners. Use your judgment, and if need be allow for extra time and resources.

Step 3: Information about lubricants (15 minutes)
4. Ask participants how much they know about condom-safe lubricants and the choices available, and correct any misinformation.
5. Get the group to repeat the demonstration on the use of condoms. Even if they protest that they know how to do this, encourage them to complete the exercise. Explain that the aim is to ensure that they can share this information confidently and simply with their peers.
Step 4: Discussion about excuses (45 minutes)

6. Divide participants into small groups (four to six per group). Give each group a large blank sheet of paper. Ask them to draw a line down the middle of the paper and list on one side all the excuses men give for not using a condom.

7. After 15 minutes, ask each group to pass their paper to the group on their left (ensuring that the last group gives their paper to the first in the chain). Ask them to look at the excuses listed, and on the other half of the paper write an argument against that excuse (15 minutes).

8. Finish by reading out all the excuses and counter-arguments. Correct, add to and modify any as necessary, using the information in Annex 7 (15 minutes).

Step 5: Safer sex without the use of condoms (15 minutes)

9. Explain that some safer sex practices may not involve the use of condoms, but emphasise the importance of effective protection of oneself and one’s partner from an STI.

10. Discuss practices that give pleasure without the use of condoms, and that remove or reduce the risk of infection with HIV or another STI (Annex 8).

11. Explain that some, such as body rubbing, may not be a risk for HIV infection but could carry a risk for STIs that are transmitted from skin to skin; for instance, herpes simplex virus.

12. Remind participants that while condoms provide an effective barrier against HIV during anal or vaginal sex, they do not protect against all STIs.
Annex 4: General information about the male condom

Condoms have been used for centuries. The male condom is a protective sleeve that is worn over the penis. It is available in different sizes, colours and flavours. It is rolled over the penis during penetrative sex, from time of erection until after ejaculation and withdrawal from the partner.

When buying condoms, users should check that they:

- are made of latex or polyurethane
- do not contain nonoxynol material (N9)
- have water-based or silicone-based lubricant (condoms should never be used with oil-based lubricants as they damage the condom)
- are electronically tested and kite marked (ET)
- have an up-to-date expiry or use by date
- are not in display units/shelves that are in direct sunlight, near heaters or in extra-hot areas
- have unopened packaging.

When storing condom before use, do not place in hot places or expose to sunlight.

Annex 5: How to use the male condom

1. Open the condom wrapper using the easy-tear edges.
   - Open the foil with your fingers – don’t use scissors, teeth or any other sharp instrument.

2. Squeeze out the air bubble when opening and put it on covering the whole of the fully erect penis. You can use a water- or silicone-based lubricant on the outside – but no creams, oils or petroleum-based lubricant – to help with penetration.

3. Immediately after ejaculation, withdraw the penis, making sure the condom does not slip off during withdrawal. Then remove the condom, tying it up and disposing of it in the bin. Condoms must only be used once.

Don’t use two condoms at the same time.
Annex 6: Information about lubricants

A lubricant is a water- or silicone-based liquid that is spread over the male condom to help with penetration during sex and add pleasure to the experience. It also reduces the risk of anal tears or pain to the person being penetrated.

Lubricants have a use-by date and should be always water or silicone based and never oil or petroleum based, which includes Vaseline. Lubricants do not kill sperm.

Annex 7: Excuses and counter-excuses

<table>
<thead>
<tr>
<th>EXCUSES FOR NOT WANTING TO USE A CONDOM</th>
<th>COUNTER-EXCUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t have any STIs so why should I use a condom?</td>
<td>There are no external signs of HIV infection, and some other STIs may likewise not always have evident symptoms. Using a condom will protect you and your partner. You can’t tell by looking whether you or your partner has any infection that can be passed through sex.</td>
</tr>
<tr>
<td>Using a condom reduces sexual pleasure</td>
<td>For some people, using a condom does reduce some sexual pleasure a little but for others not at all. Some people like using condoms as they reduce some sensation and therefore they can last longer before ejaculating/reaching orgasm. You and your partner can also attain sexual pleasure in other ways during sex. Compare the consequences of being HIV infected for life because of not using a condom with the slight change in sexual experience brought by using a condom.</td>
</tr>
<tr>
<td>I lose my erection when I use a condom</td>
<td>Some people do lose their erection when first trying to use condoms but that does not mean that this will always happen. It is a very good idea to get used to using condoms alone before being in a situation where you have to use them with a sexual partner. Getting used to masturbating and coming (ejaculating) while wearing a condom can help prepare you for the time when you will wear a condom with a sexual partner. If you have a persistent problem maintaining an erection with a condom, seek medical assistance. The problem might be physiological or psychological and nothing to do with the use of the condom.</td>
</tr>
<tr>
<td>I know my partner very well and therefore I don’t need to use a condom</td>
<td>You cannot tell whether a person is infected merely by looking at them. The condom is the most effective protective measure.</td>
</tr>
<tr>
<td>Using a condom is against my religious beliefs</td>
<td>All religions ask us to respect life: our own and that of others. When condoms are used to reduce the risk of HIV infection, they are being used to protect life and not prevent life (i.e. as a contraceptive). The latter is the reason why some religious leaders condemn condom use. You need to distinguish between protecting and preventing.</td>
</tr>
<tr>
<td>Condoms are not always available</td>
<td>Get into the habit of carrying a condom if you wish to protect yourself whenever you are sexually active. There is always the chance of having sex when you go out, so be prepared.</td>
</tr>
</tbody>
</table>
Annex 8: Safer sex without condoms

Not all sex involves penetration, and it is possible to come (have an orgasm) without penetration and reduce the risk of HIV/STI transmission. Some possible sexual practices include:

- Masturbation
- Mutual masturbation
- Erotic massage
- Sharing sexual fantasies and erotic play
- Using sex toys like vibrators and butt plugs – but it is important not to share them, or to cover them with a condom if they are shared
- Phone sex
- Cam-to-cam communication online, which could include sex chat
- Body-to-body rubbing
Session 4

Identifying the components of outreach interventions

Overview

This session prepares the ground for talking about interventions in practice in outreach work, and what can and cannot be done.

The exercise below may elicit comments that seem judgmental or prejudiced. You will need to remind participants of the ground rules for these workshops, and be prepared to challenge and discuss any unacceptable behaviours or positions.

Encourage active participation and constructive criticism.

Activity: The what, why and how of intervention initiatives

Step 1: Brief presentation on outreach work (10 minutes)

1. Give a presentation to the large group on the function of outreach work and the role of peer educators (Annex 11).

Step 2: Group work and presentations to the large group (1 hour)

2. Divide participants into three groups. Give each group one of the three case studies and discussion questions (one copy for each participant). Also give each group a large sheet of paper. Ask them to write “Case study 1” (or 2 or 3) as a heading for the page.

3. Ask them to draw a table with four columns, one for each question, with titles as provided in Annex 11. Ask them to discuss the questions listed under their case study and then complete the table with the key points identified for each question/heading (45 minutes).

4. Ask each group to present its work (15 minutes).

Step 3: Q&A (20 minutes)

5. Discuss what has been presented and elaborate as needed. Use Annex 11 to supplement points presented and stimulate discussion. Explain that the examples in the Annex 11 handouts to be distributed later are not definitive or comprehensive, but are simply there to help discussion. Round up with a general discussion and Q&As raised by the case studies.
Annex 9: Outreach and peer education

The outreach programme enables field workers to:
- identify the features of target groups (risk behaviours, knowledge, skills, services available)
- build trust with the target group and help them to open up, and start suggesting project ideas that suit their circumstances
- understand the stages of behaviour change they are going through
- help in reducing harmful behaviours and their impact, both on those involved and on community members
- provide support and refer them to the various local counselling, education and skills development services that can support their efforts to change their risk behaviours
- make available appropriate resources to address STIs
- mobilise the wider local community and raise their awareness of the various issues identified in working with MSM.

During outreach, the peer educator will:
- provide information tailored to the needs of the MSM they meet (whether gay, transsexual, heterosexual identified etc.), and in particular, information about reducing risk from HIV and other STIs, and drug use
- discuss potential risk behaviours and particular needs of the target groups
- distribute risk reduction resources – male condoms and lubricants, information flyers, hotline numbers and details of other support services.

It is also important to assess the intervention and write a report for future follow-up.

This initial approach relies on the peer educator’s knowledge about HIV prevention, STIs, drugs and reduction of risk behaviour, and their ability to communicate effectively with the target group. Understanding the behaviour change stages is important, as is the ability to match the specific stages with provision of appropriate guidance and support for risk reduction.
Case study 1

Farid is the younger brother of Wissam, a friend of yours. You grew up in the same neighbourhood and went to the same school. Farid is very handsome and has always enjoyed the company of girls more than boys. The boys used to bully him, which you associate with the fact that he was very handsome and did not enjoy boy’s games, preferring art, dancing and less boisterous activities.

Wissam comes to you one day to ask for help. He has seen gay pornographic magazines (a gift from a western friend) in his brother’s room, and two months ago his mother discovered a letter Farid had written to a friend, his first love, who has left him. His mother was outraged and told Wissam’s father. As a result, his father banned him from returning home before seeing a psychologist, labelling him a “handicap” and gay who has brought shame to the family. Farid has moved in with a friend of his.

Wissam is worried about his brother and has come to you because he knows you work for an association that deals with these issues. He explains that their father has stopped giving Farid money and that Farid’s friend, who is a sex worker, is covering all household expenses. He would like you to talk to Farid: to try to steer him away from same-sex relationships, and from using sex work as a source of income.

He tells you that Farid frequents a place that you and your colleagues visit in your outreach programme.

Case study 2

Toufik, an 18-year-old friend of your younger brother, approaches you. You have noticed that lately he’s been taking extra care of his looks, and the way he dresses looks strange: he chooses very tight and revealing clothes. You have also noticed that he’s been attracted to a young guy and you heard him say that he is planning a holiday in the company of this guy and other friends.

You wonder how he can afford new clothes. He claims he gets generous tips from working in a café.

A few weeks ago, you noticed something different: he isn’t eating much, he keeps to himself, and he has become “edgy”. Although he has been distant from you, today he approaches you and asks for help.

Case study 3

Ramy was a handsome guy who was only attracted to men. As the oldest son, he became the sole breadwinner from a young age when his father passed away. He continues to support the family financially, especially his younger siblings, by working at a laundromat owned by Abu Walid, who has a reputation for harassing young males.

Ramy has always looked effeminate and everyone refers to him as a girl. Five years ago, he left town and had sex reassignment surgery. By coincidence, you see her in a place frequented by MSM where you carry out your intervention and awareness campaigns. You immediately recognise each other and she confides in you that she is worried she has contracted HIV from her HIV-positive sexual partner of one year. She does not know what to do. Although she wants to be tested, she is afraid people will find out. She feels this is the love of her life and she plans to travel with him overseas. This is her only chance in life and she wants to raise $5,000 for this trip.
## Annex 11: Answers to the questions in the case studies

<table>
<thead>
<tr>
<th>CASE STUDIES</th>
<th>RISK BEHAVIOURS AND RELATED FACTORS</th>
<th>WHAT INTERVENTION AND WHY? BEHAVIOURS TO PICK UP ON</th>
<th>EDUCATION AND ADVICE</th>
<th>SKILLS AND INCENTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case study 1</strong></td>
<td>His father did not accept his sexual orientation</td>
<td>Discuss his present situation and the choices he is making or forced to make. He may have started engaging in commercial sex and be exposed to STIs</td>
<td>He needs to use the male condom as a sex worker</td>
<td>Practise negotiating the use of condoms with client</td>
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<tr>
<td></td>
<td>Leaving home</td>
<td>Introduce the condom and correct use</td>
<td>Correct false beliefs related to refusal to use a condom</td>
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<tr>
<td></td>
<td>He is broke and lives with a sex worker</td>
<td>Encourage him to get tested for HIV</td>
<td>Focus on the benefits of protection and risk reduction strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>He is threatened by his family</td>
<td>Explore possibilities of family reconciliation and education</td>
<td>He needs to protect himself if he wants to engage in sex work</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer to the nearest centre for HIV testing and counselling</td>
<td>Explore alternative earning options if he wants to consider this</td>
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<tr>
<td></td>
<td></td>
<td>Provide condoms</td>
<td>Refer to local associations (if any) to find paid work</td>
<td></td>
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<tr>
<td><strong>Case study 2</strong></td>
<td>He has an STI, is a sex worker, and may not be protecting himself and his clients by using condoms during high-risk sexual encounters. This is further challenged by his psychological state</td>
<td>Awareness about STIs and the importance of self-protection</td>
<td>Show him the benefits of seeking medical assistance</td>
<td></td>
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<tr>
<td></td>
<td>Going through a tough time and facing identity issues alone</td>
<td>Provide psychological support</td>
<td>Support him to develop a SMART risk reduction strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is engaged in sex work and is infected with an STI</td>
<td>Refer him to a specialised association for the necessary tests</td>
<td>Information on wider sexual health services and resources</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td>His health is important and he needs to look after himself</td>
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</tbody>
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Annex 11: Answers to the questions in the case studies

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<tr>
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<tbody>
<tr>
<td>Case study 3</td>
<td>She may have HIV. She needs money, which is pushing her to engage in sex work</td>
<td>Information on the importance of early testing for HIV</td>
<td>Negotiating the use of condoms</td>
<td>Her health is more important than others finding out about her situation. Discuss what she could disclose to whom, and what support she would need</td>
</tr>
<tr>
<td></td>
<td>Her lifestyle may expose her to harm</td>
<td>The link between the risk behaviour (in this case of STIs) and its impact on herself and her sexual partners</td>
<td>Convincing message on the importance of having the necessary tests</td>
<td>Trusting you and confiding in you. Even if she needs money, she must first look after herself. Finding out about her health condition at an early stage is better than ignoring it and others finding out. She needs to find out in order to decide whether or not she can travel</td>
</tr>
</tbody>
</table>
Session 5

Time
3 hours 20 minutes

Objectives
At the end of this session, participants will be able to:
- understand the communication cycle and its components
- test their abilities to communicate information effectively about the prevention of HIV and other STIs
- find out what helps and what hinders the communication process for the prevention of HIV and other STIs
- assess verbal and non-verbal communication skills and their use in their outreach work
- listen effectively to beneficiaries in the street.

You will need
- Large sheets of paper, markers, masking tape
- Diagram of the communication cycle on a large sheet of paper
- Handouts (one per participant) of:
  - Annex 12: Introduction to the communication process
  - Annex 13: The communication cycle and its components
  - Annex 14: What helps and what hinders effective communication
  - Annex 15: Tips on effective communication and listening skills

Communication skills

Overview
This session allows participants to strengthen their communication and listening skills, and develop their ability to discuss sensitive topics. They will evaluate these skills with the facilitator, analyse case studies and use role play.

The session is divided into two parts:
- Part 1. Communication and its components and testing our communication skills (2 hours)
- Part 2. Listening skills (1 hour 20 minutes).

As a facilitator, you need to:
- encourage everyone to participate
- set rules to encourage constructive criticism
- encourage participants to use their own experiences of not being listened to and how that made them feel.

The exercises in this session will help you to assess how much the participants know about HIV and other STIs. Focus on communication rather than correction. Make a note of any lack of knowledge and revisit this in future sessions.

Activity: Part 1. Communication and its components and testing our communication skills

Step 1: Brainstorming and presenting illustrations (30 minutes)
1. Present the communication process and the different types of communication (Annex 12).
2. Explain the components of the communication process and the communication cycle (Annex 13).
3. Present and discuss the factors that help and hinder effective communication (Annex 14).

Step 2: Group exercise (30 minutes)
4. Divide participants into five groups and give each group one topic from the list below.
5. Ask one person in each group to play the role of peer educator and another that of the client. Instruct the remaining members of each group to act as observers, noting down what helps and what hinders the communication process. Emphasise that they DO NOT interfere, make comments or otherwise show any reactions.

The topics
- What is HIV and how does it affect the immune system?
- How is HIV transmitted and what are the prevention methods?
■ What are STIs? What are their symptoms and complications?
■ How can we prevent STIs?
■ When choosing condoms, what do you check, watch out for, and what is the correct way to use them?

Step 3: Feedback and discussion (1 hour)

6. Give each group a large sheet of paper. Ask the observers to draw a line down the middle and head one side “What helps?” and the other side “What hinders?” Ask the observers in each group to discuss the helps and hindrances they have noted during the role play and to list these on their large sheet. The two people who have role played should not participate in this part of the exercise.

7. When the observers have completed their lists on the large sheets, invite the “peer educators” and the “clients” to give their feedback on the comments, assuring them that the points are not a personalised criticism of their performance. Defuse any tendencies to defensiveness or accusations/negative criticism. Ask the “peer educators” and the “clients” to share how they felt playing their roles. Close by summarising what helps and hinders the communication process, emphasising the characteristics of the message, the messenger and the receiver (Annex 14).

Part 2. Listening skills

Step 1: Partner exercise (15 minutes)

8. Ask participants to pair up and to tell their partner about an important event/incident that happened to them in the previous week. The listening partner should listen carefully. Reverse the roles and repeat the exercise.

9. Repeat the full exercise again, with partners taking turns to tell and to listen. Instruct the listening partner not to pay attention this time around.

Step 2: Discussion and summary (35 minutes)

10. Ask participants to describe their feelings when they felt listened to and then when they were not listened to. Ask participants to share what they felt helped them to listen to their partner’s story and what hindered. Summarise the main feelings that emerged and the key helps and hindrances.

Step 3: Presentation (30 minutes)

11. Present and discuss the factors that enhance effective communication and listening (Annex 15).
Annex 12: Introduction to the communication process

Communication is a basic human need and a two-way process, which includes:

- understanding the thoughts and feelings expressed by others
- responding in a helpful and beneficial way.

There are three types of communication: verbal (words and terms), non-verbal (silence, dress style, tone of voice, facial expressions and body language) and written (letters, books, stories, etc.). By learning to use communication effectively, we can achieve certain outcomes. For example, by successfully relaying information on health education, we can influence healthier behaviour in the target group.

Annex 13: The communication cycle and its components

The sender chooses a target for communication, prepares their message and sends it via a particular channel. The receiver attempts to understand it and then responds to it. At this point, the receiver becomes the sender, expressing what they understand from the message (feedback). When the original sender receives this feedback, they become the receiver and can assess whether they successfully conveyed their original message. This goes on, back and forth (see the diagram below).
Annex 14: What helps and what hinders effective communication

<table>
<thead>
<tr>
<th></th>
<th>WHAT HELPS</th>
<th>WHAT HINDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The sender</strong></td>
<td>■ No preconceived judgments</td>
<td>■ Bias caused by different perceptions: cultural, social, religious and sexual</td>
</tr>
<tr>
<td></td>
<td>■ Good listener</td>
<td>■ Insufficient knowledge of subject matter</td>
</tr>
<tr>
<td></td>
<td>■ Able to discuss the topic in a positive way</td>
<td>■ Weakness in communication skills (voice, presence, supporting audio/visual materials)</td>
</tr>
<tr>
<td></td>
<td>■ Good knowledge of the subject matter</td>
<td>■ Lack of good listening skills</td>
</tr>
<tr>
<td></td>
<td>■ Patience and a balanced approach</td>
<td>■ Lack of self-confidence</td>
</tr>
<tr>
<td></td>
<td>■ Self-confidence</td>
<td>■ Prejudice or negative attitude towards the subject and/or the target group</td>
</tr>
<tr>
<td></td>
<td>■ Trusted by the receiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Engages the receiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Able to convince</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Good listening skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Ability to control expressions, feelings, body language and tone of voice</td>
<td></td>
</tr>
<tr>
<td><strong>The message</strong></td>
<td>■ Scientifically proven, clear and consistent</td>
<td>■ Sensitivity or taboos related to the message prevent clarity</td>
</tr>
<tr>
<td>(contents)</td>
<td>■ Acceptable by and appropriate for the target (respects culture, educational and financial status)</td>
<td>■ Does not relate to the target group</td>
</tr>
<tr>
<td></td>
<td>■ Realistic (timing, effort and resources)</td>
<td>■ Does not take into consideration the way of life and attitudes of target group</td>
</tr>
<tr>
<td></td>
<td>■ Addresses a need by the target group (the receiver)</td>
<td>■ Unrealistic and unachievable</td>
</tr>
<tr>
<td></td>
<td>■ Makes use of all the senses</td>
<td>■ Ambiguous</td>
</tr>
<tr>
<td><strong>The channel,</strong></td>
<td>■ Connects emotionally</td>
<td>■ Gives conflicting information</td>
</tr>
<tr>
<td><strong>visual and</strong></td>
<td>■ Scientific and logical</td>
<td></td>
</tr>
<tr>
<td><strong>audio methods</strong></td>
<td>■ Appropriate and varied: music, spoken word, poems, pictures, models</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Matches the skills of the receiver (language, literacy etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>Receiver/ beneficiary</strong></td>
<td>■ Interested in the topic</td>
<td>■ Inappropriate for target audience</td>
</tr>
<tr>
<td><strong>target group</strong></td>
<td>■ Is willing to participate</td>
<td>■ Does not respect local customs, traditions and culture</td>
</tr>
<tr>
<td></td>
<td>■ Open-minded and receptive</td>
<td>■ Not available</td>
</tr>
<tr>
<td></td>
<td>■ Trusts the sender</td>
<td>■ Unclear/ambiguous</td>
</tr>
<tr>
<td></td>
<td>■ Can understand the sender’s message</td>
<td>■ Undiversified (does not use all senses)</td>
</tr>
<tr>
<td><strong>Time/location</strong></td>
<td>■ Timing and location of communication suits the receiver</td>
<td>■ Limited ability to understand the message as intended by the sender</td>
</tr>
<tr>
<td><strong>(external influencing</strong></td>
<td>■ Location is safe and accessible</td>
<td>■ Negative attitude towards the sender (lack of confidence/trust, previous negative experience)</td>
</tr>
<tr>
<td><strong>factors)</strong></td>
<td>■ Location is comfortable for sender and receiver (e.g. seating, heating, hygiene etc.)</td>
<td>■ Thinks they know it all</td>
</tr>
<tr>
<td></td>
<td>■ Inappropriate timing by the sender</td>
<td>■ Believes the message is not useful</td>
</tr>
<tr>
<td></td>
<td>■ Inappropriate choice of location</td>
<td>■ Believes the message is not relevant</td>
</tr>
<tr>
<td></td>
<td>■ Bad sound</td>
<td>■ Has predetermined positions towards change</td>
</tr>
<tr>
<td></td>
<td>■ Bad lighting</td>
<td>■ Friction within a target group</td>
</tr>
<tr>
<td></td>
<td>■ Publicity of event causes local hostility</td>
<td>■ Use of stimulants</td>
</tr>
</tbody>
</table>
Annex 15: Tips on effective communication and listening skills

<table>
<thead>
<tr>
<th>Planning</th>
<th>TIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identify your target audience</td>
</tr>
<tr>
<td></td>
<td>Determine the objective of your message</td>
</tr>
<tr>
<td></td>
<td>Create your message</td>
</tr>
<tr>
<td></td>
<td>Pilot test it before agreeing final version</td>
</tr>
<tr>
<td></td>
<td>Choose an appropriate delivery method</td>
</tr>
<tr>
<td></td>
<td>Identify the evaluation criteria of the message</td>
</tr>
<tr>
<td></td>
<td>Evaluate the communication process</td>
</tr>
<tr>
<td></td>
<td>Choose a good time/location: no background noise, good lighting, etc.</td>
</tr>
<tr>
<td></td>
<td>Evaluate prior and post communication</td>
</tr>
<tr>
<td></td>
<td>Planning - Identify your target audience</td>
</tr>
<tr>
<td></td>
<td>Planning - Determine the objective of your message</td>
</tr>
<tr>
<td></td>
<td>Planning - Create your message</td>
</tr>
<tr>
<td></td>
<td>Planning - Pilot test it before agreeing final version</td>
</tr>
<tr>
<td></td>
<td>Planning - Choose an appropriate delivery method</td>
</tr>
<tr>
<td></td>
<td>Planning - Identify the evaluation criteria of the message</td>
</tr>
<tr>
<td></td>
<td>Planning - Evaluate the communication process</td>
</tr>
<tr>
<td></td>
<td>Planning - Choose a good time/location: no background noise, good lighting, etc.</td>
</tr>
<tr>
<td></td>
<td>Planning - Evaluate prior and post communication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving verbal communication</th>
<th>TIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving verbal communication</td>
<td>Use simple language and rephrase where needed</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Clear explanation using illustrations and examples</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Address the receiver to suit their character</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Reduce stress</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Avoid criticising others</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Motivate, avoid giving advice, use persuasive messages that encourage and help the person to believe they can change</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Avoid bargaining or blaming</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Ask open-ended questions to help guide the discussion</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Summarise the conversation from time to time, ensure the flow of the discussion and check that you have understood correctly</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Speak clearly</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Encourage conversation with responses such as “Yes, carry on…”, “What happened after that?” and “Yes, but…”</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Do not coerce or otherwise pressurise the receiver to engage in the communication, to disclose what they do not wish to disclose, or to commit to an action</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Remember that conversations are only beneficial with willing participants</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Use the following techniques:</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Paraphrase</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Use complete sentences and messages</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Repeat back information from the receiver; e.g. &quot;I understand you are afraid of your partner's reaction when he finds out you are infected&quot;</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Clarification – keep the communication clear, lay out the facts and clear up misconceptions</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Repetition – repeat the sentence and the message, and make sure the receiver has understood</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Summary – on completion of one stage of the conversation, summarise what was said. This confirms mutual understanding and helps to focus on important points and major decisions reached</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Focus – helps to centre the conversation and focus on what is relevant</td>
</tr>
<tr>
<td>Improving verbal communication</td>
<td>Connectivity – link ideas, behaviour and culture to incidents to better understand the “problem”; e.g. &quot;Do you notice that when you avoid talking with your family they get upset with you?&quot;</td>
</tr>
</tbody>
</table>
## Annex 15: Tips on effective communication and listening skills

### Improving non-verbal communication
- Use body language that is empathetic but without giving the receiver ambiguous signals of affection
- Communicate at the same level (sit if they sit, stand if they stand)
- Don’t sit too far away from the receiver
- Avoid sarcasm
- Don’t yawn or show that you are bored
- Make eye contact
- Use a moderate tone of voice
- Avoid gestures or facial expressions of disapproval or judgment

### Feedback
- Constructive and not based on preconceptions
- Clear and accurate; reflects a realistic, objective and transparent process

### Improving listening skills or positive listening

<table>
<thead>
<tr>
<th>DO</th>
<th>DON’T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make eye contact</td>
<td>Allow yourself to be preoccupied with personal issues</td>
</tr>
<tr>
<td>Pay attention to what is being said and what is not – verbal and non-verbal communication</td>
<td>Allow terms or language they use to make you react and lose focus otherwise you will stop listening and shift your attention</td>
</tr>
<tr>
<td>Treat the receiver as a worthy human being; give feedback</td>
<td>Listen without paying attention, look at the sender without hearing what is being said or get absorbed in your own thoughts</td>
</tr>
<tr>
<td>Listen to terms and words used</td>
<td></td>
</tr>
<tr>
<td>Note helpful and important facts</td>
<td></td>
</tr>
<tr>
<td>Only form your opinion after listening to everything</td>
<td></td>
</tr>
<tr>
<td>Widen your vocabulary to increase comprehension skills</td>
<td></td>
</tr>
<tr>
<td>Avoid arguing with the sender</td>
<td></td>
</tr>
<tr>
<td>Be attentive/don’t generalise</td>
<td></td>
</tr>
<tr>
<td>Avoid prejudices/personal biases</td>
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</tr>
</tbody>
</table>
Communication during outreach

Overview

This session explores concerns that participants may have about their ability to communicate during outreach work, and any inclinations to compare themselves and their abilities unfavourably with others in the group. The session is not about the practical challenges and risks they face in outreach work but about dealing with barriers to communication that they may experience.

Activity: Identifying and addressing communication challenges

Step 1: Brainstorming (15 minutes)

1. Ask participants to brainstorm all potential communication barriers encountered during outreach work, whether by themselves or by others in their programme. Clarify that this is not about the practical challenges and risks they face in outreach work but about dealing with barriers to communication that they or others may experience.

2. List on the flipchart the key words for each barrier named. Add any barriers not mentioned that you consider should be included in further work in this session.

Step 2: Discussions in pairs (15 minutes)

3. Ask participants to work in pairs. If some have already been doing outreach work, ask them to pair up with newer recruits. Allocate one or more of the barriers listed on the flipchart to each pair until all are distributed. Ask each pair to discuss the barriers allocated and propose ways of overcoming these, either drawing on their own or others’ experiences or from suggestions that occur to them. Ask them to write their answers on A4 or similar papers supplied in two columns (Annex 16). Draw an example on flipchart paper to demonstrate.

Step 3: Summary (30 minutes)

4. Ask each pair to stick their pages onto the wall panels. Ask participants to circulate and read all of the pages (10 minutes). Invite comments, queries, additions or corrections, and wider discussion. Note all additions and corrections agreed during discussions. Tell participants that Annex 16 for this session will be expanded to include the points agreed.

You will need

- Flipchart, large sheets of paper stuck to walls/boards (wall panels), masking tape, A4 or notebook-sized sheets of paper and pens – one per participant
- Handouts (one per participant) of:
  - Annex 16: Communication barriers in outreach work (this handout will be completed after the workshop with additional material agreed by participants)

Objectives

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

- identify communication barriers to undertaking outreach work and know how to overcome them
- feel confident about their own skills and ability to communicate.

Time

1 hour

Session 6
Annex 16: Communication barriers in outreach work

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>WAYS TO OVERCOME THEM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Difficulties in building trust between peer educators and beneficiaries</strong></td>
<td>Allow time simply for developing a relationship with the client in order to gradually build his trust and engage his interest. Then focus on the objective of your communication.</td>
</tr>
<tr>
<td><strong>The street environment – noisy, no privacy, judgmental looks and interruptions</strong></td>
<td>Be attentive to who may be able to hear your conversation. Stay focused and objective, and avoid taking things personally when others appear to be judgmental.</td>
</tr>
<tr>
<td><strong>Time limit</strong></td>
<td>Communicating in the street is usually time restricted, so give as much appropriate information as possible to peers within that time.</td>
</tr>
<tr>
<td><strong>Nature of the topics and awareness material distributed – raising awareness about and discussing prevention of HIV and other STIs can be complex and often sensitive. The peer educator sometimes needs to ask personal questions, especially when it comes to prevention</strong></td>
<td>Listen carefully to the client’s verbal and non-verbal messages. Note their degree of comfort with the conversation, the time taken and the location. Introduce the awareness and prevention topics gradually as part of a wider conversation, without forcing them on the beneficiary. When giving information, education and communication material, ensure that both you and the recipient handle this discreetly.</td>
</tr>
</tbody>
</table>
Life skills

Overview
In this session, participants will develop decision-making and negotiating skills that can serve them in their everyday lives as well as in work. On a practical level, these skills may help to deal with problems such as harassment, violence, cynicism or unruly behaviour.

Skills learnt in this session are also important for participants’ outreach work and can be applied when dealing with clients in the street, helping them to sustain their chosen risk reduction strategies and to resist peer pressure to revert to risky behaviours.

Activity: Decision-making, negotiating and giving a clear message

Step 1: Pair work (20 minutes)

1. Remind participants of the characteristics of a peer educator, as discussed in Session 4. These include an ability to negotiate, make decisions, confront peer pressure and challenges from peers, and avoid violence.

2. Ask participants to work in pairs. Distribute the case studies, allocating one of the three to each pair – perhaps by numbering the pairs off sequentially. Ask each pair to apply the questions below to their allocated case study and to discuss their responses. Ask them to record these on their A4 or notebook pages supplied.

   - How will you face the challenges presented in this case study without getting into trouble?
   - How will you intervene to come up with the behaviour that is least provocative and least dangerous for yourself and for the programme?
   - What will your decision be, and how will you counteract any pressures from peers or any provocative comments?

Case studies

A. The beneficiary starts harassing you while you are conducting a peer education session with him in the street. His friends join in, and deride the information you are giving and mock you.

B. During your peer education session, an old friend (with whom you had a sexual relationship) comes along and starts hassling/jerking at you. He asks you to join him for a drink and promises to listen to what you have to say after you join him and his friends.

C. During your peer education session, you are approached by the leader of your target group, who starts asking questions about you and the project. He wants to introduce you to his friends, providing you meet him straight after the session. He puts his arms around you, trying to seduce you.
Step 2: Presentation of the pair work (45 minutes)

3. Ask all the pairs who were working on the same case study to form a single group. Give each group a large sheet of blank paper (with the option for more if they need it) and a marker. Ask the group to share their answers to each question for the particular case study they were considering, and to decide on those they want to put forward. Ask them to write the questions, along with one or two sentences for each of their agreed responses, on the large sheets of paper.

4. Ask them to write the identifying letter of the case study on their completed sheets of paper and to put these up as wall panels. Invite groups to read the wall panels for the two case studies they have not considered. Check if there are any questions or clarifications needed for any of the wall panels.

Step 3: Presentation on decision-making stages (15 minutes)

5. Present and discuss the decision-making stages (Annex 17). Distribute the A4 copies of this to participants. Explain how understanding and applying these stages can help peer educators to react more swiftly and effectively to a threatening or problematic situation.

Step 4: First role play (20 minutes)

6. Ask one group to volunteer for the role play. Choose a case they have already analysed in Step 1 and ask them to perform it as if they were in the street.

7. Ask the group to choose one member to play the role of the peer educator and another to play the role of any other leading character in the case study. Ask the other group members to play the role of the group of beneficiaries in the street.

8. Ask all other participants to act as observers, comparing the actions and reactions with the decision-making stages of Annex 17.

Step 5: Discussion (30 minutes)

9. At the end of the role play, ask the players to share to what extent they were able to apply the decision-making stages. Ask the observers to share to what extent they saw the stages being implemented.

10. Have a general discussion on the usefulness or otherwise of the decision stages and on the ease/difficulty in applying them.

Step 6: Presentation on behaviour types (15 minutes)

11. Recap the key pressures applied by peers in each of the case studies: provocation, attempted seduction, harassment, mockery, being asked to participate in risk behaviour, etc. Give a short presentation on the different types of behaviour: indifferent/passive, assertive and aggressive (Annex 18).
Step 7: Presentation on assertive behaviour, and second role play (45 minutes)

12. Distribute copies of Annex 19 to participants. Present the components of assertive behaviour and of communicating assertively.

13. Choose another group to role play the case they have discussed in Steps 1 and 2. Ask the group to choose one member to play the role of the peer educator and another to play the role of any other leading character in the case study. Instruct the peer educator to apply the steps for communicating assertively.

14. Ask the other group members to play the role of the group of beneficiaries in the street.

15. Ask all other participants to act as observers, comparing the actions and reactions with the steps for communicating assertively set out in Annex 19.

Step 8: Discussion (20 minutes)

16. At the end of the role play, ask the “players” to share to what extent they were able to apply the steps for communicating assertively. Ask the observers to share to what extent they saw the steps being applied.

17. Have a general discussion on the usefulness or otherwise of the steps for assertive communication and on the ease/difficulty in applying them.

18. Recap the main points involved in delivering a message assertively.
Annex 17: Stages in the decision-making process

<table>
<thead>
<tr>
<th>STAGE</th>
<th>EXAMPLES TAKEN FROM THE CASE STUDIES</th>
</tr>
</thead>
</table>
| Identify the problem | Peer pressure  
| | Provocative friends wanting me to engage in risk behaviour  
| | Being jeered at and propositioned by a former sexual partner while working  
| | Harassment or ridicule  
| | Lack of focus/not taking the awareness session seriously |
| Establish my goal(s) | Ask: what do I want to achieve with this particular piece of work? Responses could be to:  
| | carry out the awareness session with the peer and get the disruptive person to listen, lessening his provocative behaviour  
| | gain this person's cooperation without negatively affecting the opinion of the others  
| | act professionally and avoid being drawn into behaviours at odds with my peer educator role |
| Identify and consider the multiple choices available to me | Proceed and carry out my work in the street  
| | Refuse to carry on and leave  
| | Postpone the meeting with the peer for another time |
| Consider any advantages and disadvantages of each possible choice | Proceed  
| | I proceed and carry out my work in the street  
| | I contribute to raising awareness about HIV prevention  
| | I face challenges and do not take advantage of my position  
| | I respect my role and my profession  
| | I am committed to my work |
| Leave | I avoid problems  
| | I risk losing my job, which I love  
| | I accept being harassed  
| | Postpone  
| | I gain time to improve my skills  
| | I pull out temporarily |
| Remind myself of my personal values regarding my work | I respect my role and my profession  
| | I face challenges and do not take advantage of my position  
| | I am committed to my work |
| Make the decision | Face the challenges and implement the process as planned |
| Carry out the decision | I inform the source of the problem and my decision, and continue with my work |
Annex 18: Dealing with peer pressure

Any peer educator will experience pressures and challenges when dealing with same-sex or heterosexual relationships, and risk behaviours. They may not want to lose their friendship or relationship with others, but they must also act professionally. So it’s important to learn how to deal with someone trying to distract them or to convince them to do something they do not want to do.

It takes courage and determination to build self-confidence and retain the respect of peers. Peer educators should also discuss these kind of challenges with clients and offer guidance on how to overcome them. Not dealing firmly with them may give rise to new challenges (such as being exposed to HIV and other STIs).

<table>
<thead>
<tr>
<th>PERSONALITY TYPE</th>
<th>CHARACTERISTICS</th>
<th>FEELINGS/DISPOSITION</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indifferent/ passive</td>
<td>Does not take a stand to protect their rights</td>
<td>Powerless</td>
<td>Does not get what they want</td>
</tr>
<tr>
<td></td>
<td>Puts others first</td>
<td>Resentful</td>
<td>Not taken seriously by others</td>
</tr>
<tr>
<td></td>
<td>Gives in to others</td>
<td>Disappointed</td>
<td>Others expect them to bow to their demands</td>
</tr>
<tr>
<td></td>
<td>Allows others to make decisions for them/goes with the flow/demonstrates little sense of their own opinions or values</td>
<td>Worried and passive</td>
<td>Is exploited by others</td>
</tr>
<tr>
<td></td>
<td>Accepts others’ sarcastic remarks about them</td>
<td>Feels humiliated</td>
<td>Easily angered</td>
</tr>
<tr>
<td></td>
<td>Never takes the initiative</td>
<td>Feels worthless/inadequate</td>
<td>Has a negative self-image</td>
</tr>
<tr>
<td>Assertive</td>
<td>Fights for their rights while respecting those of others</td>
<td>Content</td>
<td>Does not hurt others</td>
</tr>
<tr>
<td></td>
<td>Has self-respect and respects others</td>
<td>Self-confident</td>
<td>Has self-respect</td>
</tr>
<tr>
<td></td>
<td>Is a good listener</td>
<td>In control</td>
<td>Their rights and the rights of others are protected</td>
</tr>
<tr>
<td></td>
<td>Expresses positive and negative feelings</td>
<td>Self-aware</td>
<td>Has a win–win attitude</td>
</tr>
<tr>
<td></td>
<td>Is self-confident</td>
<td>Competent</td>
<td>Takes others seriously</td>
</tr>
<tr>
<td></td>
<td>Is reliable and true to themselves</td>
<td>At peace with self</td>
<td>Is respected by others</td>
</tr>
<tr>
<td>Aggressive</td>
<td>Cares only about their rights</td>
<td>Angry</td>
<td>Domineering</td>
</tr>
<tr>
<td></td>
<td>Cares about themselves at the expense of others</td>
<td>Frustrated</td>
<td>Disrespects others and humiliates them</td>
</tr>
<tr>
<td></td>
<td>Controls others</td>
<td>Bitter</td>
<td>Wins at the expense of others</td>
</tr>
<tr>
<td></td>
<td>Achieves their goals at the expense of others</td>
<td>Ruthless</td>
<td>Others fear but do not respect them</td>
</tr>
<tr>
<td></td>
<td>Goes to any length to retain control and power</td>
<td>Controlling, selfish and ruthless</td>
<td>May cause resentment in others and desire for revenge</td>
</tr>
</tbody>
</table>
Annex 19: The assertive message and resistance

A variety of tactics may be employed by individuals intent on opposing your message and/or whipping up resistance or disruption among their peers. These can include:

- pulling the conversation away from the topic and encouraging others to drift away
- undermining your abilities
- arguing with you, disputing what you are saying
- threatening you verbally or physically
- diverting your audience’s attention to other things going on at the same time that are more fun, more interesting, a more appropriate use of their time, more profitable.

There are some practical steps you can follow in order to counteract this behaviour and communicate an assertive message.

| STEPS | 
|---|---|
| 1 | Clearly explain the problem and how you feel
Examples:
- I don’t like you talking to me this way
- Just because I know you does not mean you can talk to me this way
- Your behaviour is very disruptive and does not help

State clearly what you want to achieve
Always revert to the main topic when someone tries to keep you from delivering your message, distracts you or tries to convince you to do something you do not wish to do.

Examples:
- Please allow me to finish what I have to say. I have completed training on this topic: what I have to say benefits everyone and it would help if you could listen and let others listen too.
- Even if you do not wish to listen, you have no right to prevent others from benefiting from this information.

State your request
Examples:
- I would prefer to...
- I’d like to... Can you...
- Please do not...

Let the other person express their feelings or their opinions about your request.

Ask how the other person feels about your request

Call attention to your request and/or your position

 Reject any attempt to change your position
Examples:
- How do you feel about the information we talked about?
- Is it appropriate for you?
- Would you like a follow-up session?

At this stage, if the other person tries to convince you of the superiority of their own views, be strict and say “No” very clearly. If need be, leave.
Annex 19: The assertive message and resistance

<table>
<thead>
<tr>
<th>STEPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
</tr>
<tr>
<td>■ I am serious about…</td>
</tr>
<tr>
<td>■ Negotiate a deal to reach a win–win outcome (see example below)</td>
</tr>
<tr>
<td>■ Avoid confrontation</td>
</tr>
</tbody>
</table>

If the other person agrees, thank them as this is a good way to end the discussion.

**A graceful thank you**

Examples:
| ■ Thank you! |
| ■ That’s great, I appreciate it |
| ■ I am glad this doesn’t bother you |
| ■ I’m pleased you are willing to help get others involved |

**Options for resisting peer pressure include:**

■ postponing decision-making and giving a firm statement (“We can discuss the subject later”)
■ getting back to the topic (“Let me finish my sentence/please don’t interrupt/I’ve heard you, please hear me”)
■ negotiating a win–win outcome for both parties (“If you want this, I want that in return…”)
■ rejection – a clear and firm “No” (“No. Is my position clear?”).
Session 8

Self-esteem

Overview

Every peer educator needs self-esteem and self-confidence to undertake outreach work. Some participants may be shy or lack self-confidence because of their past experience. This session will help them to understand the importance of the awareness work they do through the programme and to build self-confidence.

Activity: Understanding and improving self-esteem

Step 1: Self-portrait (20 minutes)
1. Ask everyone to draw a named self-portrait on a white sheet of paper and to list three positive and three negative characteristics about themselves. Ask participants to share something of what they have drawn with their neighbour.

Step 2: Presentation on self-esteem (25 minutes)
3. Explain that there is a link between our own and others’ perceptions of our positive and negative characteristics, and our self-esteem. Self-esteem is affected by how others see us and by our own self-image. Sometimes our self-image is harsher than the image others have of us. Challenges tend to affect our self-esteem and our self-confidence (sometimes negatively and sometimes positively), and as a consequence impact on our decision-making ability (Annex 20).

Step 3: Effect of labels on self-esteem (15 minutes)
4. Ask participants to stand in a line with their backs to you. Tell them you are going to put a card which has a single word on it (see suggestions in Annex 21) on their back but they mustn’t try to look at it or look at anyone else’s. Put one card on each person’s back, attaching it to their clothing securely and safely.

5. Ask people to circulate and look at what is on the card on other participants’ backs, but without telling the person what it is. Ask them to react to that person according to what they feel about the word. They can use verbal and non-verbal expressions and gestures to convey their reaction.

6. At the end of the exercise, ask everyone to sit down and remove the card (with help, if needed) from their own back and read it.
Alternative Step 3: Real-life examples (15 minutes)

■ Ask participants to write down real-life examples of challenges, and discuss the importance of this topic and its link to the training workshop.

**Step 4: Sharing and discussion on how labelling affects self-esteem (30 minutes)**

7. Ask participants to describe the different sorts of reactions they encountered (i.e. how others treated them when they saw their card), and to say how that reaction made them feel. Did their reactions match the card? Ask them to say how their card makes them feel about themselves (reminding them that the card is not really about them, but just used for the purposes of this exercise).

8. Invite general discussion on the exercise. Bring out again the link between other’s perceptions of us and our own self-image and our self-esteem, and the link between self-esteem and behaviours, including sexual behaviour. Discuss the stigmatising and disempowering effects of labelling.
Annex 20: Self-esteem and self-confidence

Personal satisfaction comes from actions, behaviour, knowledge, skills and talents, and is expressed through self-respect, self-confidence and self-esteem. People with good self-respect and good self-esteem are usually respectful, open and objective to others, and avoid damaging behaviour, both in their own lives and in the lives of those around them.

You can improve self-respect, self-confidence and self-esteem by:

- listening to others and appreciating what is being said
- admitting that others’ views may be different and yet still of value
- accepting the differences of others – and their different opinions
- gracefully accepting praise from family and friends
- developing a hobby, or particular ability or talent that we have
- avoiding excessive self-criticism when at fault
- listening to constructive criticism from others and discerning what we can learn from this
- remembering that most people feel bad about themselves in some way and that we are all human.

Barriers that impact on self-confidence and self-esteem:

- Comparing oneself with others
- Listening to inner negative voices
- Self-loathing
- Hating others
- Lack of appreciation and praise from others
- Pain, scars and having a difficult life, emotionally or physically, now or in the past
- Negative attitudes towards oneself and others
- Lack of self-care and meeting our needs
- Having problems with others (family, marital, work)
- Inability to make decisions
- Destructive or negative criticism by others

Listening to negative inner voices and behaving in a manner that reduces self-confidence can affect someone’s work on awareness and education as they may cease to find meaning in the work they are doing.
Annex 21: Possible words to write on the labelling cards for Step 3

The following are suggested words you might use for this exercise. You may add others or compile a completely different list that works better for your context and participants.

Dirty and smelly
Rich
Kind
Handsome
Dishonest
Generous
Always angry
Ugly
Bully
Talented
Selfish
Drug-dependent
Poor
Easily led
Vindictive/nasty
Influential
Session 9

Interacting with different personalities in the field

Overview
This session helps participants to learn about different personality types and their characteristic behaviours, and to explore how this understanding can apply to their outreach and peer education work.

Activity: Dealing with different personalities

Step 1: Different personalities and how to deal with them (30 minutes)
1. Divide participants into small groups and give each group a large sheet of paper and marker pen. Ask participants to draw on their paper a table with two columns, the first headed “Personality type” and the second “Behaviour characteristics”.
2. Ask them to think about the various types of personality they may encounter in their outreach work: e.g. the aggressive personality; the one who knows everything; the sarcastic one, etc. Ask them to think about how these people behave, and to record this information in their table.
3. At the end of the exercise, ask groups to display their sheets as wall panels and to look at those of the other groups.

Step 2: Role play allocation and performance (30 minutes)
4. Ask for two volunteers to role play for five minutes. One takes the role of a peer educator discussing with an MSM group the importance of condoms in protecting against HIV and other STIs. Allocate one of the personality types listed in the wall panels to the other role player. Tell the peer educator to undertake their education work and to deal with any reactions they might get from the other person.
5. Ask other participants to act as observers and to think about how the peer educator might handle the behaviours demonstrated by the other person. Ask them to note the personality type and how they would deal with the behaviours.
6. Repeat this role play with four to five different pairs of volunteers, allocating a different personality type from the wall panels for each role play.

Step 3: Discussion and summary (40 minutes)
7. Ask each of those who role played the peer educator to share how they felt when confronted with the behaviour of the other person, and how they tried to deal with this. Ask the observers how they thought they would deal with the situation presented. Thank and applaud everyone who role played a peer educator or a specified personality type.

Step 4: Different personality types and how to deal with them (20 minutes)
8. Give a presentation (Annex 22) with a short discussion for clarification/questions.

Objectives
At the end of this session, participants will be able to:
- analyse the different personality types they may encounter in the field
- recognise their behaviour patterns that they may encounter
- identify measures to deal with them.

You will need
- Large sheets of paper, marker pens, A4 or similar-sized sheets of paper and pens (one per participant)
- Handouts (one per participant) on:
  Annex 22: Different personality types and how to deal with them

Time
2 hours
Annex 22: Different personality types and how to deal with them

The peer educator can be trained to deal with all personality types in the field. However, it is not compulsory for target groups to attend the awareness session in the street, and if some or all of them refuse to listen or participate, they are free to do so.

<table>
<thead>
<tr>
<th>POSSIBLE RESPONSE</th>
<th>BEHAVIOUR CHARACTERISTICS</th>
<th>PERSONALITY TYPES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indifferent</td>
<td>Doesn’t care about what you’re saying (apathetic). Thinks he knows it all and may not listen when you address him as his interest is elsewhere.</td>
<td>Build his trust first. Then get him engaged in the topic of conversation by emphasising the dangers he may face. Alternatively, move away from him and start a conversation with someone else as this may draw his attention and make him want to engage.</td>
</tr>
<tr>
<td>Troublemaker (harasses and provokes you)</td>
<td>He bothers you and wants to joke around while displaying indifference to the topic. This is usually because he wants to avoid the subject and considers it either unimportant or very important. Your interest in your work irritates him.</td>
<td>Stay focused on the topic and ignore his looks and provocations. If the situation escalates, do not engage in a verbal dispute. Excuse yourself and note that you cannot get him to take the matter seriously.</td>
</tr>
<tr>
<td>Criticises you and your work (he may raise his voice and cause a disturbance)</td>
<td>He opposes everything you say and thinks he knows it all. He is not interested in the information you are offering and may harass you.</td>
<td>Ask him to allow you to do your job and tell him that he can leave if he is not interested. If he threatens violence or gets violent, get out of the situation.</td>
</tr>
<tr>
<td>Opinionated</td>
<td>Not convinced by the information you have to offer. He questions its accuracy and thinks he could do better.</td>
<td>Give him accurate information and correct his misconceptions. Offer literature if appropriate. If he persists, ask him to allow others to speak and you to finish the meeting. Thank him for his input and any correct information he provided (i.e. make him feel valued to get him on side). Suggest a chat later to discuss his concerns and the possibility that he may become a peer educator.</td>
</tr>
<tr>
<td>Arrogant and cynical</td>
<td>He believes that what you have to say is not important and that your work is not valuable. He wants to criticise your work and refuses to take awareness and prevention material because he is not interested.</td>
<td>Discuss the programme results with him, show him respect, work at building trust with him and get him to listen.</td>
</tr>
</tbody>
</table>
Session 10

Objectives
At the end of this session, participants will be able to:
• identify the different kinds of stigma and discrimination experienced by the people they work with and their impact on the lives of marginalised people, especially MSM
• recognise how they themselves react to discrimination
• empathise with the experiences of discrimination of those they work with.

You will need
• Flipchart, large sheets of paper, markers, masking tape
• Handouts (one per participant) of: Annex 23: Stigma and discrimination does not help self-acceptance of one’s sexual orientation

Overview
The various exercises in this session address stigma and discrimination. They help participants to explore their own experiences and feelings, and identify and empathise with the stigma that their clients might experience and the feelings this may evoke in them. The concluding part of the session gives some (brief) consideration to the particular stigma attached to homosexuality. It will be important to ensure that this is included, as homophobia can be evident among some peer educators. This is a good opportunity to address these attitudes.

You will need
• Flipchart, large sheets of paper, markers, masking tape
• Handouts (one per participant) of: Annex 23: Stigma and discrimination does not help self-acceptance of one’s sexual orientation

Activity: Part 1. Refusing to harm others

Step 1: Personal reflection and sharing exercise (25 minutes)
1. Ask participants to work in pairs. Ask each participant to take a few minutes to think, in private, of times when they have been discriminated against.
2. Ask each participant to talk about this situation with their partner (10 minutes for each partner) without naming people but focusing on the following questions:
   • What happened?
   • How did I feel then?
   • What did I want to do but was unable to?
   • How did I deal with this situation?

Step 2: Personal reflection and sharing exercise (25 minutes)
3. Ask participants to think about a situation where they personally discriminated against someone, again allowing a few minutes for private reflection.
4. Ask each participant to talk about this situation with their partner (10 minutes for each partner) without naming people but focusing on the following questions:
   • What happened?
   • What caused you to act that way?
   • How did the other person feel?
   • How did they react?
   • How did you feel at the time?
   • How did it end?
Step 3: General discussion (20 minutes)

5. Ask participants to share something short about how they felt when they experienced discrimination. Reassure them that they don’t have to disclose more than they want to. Ask them how they felt when they told their partner about this (Step 1). Ask participants to share something short about how they felt when they discriminated against someone, again reassuring them as before. Ask them how they felt when they told their partner about this (Step 2).

6. Conclude by drawing out the difference in their feelings between when they discriminated against someone and when they experienced discrimination. Remind participants that whatever they disclosed remains confidential. Thank everyone for their openness.

Part 2. Using non-verbal communication to express discrimination

Step 1: “Statue” position (20 minutes)

7. Ask participants to work in the same pairs as before. Ask them to think of some experiences of discrimination they know about through their work, either because they encountered them or were told about them. Discuss them in pairs for a few minutes. Ask them to select one and tell them they have to represent that situation as a still-life scene: a mime, with each of them becoming statues.

8. One of them takes the role of the person who was discriminated against and the other takes the role of the person carrying out the discrimination. They must each take up a body position or mime to represent their role. Ask them to spend a few minutes planning their mimes or postures (using as much space as needed, and feeling free to stand, sit lie down, crouch, raise their hands, touch the other person etc.).

9. When they are ready, ask them to take up their positions, telling them that at this point they are like statues, unable to move or speak. Ask them to hold their positions for two minutes, paying attention to how they are feeling, and then reverse the roles and hold their new positions for two minutes, again paying attention to how they are feeling.

Step 2: General discussion (15 minutes)

10. Ask participants to share how they felt in each position. How did it feel to be the victim of discrimination? How did it feel to be the perpetrator? Record key words on a flipchart page, with those of the victim on one half and those of the perpetrator on the other. Invite participants to reflect and comment on the various feelings and the differences between those of the two roles.
Part 3. Empathy with others

Step 1: Terms used in the field (15 minutes)

11. Remind participants how stigma and discrimination affect many people, including:
   - MSM
   - sex workers
   - people living with or affected by HIV and AIDS
   - people who use drugs
   - immigrants and refugees
   - women
   - children orphaned by HIV
   - minority ethnic groups.

12. Pin up large sheets of paper on the wall. Head each with one of the categories/groups listed above (and others that you consider should appear). Ask participants to write on that sheet, using a marker, a term used in the community or in the street to speak about this group.

Step 2: Reading the terms (15 minutes)

13. Divide participants into groups, each carrying one of these sheets. Ask one person from each group to read aloud from their sheet a statement such as:
   *I am a gay man/I am a sex worker/My partner has HIV* (or whatever is the heading on their sheet) and *this is what they say about me...* (the participant then reads out the term).

Step 3: Sharing, discussion, presentation on issues of stigma and sexual orientation (15 minutes)

14. At the end of the group presentations, ask those who read aloud to say how they felt when making those statements. Then ask the other participants to share how they felt when they heard those statements, mindful that they were coming from someone they know and work with.

15. Remind everyone of the reasons behind the stigma and its consequences. Focus discussion for a few minutes on how stigma particularly affects people’s ability to accept their sexual orientation (Annex 23).

16. Talk about how accepting homosexuality is not easy for those experiencing it, or their loved ones. Discuss the stages of self-acceptance and ask participants if they themselves have gone through them. It’s important for participants to understand what the peer group has gone through with their families and communities, so that their participation in the programme doesn’t expose them to further risk.

17. Ask each participant to come up with a statement to counter stigma and discrimination that they might use in their work (e.g. a working principle or professional code).
Annex 23: Stigma and discrimination does not help self-acceptance of one's sexual orientation

Stigma and discrimination impede self-acceptance and “coming out” – an important stage where an individual feels ready to declare their sexual orientation. Prior to this, they may go through different stages:

- fear of the possible reaction of others and its negative consequences
- feeling guilty, questioning why they are different and why they cannot change the way they feel
- concern about their family and their feelings
- anger, looking for someone to blame, and low self-esteem
- frustration and inability to cope
- acceptance of their sexual identity, understanding this as normal and that they can lead a positive life
- making the decision to come out and getting prepared for the potential reactions of others
- deciding who to disclose their situation to and why
- disclosing their sexual orientation.

The family’s understanding and acceptance

A family goes through similar stages when a son or daughter decides to come out. Parents often display denial and disbelief, and this reaction may be accompanied by fear, guilt and shame – and looking for someone to blame. Homosexuality is often regarded as a disgrace or a disease that cannot be cured, so parents may take some time to reach acceptance.
Session 11

Educational and motivational messages in the field

Overview

This session helps both facilitator and participants to assess participants’ abilities to carry out their work and to gauge how much information they have taken in so far. Through replicating workplace scenarios and testing their engagement with these, participants identify effective strategies and methodologies for planning and delivering educational and motivational messages in their outreach work.

Activity: Preparing and implementing an outreach activity

Step 1: Group work (45 minutes)

1. Divide participants into three groups. Ask each group to work on a different case study and to answer the accompanying questions (Annex 24).
2. Ask the groups to prepare their feedback on the case study as a scenario which they role play, assigning the different characters to members of their group. Ask the groups to prepare this exercise as if they are doing outreach in the community.

Step 2: Group presentation and Q&A (1 hour 30 minutes)

3. Invite each group in turn to present their role play feedback on their case study. Ask the other two groups to act as observers, and to write down what made the work easy, what hindered it and what advice they would give.

Step 3: Presentation on preparing an intervention (30 minutes)

4. Present the measures to put in place in order to ensure effective preparation and delivery of interventions. Present the suggested actions for addressing problems and challenges (Annex 26). Invite questions for clarification.

Step 4: Presentation on motivational interviewing (30 minutes)

5. Present the stepwise guidelines for motivational interviewing. Invite questions for clarification.
Annex 24: Case studies

For each of the case studies, ask the participants to consider the following questions:

- What are the preparatory steps you have to take before approaching these men?
- What would facilitate your visit and what would hinder it?
- What do you think the reaction of this target group will be?
- What stage is this target group at?
- What is the outcome you wish to achieve?
- What sort of activity would you suggest?
- What are the resources that you will need for implementation?
- How would you end the activity and assess the success of your intervention?

**Case study 1**

A young guy approaches you to tell you that he is working with a group of friends at a local Turkish bath where they provide the clients with “extra” services. A friend of his is on steroids and needs help. He himself was diagnosed with an STI, although his condition has improved after taking medication. He is really concerned, especially having heard about HIV and AIDS, and wants to do something to protect himself and his friends. He asks you to come to the house they share and educate them about these issues.

You and your colleagues are peer educators for an intervention programme. What do you do?

**Case study 2**

An upmarket beach resort is preparing for some events. You have heard from friends that at some of these parties rowdy activities take place (heterosexual and same-sex), and that alcohol and drugs are allowed and served.

You know that it is important for you and your co-workers to visit this resort, check out what is happening, and provide some information and educational input. What do you do?

**Case study 3**

Three young guys wait daily under the bridge for a free lift (auto-stop). You notice from the way they are dressed and from the choice of the car they stop that they are looking for same-sex partners. You have been to this place several times to verify the situation and they all seem to get into the same car.

You are a team member of an intervention group. What do you do?
## Annex 25: Answers to case study questions

<table>
<thead>
<tr>
<th>CASE STUDIES</th>
<th>PREPARATORY STEPS</th>
<th>EXPECTED REACTIONS (POSITIVE/NEGATIVE)</th>
<th>PURPOSE OF THE INTERVENTION AND BEHAVIOURAL STAGES</th>
<th>EXERCISES/ACTIONS MATERIALS AND CONCLUSION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case study 1</strong></td>
<td>Ask a colleague to accompany you to the meeting with these young people. Consider the suitability of the proposed venue.</td>
<td>The workers are not locals and are afraid of being expelled.</td>
<td>Stage 5: asking for help for colleagues.</td>
<td>Give information about risk reduction/prevention.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the intervention is to take place in the Turkish bath, it is preferable to get a prior appointment with the owner, explaining the importance of this intervention and to alleviate his concerns.</td>
<td>The owner refuses this intervention to avoid unwanted attention.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess the possible needs of the group from the information supplied by the person who comes to you.</td>
<td>What helps? The request comes from one of the workers in the Turkish bath.</td>
<td>Raise awareness of health risks to this group and of protection options and support available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Get some background information on the Turkish bath from other people’s experiences.</td>
<td>The person approaching you is trusted by his friends.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Concerns about the risk to health has motivated this person to take action.</td>
<td></td>
</tr>
<tr>
<td><strong>Case study 2</strong></td>
<td>Contact the resort owner and explain the awareness work you do.</td>
<td>Refusal as you are accusing him of breaking the law.</td>
<td>Stage 1: denial of risk behaviour.</td>
<td>Distribution of basic material; easy to carry.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better if you inform someone close to the owner in order to create rapport.</td>
<td>People turn up to the party but don’t want to talk about the subject.</td>
<td>Raise awareness of harm reduction and call for testing and counselling.</td>
</tr>
</tbody>
</table>
## Annex 25: Answers to case study questions

<table>
<thead>
<tr>
<th>CASE STUDIES</th>
<th>PREPARATORY STEPS</th>
<th>EXPECTED REACTIONS (POSITIVE/NEGATIVE)</th>
<th>PURPOSE OF THE INTERVENTION AND BEHAVIOURAL STAGES</th>
<th>EXERCISES/ACTIONS MATERIALS AND CONCLUSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case study 3</td>
<td>Get down there and fix up a meeting with the guys before they start work</td>
<td>Assess their risk behaviours (especially if into sex work)</td>
<td>Build trust and don’t install fear. Build trust with one person who can tell others</td>
<td>Get them to practise negotiating the use of condoms</td>
</tr>
</tbody>
</table>
Annex 26: Pointers for preparing an intervention

### STEP 1: PLANNING

<table>
<thead>
<tr>
<th>SPECIFICS OF THE PLACE</th>
<th>CONTACTING KEY ENABLERS</th>
<th>PREPARATIONS</th>
</tr>
</thead>
</table>
| ■ Type of services available  
■ Who uses the place  
■ What they do; special events, behaviours  
■ Working hours  
■ Who is in charge  
■ Time frequented by the target group  
■ Best time and place for intervention | ■ Present identification (ID) and the type of activities you do  
■ Obtain approval and support  
■ Emphasise importance of privacy/confidentiality | ■ What can be done – define the objective of the intervention in line with the findings  
■ Contents of the intervention – the messages  
■ What you will need (skills and techniques)  
■ Best timing and places for intervention  
■ The target group  
■ Contact the person in charge and inform them of the activity (if necessary, depending on the place of intervention) |

### STEP 2: THE INTERVENTION

- Introduce the team and the project briefly
- Give a clear objective
- Emphasise the importance of privacy and confidentiality
- Think of stakeholders and decision-makers that may influence the intervention
- Always carry ID and an introductory letter from the centre
- Always notify the centre of your whereabouts and the time you expect to finish the session

### STEP 3: BUILD TRUST AND COMMUNICATE WITH THE TARGET GROUP

- Implement what you planned: provide the useful information, necessary materials and referrals
- Ask people about their needs or problems
- Ask for feedback
- Ask them if they are interested in specific topics
- Maintain privacy about what was discussed

### STEP 4: CONCLUDE AND EVALUATE

- Inform them about a follow-up meeting
- Inform them of the report you will make, and what is and is not documented
- Thank them for their interest and leave
- Evaluate the need to come back to the same place or not
- Thank the person in charge
- Report writing: document what you did, what materials and activities you used, how the intervention was received, any evidence of immediate outcomes, and note proposals for future/follow-up work
### Facing Problems and Challenges

#### Step 1
- Identify and pay attention to geographical area and places frequented by the target groups
- Do several field visits (as needed) and at different times
- Pay attention to everything that happens and discuss later with your group and field observer (trading places for drugs, drug use, needles, bars, alcohol, etc.)
- Make sure you prepare all the necessary contacts ahead of time
- Prepare content of the intervention within the team and with the field observer
- Take an ID card to identify yourself and the project, and have the necessary flyers

#### Step 2
- Maintain privacy and confidentiality
- Set clear ground rules from the outset
- Be clear and concise in what you say
- Do not pressure the target group: they have a right to participate or to refuse
- Choose suitable conditions for intervention
- Be confident in your work and the information you provide
- Be honest about what you do and do not know, give alternatives, and offer to chase up information on points you do not know

#### Step 3
- Be punctual with your appointments
- Allow for dialogue/discussion and listen to their problems
- Don’t take things personally, and always clarify that you are simply the link and that there is a professional capacity
- Reassure them that your programme is not affiliated to interests or groups opposed to the wellbeing of those attending this event
- Be aware of negative reactions and stay calm
- Take participants’ needs seriously, write them down and reassure them that you will address them
- Provide all the information that addresses their needs
- Be realistic
- Be mindful of not conducting activities according to what the clients want
- Be vigilant: keep your relationship with the client professional and honest

#### Step 4
- Thank those who received you and build trust
- Remember and document everything that happened
- Be objective, realistic and honest in recording the events
- Write down what you were able and what you were not able to do
- Help in the preparation of future work plans: identifying needs and resources

### Remember:
- What you plan may not be carried out
- You will sometimes visit difficult places where you cannot discuss certain topics
- Commit to your group and be professional
- Observe the rules laid down for you to maintain your safety
- Respect the rules of the place you visit
- Conditions may change from week to week (climate, emotions, the police, the level of alcohol intake)
- Focus on the type of relationship you build (some may last and require follow-up time and energy, and some may be limited to giving information – do not make the target group become dependent on you)
- Do not force the target group to go to the centres that provide services
Annex 27: Motivational interviewing

The purpose of communicating with peers in the street is to encourage them to change their risk behaviour to a healthier one. The peer educator’s role is to get them to understand those risks and start planning for change. The motivational interviewing consists of the following steps:

**STEP 1: BUILDING TRUST**

Get the client’s consent to talk about their condition:
- Do you mind if we talk about this subject?
- Can we discuss your behaviour?

**STEP 2: TALKING ABOUT CHANGE**

Get the client to talk about the benefit of behavioural change. Clients usually talk implicitly about this, so you should help them to identify these benefits and explain the discrepancy between what they say and what they do. It also helps you to discover the values that concern them in the street.

Sample questions:
- What do you want to change?
- Why do you want to change?
- What happens if you don’t change?
- What would be a good outcome of changing your behaviour?
- What stops you from changing?
- How can I help you to change?
- How important is it for you to achieve the change you want?
- What will change in your life if you move from this stage to another?

**STEP 3: ASKING OPEN-ENDED QUESTIONS**

- Tell me about your behaviour.
- What happens to you?
- What is usually on your mind when you don’t protect yourself?

**STEP 4: INTERACTIVE LISTENING**

- Focus on the conflict between emotions, behaviour and thinking: How do you benefit from unhealthy behaviour?
- Help the person to weigh up decisions: What will happen if you choose this rather than that? What are the different options? What will be the consequences of continuing as you are, and what will be the consequences of the proposed changes?
- Recap/summarise occasionally: From what you are saying... I understand that you want...
- Clarify and focus on the key issue: What exactly is the risk resulting from your behaviour?
Annex 27: Motivational interviewing

**STEP 5: CONFRONTATION**

- You say that cocaine helps you to confront others and that you use it with clients, yet you also say you don’t wish to see anyone when you use it. So how does it help?
- You say that you are committed to one sexual partner and are willing to sacrifice everything for him, yet you also mention that you have sexual relationships with other partners and do not use protection. How does that behaviour help you in protecting the partner you love?

**STEP 6: HIGHLIGHTING CAPABILITY**

- From our conversation, it seems that you have managed to face a problem, so what stops you from doing the same now?
- Last week you said you hadn’t shared a needle with anyone for over a month. How did you manage that?

**STEP 7: WILLINGNESS TO CHANGE**

- When I saw you last month you refused to take a condom because you said you didn’t need it. Today you’re asking me for one and promise to no longer have unprotected sex. From 1 to 10, how would you rate your change? Where you were last month and where you are today?
- How did you manage to take that step?
- Last month you said you would not use a condom if the client paid you more. Today you say that you have recently done so. What made you regress? What can be done to make you go back to the medical centre?

**STEP 8: READINESS FOR CONTINUED FOLLOW-UP**

- Follow up to encourage lasting behavioural change
- Be motivated to refer friends
- Ask questions and answer them
Session 12

Importance of the outreach programme and influencing decision-makers

Overview
This session uses an extended role play, involving all participants to explore the power of key people within a community to enable or block crucially important initiatives. It features again on some of the stigma and judgmental attitudes touched on in earlier sessions, and probes the key skills needed to engage with and gain the support of decision-makers.

Activity: Convincing decision-makers

Step 1: Preparation of roles (1 hour)
1. Hand out the story (Annex 28) for participants to read, and then read it aloud. Ask participants to organise an extended role play of the scenario where the activists come to dinner and meet with key people invited by the politician. Tell them they have one hour for preparation and 45 minutes for performance. Tell them they may use any props and accessories they wish/can find.
2. Ask participants to select a small group to play the role of activists. Ask participants to distribute all the other roles/characters between them, duplicating some or adding new ones if required. All participants should end up having at least one role in this activity.
3. After the roles have been distributed, ask each character or group to prepare for their role and to be as persuasive as possible in whatever view they are promoting.

The roles

The activists
Carry out awareness campaigns about HIV, AIDS and STIs involving information, prevention and referrals for young people and MSM, particularly justifying the importance of interventions for MSM.

Characters playing the opponents
- Affluent lawyer presents convincing evidence to justify the lack of investigation over recent deaths in the town.
- Radical cleric refuses to discuss the matter, uses religious teachings to justify his actions and condemns MSM as a promiscuous immoral group.
- Provincial doctor stigmatises and disapproves of MSM, believes that their behaviour brings disease and that we should get rid of them to protect the townspeople.
- Community representatives are intolerant, concerned only for the future and safety of their young people and the reputation of the town.
- A newspaper owner.
Characters playing the supporters

- Defence lawyer is not from the MSM group but is sympathetic to their situation.
- Manager of a social organisation is aware of MSM health problems and of the risks presenting for young people. Wants abuse against MSM to stop and supports fundraising for intervention programmes. Understands importance of building partnerships with stakeholders.
- Moderate cleric comes up with rebuttals to counter the arguments of the radical cleric.
- Two people representing the local population who want to support the campaign. They are open-minded and one of them lost a child for unknown reasons, possibly an MSM who died of AIDS.

Step 2: performance (45 minutes)

4. The role play is performed with only you, the facilitator, and any invitees as audience. You may invite field supervisors and programme developers to attend this session.

Step 3: Discussion and rounding up (30 minutes)

5. After the performance, invite comments from the audience and from the players on what they think worked or didn’t work in the efforts to win support for the MSM initiative. Invite comments from the players on difficulties they encountered and how they might address these.

6. In conclusion, explain the importance of the outreach programme: how it helps in addressing the problem of increased HIV infection among MSM, and how it should work in culturally sensitive ways, while also challenging prejudice and discrimination. Explain the importance of gaining the support of key enablers.
Annex 28: The story

“Romance” is a town where inhabitants still respect the old ways and whose rulers come from a large and influential tribe. It is considered a first-class tourist destination and has a large youth population. Resources are limited to the summer season, when the markets, cafes and restaurant are in full swing.

Many single men and the elderly have been taking part in the tourist business and dedicating their time to serving tourists.

In this town, like many others, MSM are rejected by society and face many challenges. They are considered the dregs of society, deserving stoning or imprisonment. There are cases of harassment, robbery, expulsion from entertainment venues and, in some cases, even death threats. No one knows who the perpetrators are, as they are protected by the authorities and religious leaders.

Among the transgender, transsexual, homosexual and bisexual community, each sub-group faces its own challenges but all conceal their sexual identities, except at special events. To end the summer season, this community organises a big traditional wedding for tourists, dressing up and disguised as women.

The HIV infection rate among this vulnerable group has increased, with around 100 new infections per year, 90% of which are among young people.

Rumours have started, suggesting that some of these sub-groups are taking hormones without medical prescription (or on the recommendations of peers) following abusive treatment from their doctors.

Some of the groups are sex workers (especially in the summer season) and some use drugs occasionally. Others are drawn into MSM activities in order to raise money for their studies.

Recently, two young men passed away in strange circumstances and no one will talk about it – not even their immediate families. In another incident, a young man was found dead – presumably from a drug overdose – although no one knew that he was using drugs.

A group of his friends has got together and has decided to do HIV awareness campaigns in the town, targeting the MSM population. However, these activities are not tolerated. The police have rounded up the educators/activists and have released only a few. They have also accused them of encouraging young people to pursue “abnormal” activities and behaviour. They have been told that the next time they are caught, the penalty will be harsher.

These activists are frightened but decide to keep going. They approach an affluent politician, asking him to give them permission to continue with their awareness campaigns. He invites the group for dinner at his house, together with some influential community members, so that they can talk about the objectives of their intervention. He invites them to bring along anyone who might support their cause.

A week before the scheduled dinner party, the group learns that the following VIP members of the community will be present:

- An affluent lawyer who has presented convincing evidence to justify the lack of investigation over the recent deaths.
- A radical cleric who categorically rejects all discussion on this subject, using religious teachings to justify his position.
- A doctor from the town who wants nothing to do with this population and backs up his point of view with myths and false beliefs.
- A community of local activists who can no longer tolerate this population because they are concerned for the future and safety of their young people and the reputation of the town.
About the International HIV/AIDS Alliance

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

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

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

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Cairo, Egypt
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MODULE 3
IMPLEMENTATION AND EVALUATION

TRAINING MANUAL FOR MSM PEER EDUCATORS
Acknowledgements

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

This orientation manual was written by John Howson and Nadia Badran. Simone Salem, on behalf of UNAIDS, and Manuel Couffignal, on behalf of the Alliance, revised and completed the report. Special thanks to Eltayeb Elamin from UNAIDS RST MENA, who provided critical feedback during the writing process.

The Alliance worked within the framework of the Responding to Key Populations in the Middle East and North Africa programme (MENA programme), which is a regional programme targeting MSM and people living with HIV funded by the United States Agency for International Development (USAID) and implemented through the Leadership, Management & Governance (LMG) Project in partnership with civil society organisations in Algeria, Lebanon, Morocco and Tunisia.

We sincerely thank the associations that organised and facilitated local workshops in April 2014 to review the toolkit: APCS in Algeria, AMSED in Morocco, ATL in Tunisia and SIDC in Lebanon. We are also grateful to the stakeholders who participated in these local workshops and provided valuable comments and input: ASCS, Association de Lutte contre le SIDA (ALCS) and OPALS-Fes in Morocco, Helem, Oui Pour la Vie, Lemsic and Lebmash in Lebanon, Arken and Damj in Tunisia, and Green Tea and AIDES-Algérie in Algeria.

Last but not least, we would like to thank Arab Foundation for Freedoms and Equality (AFE) and M-Coalition for their valuable comments during the review process.

The MENA programme’s partner associations

- APCS (Association de Protection Contre le Sida) in Algeria
- SIDC (Soins Infirmiers et Développement Communautaire), OPV (Oui Pour la Vie) and Helem in Lebanon
- AMSED (Association Marocaine de Solidarité et de Développement), ASCS (Association Sud Contre le Sida) and OPALS-Fes (Organisation Panafrique de Lutte Contre le Sida, section de Fes) in Morocco
- ATL (Association Tunisienne de lutte contre les MST/SIDA) in Tunisia
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MODULE 3
IMPLEMENTATION AND EVALUATION
OVERALL TIMING

30 hours

OBJECTIVES

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

SESSIONS IN MODULE 3

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

Time
3 hours

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

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

You will need
■ Large sheets of paper, coloured markers, masking tape
■ Five pre-prepared sheets (see Part 1, step 1)
■ Real-life case studies (printed)
■ Handouts (one per participant) of:
  - Annex 1: Advocacy, networking, partnership building and resource mobilisation
  - Annex 2: Questions
  - Annex 3: Successful case studies on advocacy

Designing a non-discriminatory programme free from stigma

Overview
In this two-part session, the facilitator prepares real-life case studies and brings examples to analyse. Part 1 may be done in two ways. The facilitator may invite an advocacy expert to moderate the session, and provide clarifications as needed and practical examples.

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

Activity: Creating an enabling environment for intervention

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

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

1. To reach MSM through outreach, it is important to start by understanding their context and needs. Earlier in the training we used the Problem Tree methodology to better understand the root causes of the challenges faced by MSM. To respond holistically to these challenges, we need to use a number of approaches. These include using educational materials, community mobilisation, partnership building and/or resource mobilisation.

2. Split participants into five groups and assign each group to one of the large sheets of paper hanging on the wall entitled: advocacy, educational materials, community mobilisation, partnership-building and resource mobilisation. Ask them to answer following questions on their sheet:
   - What does this method/approach encompass?
   - What can be changed through this method?
   - Who is the target group using this method/approach?
   - What methods and materials would you use?
   - How can I measure the effectiveness of this method?

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

Step 2: Feedback (45 minutes)

3. Ask each group to share the work they have done in their small groups. It is useful to provide a summary of the method/approach at the end of each group’s feedback (see Annex 1).
Part 2: Examples from everyday life (1 hour 30 minutes)

Step 1: Group work and presentations (1 hour)

4. Prepare case studies in advance on advocacy and partnership building from other countries in the region (you can use the examples in Annex 3 for reference). These should be about HIV and AIDS and marginalised groups, and include activities carried out by local organisations, media, individuals, etc.

5. Create small groups to look at each case study and consider the following questions:
   - What were the objectives of the intervention or project?
   - Who carried it out?
   - Who was the target group?
   - Was it successful and how do we measure its success?

6. An alternative Step 1 is provided below.

Alternative Step 1: Potential problems (1 hour)

4. Highlight the most serious or frequent problems expressed on the Problem Tree and ask the groups to select one (e.g. “The group was exposed to HIV or other sexually transmitted infections”). To address the challenge, they will need to implement an outreach intervention programme. In order to do this, they first need the consent of the decision-makers, because without it they can prevent them from carrying out this activity.

5. Ask each of the five groups to identify a key advocacy message, the outcome they want to achieve and the approach they will take to discussing their message with the decision-makers (or those able to influence the decision-makers). For example:
   - Get approval for the street intervention.
   - Gain support for the programme rather than opposition to it.
   - Let the public health and human rights importance of the programme take precedence over any law enforcement issues.
   - Facilitate the work of the programme.
   - Collaborate with the organisation conducting the outreach and provide financial support.

Step 2: Discussion (30 minutes)

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

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

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

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

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

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

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1. International HIV/AIDS Alliance, with ICASO (2002), Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS.
Annex 2: Questions

<table>
<thead>
<tr>
<th>What does this method/approach encompass?</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What can be changed through this method/approach?</td>
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</tr>
<tr>
<td>Who/what is the target group using this method/approach?</td>
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<tr>
<td>What examples can you give of methods/approaches that could be used to undertake this work?</td>
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<tr>
<td>How can I measure the effectiveness of this method/approach?</td>
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</table>
Annex 3: Successful case studies on advocacy

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

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

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

"في ناس مبتصرف وين حقها"
اعرف حقوقها، وساعد في الدعوة عنها
عن الإناث العالمى لحقوق الإنسان

On a tous des Empreintes différentes,
On a tous les mêmes DROITS
Droit à l’éducation, droit au travail, droit aux soins, droit aux droits, droit à la santé
Non au rejet, Non à la violence, Non à la stigmatisation
Annex 3: Successful case studies on advocacy

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

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

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

Actrice, Lebanon

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

“Your life is entrusted to you, you need to protect it.”

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

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

“How important it is to protect and love your life. The person that loves his life, protects it.”

Muslim religious leader

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

Parliamentarian
Session 2

Choosing places for intervention

Overview

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

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

Activity: Mapping

Step 1: Definition of mapping (15 minutes)

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

Step 2: Drawing the maps (45 minutes)

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

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

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

3. Ask the groups to display their maps and then ask them:

- What are the characteristics of MSM and their sexual partners in this area?
- How do you identify them?
- Why is it important to meet this group in these places?
- Is there another description of these places where this population meets?
- What are the kinds of behaviours specific to these places that contribute to increased risk?
- Is there exchange of money for services?
■ Does this group prefer engaging in sexual relations or in other risk behaviours?
■ Do they use condoms?
■ What are the potential challenges faced when intervening and possible solutions?
■ Are other specific activities occurring in these places?
■ Are there other significant times in addition to the usual gatherings’ times?
■ Are the authorities present in these places, and if so what is their relationship with the groups?
Annex 4: The importance of mapping

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

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

Time
1 hour 30 minutes

Objectives
At the end of this session, participants will be able to:
- identify accessible and non-accessible places
- select appropriate places and available times for intervention.

You will need
- Large sheets of paper, coloured markers, masking tape
- Strips of small coloured stickers (an option in step 2)
- Handouts (one per participant) of:
  - Annex 5: Summary of places
  - Annex 6: List of places frequented by MSM that are important for the intervention

Evaluating and testing places for intervention

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

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

Step 1: Summary of places for intervention (45 minutes)
1. Ask participants to work in small groups and to refer to the mapping exercise in Session 2. Give each group two large sheets of paper and coloured markers. Referring to Annex 5, ask them to draw a table on one of the sheets consisting of five columns with headings as provided the annex.
2. Ask them to make a list of places frequented by MSM in the column headed “Sites”. Then ask them to complete the information for each site in response to these questions:
   - Column 1: Is it accessible? Are there any obstacles and what kind?
   - Column 2: If easily accessible, what existing behavioural patterns can you list?
   - Column 3: If not easily accessible, what existing behavioural patterns can you list?
   - Column 4: How can you address each area’s problems?

Step 2: Identifying important sites (45 minutes)
3. Ask participants in their small groups to use a marker to put a tick beside those sites they think particularly need awareness-raising activities to reduce stigma and discrimination and to influence local authorities. Each person may select up to three sites. (An alternative would be to give each person a strip of three small coloured stickers and ask them to place these against the three places they want to select.) Each person should choose for themselves, without discussion with other group members or feeling pressured by them.
4. When everyone has made their choices, ask the group to count the number of votes given to each place. Ask them to draw a table on their second sheet of paper like the one provided in Annex 6, and to enter the list of places they voted as most important for undertaking awareness-raising activities.
5. Ask all of the groups to attach both of their sheets of paper to the walls, and then ask the groups to walk around viewing them all. Back in the large group, invite comments, questions and suggestions from each of the small groups in turn.
Annex 5: Summary of places

<table>
<thead>
<tr>
<th>SITES</th>
<th>COLUMN 1</th>
<th>COLUMN 2</th>
<th>COLUMN 3</th>
<th>COLUMN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>EASY ACCESS</td>
<td>RISKY AREAS? TYPES OF EXISTING BEHAVIOURS</td>
<td>RISKY AREAS? TYPES OF EXISTING BEHAVIOURS</td>
<td>HOW TO FACE THE CHALLENGES</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>SITES IDENTIFIED BY PARTICIPANTS AS IMPORTANT FOR CARRYING OUT ACTIVITIES TO ADDRESS STIGMA AND DISCRIMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>9.</td>
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<tr>
<td>10.</td>
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Session 4

Time
6 hours

Objectives
At the end of this session, participants will be able to:
■ verify accuracy and effectiveness of the maps for future interventions
■ modify maps according to their observations on the street
■ apply the skills learnt in the observation exercise to their actual work of planning outreach interventions.

You will need
■ Observation report forms (one per participant)
■ Handouts (one per participant) of:
  Annex 7: Sample ID card for the peer educator
  Annex 8: Sample letter introducing the peer educator (for example, to police officers)

Observing places for intervention

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

Activity: Verifying the map and making modifications where necessary

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

Step 2: Site visit (3 hours)
2. Ask each group to go to the observation sites selected from the mapping exercise and observe the dynamics of the place. Remind them of the importance of privacy and confidentiality. Instruct them to stay within their team and walk around without drawing attention to themselves. Give each of them an ID card and a letter to show if they are stopped by police officers (see Annex 8).
   Allow them about three hours to carry out this exercise.

Step 3: The following day (2 hours)
3. Ask each group to present their observation reports under the headings listed in Step 1. Invite discussion of the challenges they faced in the field and how they dealt with these.
Annex 7: Sample ID card for the peer educator

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

Name and surname: .............................................................................................................

Occupation: Peer educator

Valid until: ..........................................................................................................................

Signature: ..........................................................................................................................

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

.............................................................................................................................................

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

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

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

Signature: ..........................................................................................................................

Title: ..........................................................................................................................................

In case of emergency, please call the following numbers: .................................................
Session 5

Time
1 hour 30 minutes

Objectives
At the end of this session, participants will be able to:
- define the concept of “referral”, its principles and limitations
- identify the services available
- identify the roles and requirements of those providing referral services
- understand the features of a hotline
- identify how to build partnerships with potential referral services.

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

The referral system

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

Activity: Available services

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

2. Ask each small group to present their completed table.

Step 2: Presentation on referral systems and hotlines (30 minutes)
3. Give an extensive presentation on referral systems using Annex 9 and explain how they should be linked to the programme. Invite any clarifications needed.
4. Give a short presentation on hotlines and what qualities hotline operators need (see Annex 10). Invite clarifications.

Mourad, 21, is unemployed and single in Algeria

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

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

APCS helped me and supported me a lot, morally and financially, because without their support I would really have been lost in the wilderness, and especially in our Algerian context, it is even doubly more difficult to say that I am a homosexual living with AIDS."
Annex 9: Objectives and features of the referral system

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

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

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

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

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

Types of referral services
- Guidance on reproductive and sexual health
- Medical examination, prevention and treatment of STIs
- Support to parents to understand their children’s sexuality
- Guidance and follow-up for people living with HIV
- Voluntary counselling and testing for HIV and other STIs
- Healthcare: medical clinics, laboratory and dispensary
- Social and psychological support and referral
- Social care: home visits and one-to-one sessions
- Legal aid and other specialised services
- Guidance, follow-up and rehabilitation of people who use drugs
- Support groups
- Hotlines
Annex 10: The referral system and using a hotline service

Definition and objectives of a hotline service
A hotline provides a response to callers’ queries during calls of 10 minutes or less. A team experienced in counselling and follow-up assesses each caller’s risks in relation to HIV and other STIs. The team:
- provides information on preventive measures to reduce the risk of HIV and other STIs
- provides the caller with information on appropriate available services within the local community
- encourages the caller to use services detailed in the referral system.

Ethical principles
The hotline service must:
- protect the confidentiality and privacy of every caller
- provide appropriate and accurate information, with respect and without prejudice, regardless of the cultural and social status, behaviour, sexual orientation and/or age of the caller.
Designing an MSM outreach programme

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

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

Activity: Development of the referral system

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

1. Ask participants to work in small groups. Give each group a large sheet of paper, a marker and a copy of the table provided in Annex 11 with the second column left blank. Ask them to discuss a programme initiative provided for MSM, drawing on their own work experience. They will need to identify content for each stage of the planning process that is listed in the first column of their tables.

2. Ask them to draw a copy of this table on to their large sheet and enter into the second column the content they have identified for each stage. Explain that their plans need to be realistic and not overambitious.

Step 2: Group presentations and discussion (30 minutes)

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

Step 3: Presentation on programme planning (30 minutes)

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

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

5. Give a short presentation using the example of the organogram provided in Annex 12. Ask for any clarifications needed. Ask each group to revisit their wall panel and quickly identify the structures they would need to establish for their plan. Ask them to note these on an A4 sheet and stick it on to their wall panel.
## Annex 11: Sample implementation exercise

### PLANNING THE INTERVENTION PROGRAMME

| Overall objective: what are the long-term goals? | Reduce the number of HIV infections among MSM |
| Define the best strategy: what could be done to reduce short-term problems? | Raise awareness among the target group and in the gathering places of sex workers |
| | Provide voluntary counselling and testing (VCT) services for HIV |
| Who is the target? Are there direct and indirect target groups? | Direct target groups: men who have sex with men in exchange for money |
| | Indirect target groups: owners of venues where men have sex with men |
| What are the tasks/activities? | Awareness-raising during outreach about HIV and other STIs |
| | Distribution of publications and business cards for the VCT services |
| | Distribution of condoms |
| What are the messages that could help to alleviate the risks of this target group? | The use of condoms for self-protection |
| Who could give these messages? Who is the team? | A team of trained peer educators, some of whom are former sex workers |
| What supportive financial and human resources would the team need? | Male condoms |
| | Flyers with messages |
| | Awareness-raising publications |
| | Support from the institutions concerned |
| | Support (or at least no opposition) from decision-makers |
Annex 12: Implementation of the outreach programme

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

A typical structure may include a:
- steering committee
- programme coordinator
- field supervisors
- peer educator
- professional team of social and health workers.

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

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

Roles and responsibilities of the programme coordinator
The programme coordinator may be the director of the organisation running the intervention programme, or an experienced staff member in an outreach or similar programme. They should have social work experience and be trusted by local organisations and authorities. They may participate in referral system training, and are in charge of steering committee activities, such as meetings. Their most important function is to provide support to the field supervisor and peer educators.
Session 7

Time
2 hours 15 minutes

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

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

You will need

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

The roles and ethics of field supervisors and peer educators

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

Activity: The roles of field supervisors and peer educators

Part 1: The roles of field supervisors and peer educators

Step 1: Group work (30 minutes)
1. Divide participants into two groups. Give each group a prepared large sheet of paper, one of them headed with the first question provided below and the other headed with the second question:
   ■ What do you think are the responsibilities/limitations of the peer educator?
   ■ What do you think are the responsibilities/limitations of the field supervisor?

Step 2: Sharing and discussion (30 minutes)
2. Ask the group to discuss their question and then write on Post-it notes all of the points they agree on. Instruct them to use a different Post-it note for each point. Ask the group to stick their Post-it notes on to their large sheet and to display this as a wall panel.
3. Invite each group to look at the work of the other group and ask for any clarifications needed. Ask participants to make any additions or corrections to their sheets that were agreed during this discussion.

Step 3: Presentation on the roles of field supervisors and peer educators (15 minutes)
4. Summarise the different roles and responsibilities using Annexes 13 and 14. Ask for any clarifications needed after each part of your presentation.
Part 2: Professional ethics

Step 1: Brainstorming ethical principles (30 minutes)
5. Ask participants to brainstorm the professional ethics that should be observed by any programme staff member from first point of contact with the beneficiary. For example, these should include principles such as privacy, confidentiality, safety, objectivity, non-discrimination.
6. Record these on a flipchart sheet. Review the list and check for appropriateness and understanding. Then finalise a list focusing on professional ethics in the field.

Step 2: The pledge (30 minutes)
7. Present the idea of a pledge and provide Annex 15 as an example. Discuss and invite questions and comments. Ask participants how they would feel about having to sign a pledge like this. Probe what they consider are the advantages and any disadvantages. Ask participants to work for a few minutes in informal groups (turning to their neighbour) to prepare pledges for both peer educators and field supervisors.

A peer educator from Oui Pour la Vie, Lebanon

I believe in youth, who have to play a great role in society, but they have to protect themselves. I love social work. I can work with a team and I know how to communicate with others. I will respect the codes of the work and act as a responsible person."
Annex 13: Characteristics and duties of field supervisors

**Selection criteria** (adapt according to region/country)
Field supervisors should:

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

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

**Duties of field supervisors**

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

Annex 14: Duties of peer educators

- Meet beneficiaries in their environment.
- Conduct awareness-raising sessions in the street.
- Ensure that beneficiaries receive the information they need, and that the centre where they work has the resources and capacity to provide support.
- Acquire appropriate and sufficient training on the core knowledge and skills required for their work, and take up any ongoing training provided by the programme.
- Acquire appropriate and sufficient training on the referral mechanism and referral techniques.
- Maintain a good working knowledge of services available within the referral system.
- Keep the programme coordinator up to date regarding peer educators’ whereabouts through time schedules prepared for each outreach initiative and by attending regular meetings.
- Attend monitoring and evaluation (M&E) meetings.
- Share experiences with peers.
Annex 15: The pledge

The pledge

(Example of a peer educator oath)

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

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

I value who I am

I am a supportive, educated human being and a leader
Session 8

An ethical framework for implementation

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

Activity: Respecting the confidentiality of target groups

Step 1: Discussion (30 minutes)
1. Discuss important ethical considerations when planning the programme, such as respect for local culture. Talk about the challenges involved in protecting both the target group and the community against HIV and other STIs, while operating within human rights and public health rights boundaries.
2. Use Annex 16 to emphasise the particular importance of applying sound professional ethics at all times, since MSM are vulnerable in their different ways to stigma, exclusion and violation of their human rights.

Step 2: Identify the professional ethics that should apply to outreach work (1 hour)
3. Divide participants into small working groups. Hand each group a large sheet of paper and ask them to draw the table on your demonstration sheet.
4. Ask them to discuss and write in their table what professional ethics should be observed at each stage. For example, in planning there may be ethical considerations regarding relationships with referral services or selection of peer educators.

You will need
- Large sheets of blank paper, markers
- One large sheet of paper containing the table from Step 2, for demonstration
- Flipchart
- Annex 16: Ethics and human rights
Step 3: Sharing and discussion (1 hour)

5. Ask each group to briefly present their work and then display it as a wall panel. As each group names the professional ethics they have identified, prepare a summary list of these on a flipchart page. These might include:
   - Privacy and confidentiality
   - Respect for the health of the group
   - Avoiding prejudice
   - Protecting the work team and the target groups

6. Invite comments and questions for clarification, and correct any errors or misunderstandings. Review the final flipchart list. Identify and discuss likely challenges that may arise. Remind the group of the pledge they developed in Session 7.

Step 4: Presentation (30 minutes)

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

A peer educator from SIDC, Lebanon

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

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

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

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

"Before we start the outreach work, we have to discover the place where we are doing the work. I encountered a lot of problems. I dealt with MSM who tried to steal from me, others were aggressive, they lied to me, and others were using drugs. It is important in my opinion that the peer educator should act wisely and to be trained to deal with vigilance with different situations and personalities.”
Annex 16: Ethics and human rights

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

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

Human rights

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

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

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

The peer educator should:

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

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

- homophobia, harassment and insults
- disclosure of confidential information
- fraudulence in preparing reports, documenting names and recording project funding
- failure to protect those participating in research or sharing life stories
- manufacturing non-existent needs or exaggerating situations
- use of published or archived images of beneficiaries without their consent
- harassment of the target group and failure by staff to abide by their professional ethics
- human trafficking involving beneficiaries
- staff or beneficiaries getting into trouble with the authorities or the community.
Annex 16: Ethics and human rights

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

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

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

Disclosing private information is appropriate where:
- the beneficiary is intending to harm themselves or others (overdose, suicide attempt, harmful or violent behaviours, revenge, planning to infect someone with HIV)
- the beneficiary is incapable, for psychological reasons, of understanding the consequences of their risk behaviour or of making decisions that may adversely affect their life or the lives of others.
Session 9

**Time**
1 hour 30 minutes

**Objectives**
At the end of this session, participants will be able to:
- discuss the importance and objectives of the M&E plan
- identify the respective roles of the field supervisor and peer educator in data gathering
- understand the role and process of supervision.

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

The M&E system and measuring impact

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

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

**Step 1: Brainstorming (15 minutes)**
1. Conduct a brainstorming session, asking:
   - What types of activities are you carrying out in the field?
   - What is the purpose of your work in the field?
   - What impact do you want to achieve?

2. Record key points for each question on a flipchart page (for documentation purposes).

**Step 2: Have we achieved our objectives? (45 minutes)**
3. Pin up the large pre-prepared sheet/s of questions (see below). Ask participants to work individually. Give each participant a set of Post-it notes. Ask them to write their answer to each question on a Post-it note and to stick these on the sheet in the space below each question. Ask participants to read out their answers as they position their Post-it notes.
   - Why is it important to know whether you have reached your goals?
   - Why is it important to know whether your activities were appropriate?
   - Who has the answers?
   - How can you get the answers?
   - What sort of questions can you ask yourself in order to assess whether you have reached your objectives?
   - How can the programme help you to better perform your role?
   - Whose role is it to provide this help?
   - How can we measure your performance and the challenges you face?

**Step 3: Presentation on supervision, monitoring and evaluation (30 minutes)**
4. Summarise the importance of monitoring and evaluation of outreach work using Annex 17. Discuss possible M&E tools, such as field reports, diary information and regular meetings.
Annex 17: Supervision, monitoring and evaluation of the work

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

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

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

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

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

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

The peer educator should keep up-to-date with each beneficiary’s progress and make sure that they understand any actions that are needed. In the case of referrals made to other services, the peer educator should follow up and get feedback from the service provider (e.g. whether the individual went to the appointment and what were the benefits of the visit) and record this. The field supervisor should ensure that the peer educator is on track with their work.
Annex 17: Monitoring and evaluation of the work

### Supervision and Evaluation

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHAT</th>
<th>HOW</th>
<th>METHODS USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>The peer educator</td>
<td>- Self-monitors.</td>
<td>- Reports.</td>
<td>- Daily report with comments on job performance, the number of beneficiaries accessing services and any other matters.</td>
</tr>
<tr>
<td></td>
<td>- Monitors the impact of their work in the field.</td>
<td></td>
<td>- Personal notes about fear, feelings and strengths.</td>
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<td></td>
<td>- Monitors certain events in the street.</td>
<td></td>
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</tr>
<tr>
<td>The field supervisor</td>
<td>- Checks results of the street intervention, analyses them and asks questions.</td>
<td>- Regular meetings with the field/outreach work team.</td>
<td>- Individual meetings and follow up with the peer educators.</td>
</tr>
<tr>
<td></td>
<td>- Evaluates job performance.</td>
<td>- Evaluates an awareness session in the street.</td>
<td>- Reviews the reports of the peer educator.</td>
</tr>
<tr>
<td></td>
<td>- Monitors the results of the fieldwork.</td>
<td></td>
<td>- Organises peer educator meetings to look at recurring problems.</td>
</tr>
<tr>
<td></td>
<td>- Supervises the performance of the peer educators.</td>
<td></td>
<td>- Evaluates peer educator awareness sessions at the end of their shift and shares results during team meetings. The field supervisor may also ask for a one-to-one meeting to discuss points raised.</td>
</tr>
<tr>
<td></td>
<td>- Supervises the performance of the peer educators.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Undertakes field/outreach monitoring visits, completing the necessary forms and writing reports.</td>
<td></td>
<td>- Uses a few standard questions:</td>
</tr>
<tr>
<td></td>
<td>- Regular meetings with the field/outreach work team.</td>
<td></td>
<td>- Did you have enough time to answer all the beneficiary’s questions?</td>
</tr>
<tr>
<td></td>
<td>- Evaluates an awareness session in the street.</td>
<td></td>
<td>- Did the meeting end on a good note?</td>
</tr>
<tr>
<td></td>
<td>- Undertakes field/outreach monitoring visits, completing the necessary forms and writing reports.</td>
<td></td>
<td>- What was beneficiary feedback? Would he come back?</td>
</tr>
<tr>
<td></td>
<td>- Individual meetings and follow up with the peer educators.</td>
<td></td>
<td>- As a peer educator, how did you feel the session went?</td>
</tr>
<tr>
<td></td>
<td>- Reviews the reports of the peer educator.</td>
<td></td>
<td>- How can it be improved?</td>
</tr>
<tr>
<td></td>
<td>- Organises peer educator meetings to look at recurring problems.</td>
<td></td>
<td>- Uses a few standard questions:</td>
</tr>
<tr>
<td></td>
<td>- Evaluates peer educator awareness sessions at the end of their shift and shares results during team meetings. The field supervisor may also ask for a one-to-one meeting to discuss points raised.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Uses a few standard questions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Did you have enough time to answer all the beneficiary’s questions?</td>
<td></td>
<td>- Uses a few standard questions:</td>
</tr>
<tr>
<td></td>
<td>- Did the meeting end on a good note?</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- What was beneficiary feedback? Would he come back?</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- As a peer educator, how did you feel the session went?</td>
<td></td>
<td>- As a peer educator, how did you feel the session went?</td>
</tr>
<tr>
<td></td>
<td>- How can it be improved?</td>
<td></td>
<td>- How can it be improved?</td>
</tr>
<tr>
<td></td>
<td>- What is the best way to improve the awareness session?</td>
<td></td>
<td>- Uses a few standard questions:</td>
</tr>
</tbody>
</table>
Session 10

**Time**
2 hours 15 minutes

**Objectives**
At the end of this session, participants will be able to:
- understand the importance of documentation and identify components
- make the link between documentation and communication in the street
- identify the challenges of documentation
- list key issues for documentation
- understand and identify indicators
- be familiar with the intervention documentation forms and their uses.

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

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

**Activity: Observing, documenting and evaluating work**

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

**Step 2: Sharing and discussion (30 minutes)**
5. Ask groups to display their final template as a wall panel. Invite groups to inspect each other’s proposed templates. Take questions for clarification of each template. Ask participants to say what they think are good features of each proposal and what areas might need changing, correcting, improving or removal.

**Step 3: Presentation of guidance for developing templates (15 minutes)**
6. Distribute and discuss guidance in Annex 19, followed by questions for clarification.

**Step 4: Indicators – presentation and discussion (30 minutes)**
7. Present the definition of “indicator” (see Annex 20). Give examples highlighting the importance of indicators as means of gathering evidence of the effectiveness of initiatives carried out to achieve the programme’s objectives. Present the different types of indicators and ways of verifying or measuring these.
Annex 18: Documentation and communication related to the outreach programme

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

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

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

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

To be effective, all documentation should be:

- clear
- concise
- respectful of confidentiality and privacy.

Annex 19: Guidance for contents of documentation templates

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

<table>
<thead>
<tr>
<th>TYPES OF FORMS</th>
<th>TO BE COMPLETED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific form for the programme</td>
<td>Programme coordinator?</td>
</tr>
<tr>
<td>Work documentation form</td>
<td>Field supervisor?</td>
</tr>
<tr>
<td>Activity form (date of activity, workers, number of beneficiaries, etc.)</td>
<td>Peer educator</td>
</tr>
<tr>
<td>Peer educator report (per activity)</td>
<td>Peer educator</td>
</tr>
<tr>
<td>Field supervisor report (monthly)</td>
<td>Field supervisor</td>
</tr>
<tr>
<td>Case study form</td>
<td>Peer educator?</td>
</tr>
<tr>
<td>Follow-up form for beneficiaries</td>
<td>Peer educator</td>
</tr>
<tr>
<td>Template for daily journal</td>
<td>Peer educator</td>
</tr>
<tr>
<td>Template for follow-up on risk behaviours (as an attachment to the peer educator report)</td>
<td>Peer educator</td>
</tr>
</tbody>
</table>
Annex 19: Guidance for contents of documentation templates

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

<table>
<thead>
<tr>
<th>TYPES OF FORM</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For work documentation forms, you should record</strong></td>
<td>■ Date and time of intervention in the street&lt;br&gt;■ What was successful about what you did&lt;br&gt;■ What you would do differently next time&lt;br&gt;■ Feedback from the target groups</td>
</tr>
<tr>
<td><strong>For peer educator reports, you should document</strong></td>
<td>■ Date and time of intervention in the street&lt;br&gt;■ Name of peer educator/ID number/code&lt;br&gt;■ Place of intervention: cafe, public square, suburb etc.&lt;br&gt;■ Target group: age, sex, social status&lt;br&gt;■ Information provided&lt;br&gt;■ Risk behaviours that have been addressed&lt;br&gt;■ Resource materials that were distributed&lt;br&gt;■ Decisions made and questions not answered for some reason (write down the reason)&lt;br&gt;■ Services required and referrals made&lt;br&gt;■ Problems and obstacles encountered</td>
</tr>
<tr>
<td><strong>For the process of report-writing and record-keeping, you should ensure these points are adhered to</strong></td>
<td>■ Reports containing specific and personal information must be kept in a safe place&lt;br&gt;■ Have a lockable filing cabinet for keeping files, documents and M&amp;E records&lt;br&gt;■ Use a computer for electronic record-keeping and data entry&lt;br&gt;■ Limit eligibility to access and refer to the reports&lt;br&gt;■ When working from home, take only documents that do not violate work privacy and confidentiality</td>
</tr>
<tr>
<td><strong>Follow-up forms for beneficiaries can be one of two types</strong></td>
<td>■ Information form – for use after several encounters with the beneficiary and after having studied his case (health condition, needs, etc.)&lt;br&gt;■ Case progress form – for taking notes after each meeting with the beneficiary (it helps to monitor the change in behaviour)</td>
</tr>
<tr>
<td><strong>Template for daily journal</strong></td>
<td>■ A notebook in which the peer educator writes their notes during or immediately after a street intervention. They may include thoughts, feelings, ideas emotions, reactions, strengths and concerns</td>
</tr>
<tr>
<td><strong>Template for follow-up on risk behaviours (as an attachment to the field report)</strong></td>
<td>■ Choose a group of beneficiaries and fill in an evaluation form about their knowledge before the intervention&lt;br&gt;■ Give them a code&lt;br&gt;■ Do weekly visits and document the quality of services provided&lt;br&gt;■ Fill out an evaluation form two months after the intervention to measure the level of any change in behaviours</td>
</tr>
</tbody>
</table>
Annex 20: Definition of indicators and methods of measurement

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

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

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

<table>
<thead>
<tr>
<th>METHOD</th>
<th>IMPLEMENTATION METHOD</th>
<th>DOCUMENTATION AND THE BENEFITS OF INTERVENTION AND INDICATORS ANALYSIS</th>
<th>ADVANTAGES AND DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify the location of the intervention and determine the number of peer educators and the hours and days spent preparing before going to the street. The documentation should be based on multiple interventions and observation of the movements and type of target groups and their relationships. You can then ask peer educators to do awareness sessions in the street, recording the number of people they meet, what activities they have carried out, the number and type of condoms distributed, as well as other resource materials. They may revisit the same place, but should record the number of new people they encounter each time. This means remembering the people met previously, so sending the same team is useful. The group usually frequents the same place for a while before moving to another location.</td>
<td>A form to be filled out at every intervention.</td>
<td>Benefits are in accordance with needs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Can provide counselling services in a mobile unit in some places.</td>
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<td></td>
<td></td>
<td></td>
<td>Reach a large number of beneficiaries.</td>
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<td></td>
<td></td>
<td></td>
<td>Speed of providing resources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>In some places it may not be possible to distribute condoms, so peer educators may have to make several visits, more than once a week, in order to give out condoms to the same people.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Intervention varies according to area rather than need. The environment affects the extent of the intervention.</td>
</tr>
</tbody>
</table>
Annex 20: Definition of indicators and methods of measurement

<table>
<thead>
<tr>
<th>METHOD</th>
<th>IMPLEMENTATION METHOD</th>
<th>DOCUMENTATION AND THE BENEFITS OF INTERVENTION AND INDICATORS ANALYSIS</th>
<th>ADVANTAGES AND DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Ask the same peer educators to go to the same area and build relationships with just five people. Continue to see them for a month and then assess their knowledge, behaviour and needs. After that period, assess their levels of knowledge and behaviour, and assess whether a follow-up session is needed or not, determining the nature of follow-up (once a month, appointments outside of the area, and so on).</td>
<td>ID card for each beneficiary to keep.</td>
<td>Monitors development and behaviour changes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assessment form to measure knowledge and behaviours when handing the card to the beneficiary and before starting the awareness session. Follow up for a few months, after which re-assess and compare notes on the level of knowledge and change of behaviours.</td>
<td>Nurtures a good relationship with beneficiaries and raises their confidence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A form for each intervention stating if any problems occur. Add the type of intervention on the beneficiary form.</td>
<td>Only a limited number can be reached.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has been successful in other countries. Used in our areas, and in particular in the studies.</td>
<td>The beneficiary must carry an ID card and present it when accessing services and when being visited by the peer educator.</td>
</tr>
<tr>
<td>3</td>
<td>Ask peer educators to find five people. Give each of them a means of identification. They in turn have to find five more, and so on until more and more people (from more diverse backgrounds and subcategories) are attracted to the programme.</td>
<td>Has been successful in other countries. Used in our areas, and in particular in the studies.</td>
<td>Beneficiaries come looking for the peer educator and not the other way around.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Requires long-term perseverance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Numbers may drop.</td>
</tr>
</tbody>
</table>
Session 11

Problems and challenges in data collection

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

Activity: The challenges of data collection
Step 1: Group work (30 minutes)
1. Divide participants into three groups. Ask each group to work on one of the questions below, and give them the relevant pre-prepared sheet. Vertically divide a flipchart sheet and ask them to discuss their question, then to list their answers on one half of the sheet, leaving the second half empty.

   - **Group 1:** What type of challenges might a peer educator encounter when collecting data and why?
   - **Group 2:** What type of challenges might a field supervisor encounter when collecting data and why?
   - **Group 3:** What type of challenges might a programme developer encounter when assessing data and why?

Step 2: Responding to challenges (30 minutes)
2. At the end of Step 1, swap around the sheets of the three groups. Ask each group to read through the points listed on their new sheet. Ask them to answer the question below for each challenge recorded and to write their answers in the empty half of the sheet:

   - How might they face each challenge on the list?

Step 3: Presentation and discussion (30 minutes)
3. Ask each group to present the work recorded on the sheets they are currently holding. Invite comments and reactions from the other groups. Ask the presenting group to add to their sheet any further relevant points that emerge in discussion. Finish the session by stressing the important role of the field supervisor and the peer educator in terms of collecting accurate data, and the need to formulate strategies for addressing challenges encountered.

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

Objectives
At the end of this session, participants will be able to:
- identify and address the types of challenges that a peer educator, a field supervisor and a programme developer may encounter when collecting data.

Time
1 hour 30 minutes
Session 12

Time
2 hours

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

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

Problems and challenges in the street

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

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

Step 1: Brainstorming and preparation of the list (15 minutes)
1. Ask participants to brainstorm the possible risks/harms they may encounter in practice during their work. Jot down on a flipchart page key words for the risks they have named.

Step 2: Cases, presentation and discussions (1 hour 15 minutes)
2. Ask participants to work in pairs. Number off the risks listed in Step 1. Allocate one or more risks to each pair until they have all been distributed. Ask each pair to create a story of a work experience where the events lead to exposure to one or more of the risks allocated to them.
3. Ask each pair to review their stories and to propose ways that might help the peer educator to minimise or completely prevent the risk developing. Invite each pair to tell their story to the whole group, complete with the strategies they propose for addressing their potential risks. When all of the stories have been told, ask participants to offer short comments on any strategies that particularly struck them as workable or not applicable.
4. Give a short presentation on dealing with possible challenges that may be present for peer educators (see Annex 21)

Step 3: Talking about stress (30 minutes)
5. Explain the particular importance of the peer educator's health and safety and that of the project or the programme as a whole. Talk about the stress that a peer educator may encounter and discuss ways of dealing with this issue, highlighting the supportive role of the field supervisor (see Annex 22). Let participants discuss and identify potential sources of stress in their work, and how they and their organisation deal with it, or could deal with it.
Annex 21: Some of the challenges that may present in the field

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

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

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

Dealing with challenges
- Obtain support and approval from decision-makers and local organisations.
- Choose a team of peer educators in accordance with the criteria set for this work.
- Form teams consisting of peer educators and members drawn from outside the target group.
- Carefully map and survey places well in advance, and start with safe and accessible locations.
- Obtain approved ID cards for peer educators from the national AIDS programme or ministry of health.
- Ensure confidentiality of records, reports and meetings at all times.
- Avoid so-called “hot” spots where violence and hostility against the team or target group may occur.
- Hold regular meetings with team members, key community figures and/or target group members to resolve problems before they escalate.
- Observe public safety regulations and avoid getting into trouble.
- Ensure that there are always at least two people in the field, and liaise with the field supervisor to keep them informed of the team’s in and out times.
- Manage stress and don’t get emotionally involved in the problems of the beneficiaries.
Annex 22: Stress

Definition of stress, its causes and how to manage it

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

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

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

Stress management strategies

- Develop strategies for maintaining enthusiasm and job satisfaction, perhaps through periodic reviews focusing on your successes and achievements, or finding opportunities to see the bigger picture and not just the present stress-causing situation.
- Seek support for dealing with and overcoming stressful feelings, in particular discuss your feelings with the field supervisor.
- Share concerns and causes of stress with your colleagues to help you put these into perspective and see how they deal with similar situations.
- Keep abreast of work developments.
- Participate in training and workshops on a regular basis.
- Adopt relaxation and exercise techniques.
- Get involved in out-of-work activities.
- Establish a healthy balance between your professional and personal lives.
APPENDICES
Appendix 1: Sample daily evaluation form for the workshop

To be completed by participants

**Daily evaluation form**

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

Why? ...........................................................................................................................................................

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

..................................................................................................................................................................

..................................................................................................................................................................

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

..................................................................................................................................................................

..................................................................................................................................................................

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

Angry Bored Nervous Happy Very happy
Appendix 2: Sample evaluation form for each module

To be completed by participants

<table>
<thead>
<tr>
<th>Question</th>
<th>Totally agree</th>
<th>Agree</th>
<th>Don’t know</th>
<th>Disagree</th>
<th>Totally disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you find the information useful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were the exercises useful?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>What was the most important exercise for you?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Write down one new thing that you learnt</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Write down an attitude that you wish to change</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Write down a new behaviour that you learnt</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Any other suggestions?</td>
<td></td>
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</tr>
</tbody>
</table>

Write down one new thing that you learnt:

Write down an attitude that you wish to change:

Write down a new behaviour that you learnt:

Any other suggestions:

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
Appendix 3: Sample toolkit evaluation form

To be completed by the facilitator after using the toolkit

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

<table>
<thead>
<tr>
<th>Name ..................................................................................................................................................................</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation and work address ........................................................................................................................................</td>
</tr>
<tr>
<td>The toolkit was used: when........................................................ where ........................................ with whom..................................................</td>
</tr>
<tr>
<td>Did you find the toolkit useful? Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>Please elaborate.......................................................................................................................................................</td>
</tr>
<tr>
<td>Did the toolkit help you to prepare practical exercises for the training workshop? Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>Please elaborate.......................................................................................................................................................</td>
</tr>
<tr>
<td>Was the language and terminology clear? Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>If your answer was “no” to the above question, please indicate the term and the page number ........................................</td>
</tr>
<tr>
<td>How did you find the exercises?</td>
</tr>
<tr>
<td>Varied Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>Energising Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>Practical/easy to use Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>Suited the objectives Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>Did you need additional exercises when preparing the technical contents of the training workshop and would you like to see them added to this toolkit? Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>If your answer to the above question was “yes”, please say what you needed ......................................................................</td>
</tr>
<tr>
<td>Were the exercises in a logical order? Yes ☐ No ☐ Somewhat ☐</td>
</tr>
<tr>
<td>How can we better produce this toolkit? ..................................................................................................................................</td>
</tr>
<tr>
<td>Were any sections not useful and could be deleted? Yes ☐ No ☐</td>
</tr>
<tr>
<td>If “yes”, please list them..................................................................................................................................................</td>
</tr>
<tr>
<td>Were there any exercises that you preferred over others? Yes ☐ No ☐</td>
</tr>
<tr>
<td>If “yes”, please list them..................................................................................................................................................</td>
</tr>
<tr>
<td>Overall, what did you think of the toolkit? weak ☐ acceptable ☐ good ☐ very good ☐ excellent</td>
</tr>
</tbody>
</table>
Appendix 4: Sample module report

To be completed by the facilitator

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

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

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

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

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

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

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

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

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

Are there any recommendations you would give to yourself?
..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................

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

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

1. On homosexuality

<table>
<thead>
<tr>
<th>TICK THE APPROPRIATE BOX</th>
<th>TRUE</th>
<th>FALSE</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOMOSEXUALITY IS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A natural tendency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A tendency to be corrected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An attraction towards someone of the same sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible if a person has been raped at a young age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determined during adolescence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WHAT DO YOU THINK ABOUT THESE STATEMENTS?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transgender people feel that their gender identity does not match their biological state</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transvestites have male and female characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homophobia is a natural response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no gay men or lesbians in the Arab world, they only exist in the West</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men having sex with other men is a perversion and needs to be corrected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexuals have female mannerisms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men become homosexual at a young age when they start hating women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If parents were more strict about their children’s upbringing they would be able to control their sexual orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A homosexual may come to terms with his sexual orientation but will go through tough times</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is impossible to help a person without taking into account the influence of their level of education and their immediate environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vulnerability means that there are factors that expose a certain group to risk or to engage in risky behaviours</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Module 3: Implementation and Evaluation

### WHAT MIGHT BE THE CONSEQUENCES OF NOT ACCEPTING OUR SEXUAL ORIENTATION?

<table>
<thead>
<tr>
<th>WHAT MIGHT BE THE CONSEQUENCES OF NOT ACCEPTING OUR SEXUAL ORIENTATION?</th>
<th>TRUE</th>
<th>FALSE</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling guilty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually abusing children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergoing a sex change operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling unsafe with our own identity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overeating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing a serious mental health problem</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### WHAT DO YOU THINK ABOUT THESE STATEMENTS?

<table>
<thead>
<tr>
<th>WHAT DO YOU THINK ABOUT THESE STATEMENTS?</th>
<th>TRUE</th>
<th>FALSE</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM have to denounce their belief in God</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM are a social group more exposed to risk of HIV infection</td>
<td></td>
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<tr>
<td>HIV testing should be compulsory for all MSM to stop the virus from spreading</td>
<td></td>
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<tr>
<td>MSM tend to have similar problems</td>
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<tr>
<td>Law enforcement measures against MSM will deter them and change their behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The media is usually unkind to MSM but this is good because it helps to stop HIV from spreading</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some MSM engage in commercial sex and that exposes them to harm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexuality is the reason behind the spread of HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is the right of MSM to access social and health services as and when they need them</td>
<td></td>
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</tr>
<tr>
<td>A positive institutional response to the needs of MSM is a reflection of the wellbeing of the community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When parents accept their son's sexual orientation they help him come to terms with it</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. On HIV, AIDS and other STIs

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

<table>
<thead>
<tr>
<th>Statement</th>
<th>TRUE</th>
<th>FALSE</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing should be mandatory for all homosexuals, sex workers and people who inject drugs to stop the spread of HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having strict rules targeting homosexuals is the best way to stop the spread of HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV is the sex workers’ disease</td>
<td></td>
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</tr>
<tr>
<td>Testing for HIV should respect privacy and confidentiality, and be voluntary and available</td>
<td></td>
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</tr>
</tbody>
</table>

**STIs INCLUDE**

- Hepatitis B
- Syphilis
- Pubic lice
- Gonorrhea
- Chlamydia

**THE FIRST SYMPTOMS OF STIs ARE**

- Discharge
- Headaches
- Pain while urinating
- Sores on the genitals
- Painful ejaculation
- Common cold
- Nausea

**WE CAN PROTECT OURSELVES FROM STIs BY**

- Having multiple sexual partners
- Avoiding having sex with someone experiencing itchiness, pain, discharge or ulceration of the genitals
- Using the male condom
- Sharing towels, sheets and underwear
- Using clean toilets
- Using sterilised tools
### 3. On drug use

<table>
<thead>
<tr>
<th>TICK THE APPROPRIATE BOX</th>
<th>TRUE</th>
<th>FALSE</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A DRUG IS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A natural substance that affects the respiratory system</td>
<td></td>
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<tr>
<td>A natural substance that affects the central nervous system</td>
<td></td>
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<tr>
<td>A natural substance that one can easily stop using</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PEOPLE WHO INJECT DRUGS CAN PROTECT THEMSELVES FROM HIV BY</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Using a clean needle every time</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Becoming knowledgeable about the effects of the drug they are using and avoiding mixing it with other drugs</td>
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<tr>
<td>Carrying on using their own needle without sterilising it so long as they do not share it with others</td>
<td></td>
<td></td>
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<tr>
<td>Always having protected sex</td>
<td></td>
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<tr>
<td>Knowing how to use the drug without it affecting their behaviour</td>
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<tr>
<td>Disposing of needles responsibly</td>
<td></td>
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<tr>
<td>Visiting specialised harm reduction centres in their area</td>
<td></td>
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<tr>
<td>Avoiding sharing snifffing tools</td>
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</tbody>
</table>
Choose the appropriate definition for each of these terms

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

4. On behavioural change

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

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is about giving accurate information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives a free medical consultation to everyone</td>
<td></td>
<td></td>
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<tr>
<td>Distributes leaflets on behaviour change</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Distributes free condoms</td>
<td></td>
<td></td>
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<tr>
<td>Reduces the harm experienced by certain groups</td>
<td></td>
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<tr>
<td>Involves meeting young people</td>
<td></td>
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<tr>
<td>Refers the target group to medical, social and medical centres for follow-up</td>
<td></td>
<td></td>
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<tr>
<td>Changes the sexual orientation of young people</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Involves going to the places frequented by the target group and providing them with information, educational and preventive materials for follow-up</td>
<td></td>
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</tbody>
</table>

### A PEER EDUCATOR

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manipulates the police and can run away when in trouble</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is trusted by his peers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Is convinced of the importance of the programme he works for</td>
<td></td>
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<tr>
<td>Is concerned about the health of his peers</td>
<td></td>
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<tr>
<td>Has the proper health and prevention information, and is trained in providing them</td>
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</tr>
<tr>
<td>Has a good relationship with the police</td>
<td></td>
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<tr>
<td>Is willing to assess his own work</td>
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</tbody>
</table>

### WHAT DO YOU THINK ABOUT STIGMA AND DISCRIMINATION?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma is a positive attitude</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination is a negative attitude</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Discrimination is unfair to an individual or group with unacceptable behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination could come from the law in some countries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma is a negative attribute given to an individual or a group merely for engaging in a behaviour that is not accepted by many in the community</td>
<td></td>
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</tr>
<tr>
<td>Stigma and discrimination have a negative impact on the lives of those discriminated against</td>
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<tr>
<td>Vulnerability is a combination of factors that cause harm to a person and to those around him</td>
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</tbody>
</table>
5. On advocacy

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

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

<table>
<thead>
<tr>
<th>TICK THE APPROPRIATE BOX</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOCUMENTATION, M&amp;E AND COMMUNICATION ARE ABOUT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding practical ways to document the findings, the experiences, success stories and lessons learnt in the programme</td>
<td></td>
<td></td>
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<tr>
<td>Learning from the challenges in the programme</td>
<td></td>
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<tr>
<td>Ways of promoting the programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creating supportive documents for advocacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REFERRAL HELPS US TO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control the behaviour of MSM</td>
<td></td>
<td></td>
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<tr>
<td>Map MSM and available services</td>
<td></td>
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</tr>
<tr>
<td>Provide services that respect the privacy of these groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect data about the kind of services needed and their availability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WHAT DO YOU THINK ABOUT THESE STATEMENTS?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One of the selection criteria for a peer educator is his ability to control the target group in the street</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The peer educator adheres to a set of professional ethics that respects the privacy and confidentiality of the target group</td>
<td></td>
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</tr>
<tr>
<td>In order for the field supervisor to monitor the performance of the peer educator, he has to assign the role to someone close to him so he can keep an eye on the behaviour of his friends and report them</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The field supervisor is someone who is knowledgeable about the specifics of working in the street</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>TICK THE APPROPRIATE BOX</td>
<td>AGREE</td>
<td>DISAGREE</td>
<td>DON’T KNOW</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>The hotline is available to receive calls from beneficiaries when they are in trouble with a peer educator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The referral system is a set of services needed by beneficiaries and it is important to refer them to these services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One of the principles of the referral system is to maintain the privacy of the beneficiary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral services have to cooperate with the authorities by arresting people living with HIV on arrival at the centre in order to prevent them from having sexual relationships and thereby reduce the spread of HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When a social worker at the centre encounters an MSM, he must report him to his family</td>
<td></td>
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</tbody>
</table>

**SUPERVISION IS**

To help a peer educator to be successful by discussing his work with a field supervisor, who is an expert trainer in the same field

Unnecessary for those who have more expertise in the field

Inappropriate for identifying and discussing difficult cases

**WHEN SUPERVISING AND EVALUATING AN INTERVENTION, THE FIELD SUPERVISOR HAS TO**

Supervise the quality of information provided by a peer educator and the way it is offered

Lecture a peer educator on how to behave properly

Give orders on how to take appropriate action

Reprimand a peer educator and fire him if necessary

Evaluate the work and its suitability for the target group

Change the implementation plan when necessary

**DOCUMENTATION IS ABOUT**

Following up thoroughly on programme activities and monitoring the implementation process

Helping to remember what was done, with whom, when and how, and what needs to be done in the future

Helping with the design of new programmes

Taking photographs and recording conversations with beneficiaries in the street, and publishing them later in the media

Interviewing beneficiaries

**WHAT DO YOU THINK ABOUT THESE STATEMENTS?**

The number of condoms distributed and the number of those reached by the programme are qualitative indicators

The nature of the programme, and beneficiaries waiting for a peer educator to ask for condoms are quantitative indicators
The number of peer educators working in the programme is an indicator of the success of the programme

Programme evaluation is only carried out with beneficiaries, as what they have to say indicates whether the programme has been successful or not

The indicators have to be analysed by national AIDS programmes to determine what has been useful

<table>
<thead>
<tr>
<th>TICK THE APPROPRIATE BOX</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of peer educators working in the programme is an indicator of the success of the programme</td>
<td></td>
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<td>Programme evaluation is only carried out with beneficiaries, as what they have to say indicates whether the programme has been successful or not</td>
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<tr>
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</tbody>
</table>
About the International HIV/AIDS Alliance

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

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

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

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Nasr City
Cairo, Egypt
Tel: (+20) 222765257