HIV / AIDS Prevention and Capacity Development in the Pacific: Peer Education and Support Program Mapping Consultancy

Kiribati: Country Report

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Country Report

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1.0 Country summary

According to figures reported by Kiribati to SPC's HIV & STI surveillance unit, cumulative HIV cases (including AIDS) at the end of 2008 were 56—30 male, 16 female and 10 unknown—of which 28 are AIDS cases including 23 AIDS related deaths. In the *Kiribati STI and HIV/AIDS Strategic Plan 2005–2008* it states that the first HIV positive person was identified in 1991 and initial infections were concentrated with seafarers and their wives and children. However the socio-economic context makes other populations vulnerable as well including young people and those who exchange sex for money or resources.

2.0 Findings

This mapping of HIV & STI peer education programs for vulnerable populations involved: examination of national strategies, and other relevant documentation; surveying and interviewing national organisations involved in peer education; and consulting with regional organisations involved in the delivery of HIV & STI services

The following 'tight' definition of peer education has been used in this analysis:

> *the teaching or sharing of health information, values and behaviours by members of similar age or status groups*.

Peer education therefore is an education program run by, and for, members of the same peer group; and a peer is someone from the same group, in which the group members identify with each other because of certain features they have in common.

Using this definition, the information gathered is discussed with the following ten criteria in mind:

1. The project **targets a vulnerable community** in the country. The intervention is well targeted. (Basis for this comes from the national strategy and from the feedback about what the vulnerable populations are in the country.)
2. **Governance.** The peers are involved in the way things are run and the decision-making. There is **engagement with the target population** in the design, implementation and evaluation of the project. There is engagement at some levels and constant attempts are made to pursue this engagement.
3. There is obvious **support** for the peer education project at an organisational and national level.
4. **Collaborative relationship** with other organisations who are undertaking HIV peer education based activities in the country so that there is no duplication (competition) of services.
5. **Recruitment strategies** for peer educators are appropriate, systematic, ongoing and sustainable. This includes developing defined marketing strategies. There is an accepted and celebrated **exit strategy** for peer educators.
6. There is initial and follow-up education for the peer educators. There is **sustainable capacity building** of peers.

7. **Referral systems** are in place to address the needs of the target population as things arise. This includes the ability to follow-up on whether anything happened as a result of the referral (did the person actually attend for VCCT), and an ability to assess whether the referring agency is effective and provides suitable service.
8. **Evaluation**. There are set outcomes. How is the **effectiveness of the project determined?** What agreed measures are in place to assess whether this project 'makes a difference' or not, and is there a defined mechanism to report against these? It is acknowledged that this is extremely difficult, however are there attempts to do this?
9. Monitoring. A code of behaviour is defined and followed. This includes a **monitoring mechanism for the knowledge, skills and conduct of peer educators**.
10. The project makes an **obvious and tangible impact**. Things that have changed as a result of the project being in existence are able to be discussed.

2.1 The national strategy

The current national strategy is titled *Kiribati STI and HIV/AIDS Strategic Plan 2005–2008*. A detailed analysis of this strategy with reference to peer education appears as Appendix One and is summarised below.

Strengths include:

- Guiding principles highlight the right to education and preventive services for all people, including young people. Emphasis is given to the need for community support for PLWHA.
- Key target groups are identified with specific strategies referenced to each.
- Interventions are described in detail and peer education is strongly featured
- Engagement and consultation with stakeholder groups, including representatives of vulnerable populations, is demonstrated both in the development of the national strategy, and in the design and implementation of strategies.
- The training and ongoing support of peer educators is strongly supported in the strategy.
- Overall the strategy identifies a strong commitment to targeting interventions at those most at risk of HIV; encouraging stakeholder engagement and active participation at all levels of program development; the delivery of peer based interventions; and the ongoing training and support necessary to sustain those interventions.

Areas for improvement in peer education include:

- Partnership with affected communities to better facilitate program development is not identified.
- Target groups are featured as a collective and quite different populations (e.g. youth, seafarers, bus drivers, police and sex workers) are grouped together as recipients of generic peer education. There is no differentiation of strategies for separate groups.
- Stakeholders are often not defined and given the broad spectrum of vulnerable groups included in this strategy, there is no guarantee that the most marginalised will be included.

- Two vulnerable populations—sex workers and MSM—are rarely identified and the vulnerable populations that are readily referred to throughout the document tend to be occupational groups.

2.2 Other documentation

The draft *Kiribati STI, HIV and AIDS and Sexual and Reproductive Health Peer Education Strategic Plan 2009–2013* was the second document included in the review. Kiribati is one of the few countries to have developed a strategy specifically for peer education.

The strategic plan highlights the following target populations as being appropriate for peer education initiatives: PLWHA, seafarers, seafarer's wives, both in and out of school youth, transactional sex workers, MSM, shipping agents and wharf labourers.

Three priority or focus areas were identified during strategic planning workshop:

1. Capacity building of peer education project staff
2. Reducing the vulnerability of specific groups
3. Coordination, collaboration and networking of the national peer education response to STI, HIV and AIDS and sexual and reproductive health.

Within each of the priority areas, objectives, strategies, outputs and activities are listed. Although not all of the activities listed fall into the definition of 'true peer education' they do support the environment so that peer education is able to be undertaken and is able to succeed.

The strategy itself highlights this. The following paragraphs are taken directly from the section *Kiribati context and challenges*:

> In Kiribati like in other pacific Islands, peer education programs have flourished with the need for change of behaviours around STI, HIV and AIDS and sexual and reproductive health issues. With the current rapid social-economic and demographic factors contributing to a real risk of HIV infection and dysfunctional reproductive health the call by stakeholders for a Peer Education Strategy to consolidate effects is timely.
>
> The use of peer education in Kiribati has remained focussed to the South Tarawa area of Kiribati…..(and) activities have been limited to; in school youth, church youth groups, one off community talks and drama performances as well as ad hoc visits to neighbouring islands on occasion. Activities have been based on awareness campaigns around; STIs, HIV, teenage pregnancy, smoking and alcohol abuse and other sexual and reproductive health issues.
>
> It has been noted….there are still issues that remain prevalent in Kiribati such as; stigma and confidentiality, increase in reported cases of STIs, increase in teenage pregnancy and related sexual and reproductive health issues.

The Kiribati peer education strategy brings organisations together and attempts to coordinate the use of this methodology. As such it is the first step to the delivery of effective peer education in the country.

2.2 Organisations involved in peer education

Different organisations target different populations and undertake peer education in different ways. In Kiribati four organisations were identified as being involved in peer education.

2.3.1 Red Cross

Red Cross office employs two paid FTE staff, one HIV officer and 21 active peer educators (with more available as needed). The project does outreach to communities, hotels, bars, sporting events and secondary schools. This includes condom distribution and drama productions. They also work with youth groups to train youth leaders within those groups who can then network into schools. Peer educators are provided $10 remuneration for their outreach. They are also active as first aid trainers. The drama group comprises of young people aged 18–28-years, mostly unemployed who outreach to communities. Refresher training is provided as required.

The project targets marginalised youth, young people in schools (primary, secondary and tertiary), seafarers and their partners, fishing trainees, sex workers, police, transgender and MSM.. The project is currently considering targeting antenatal mothers.

Whilst the project is unable to measure its impact, there is an acknowledgement that greater awareness has been generated through the project. This has been identified through informal discussion with community members.

Referrals are made of young people to the hospital for testing. These referrals can be followed up by contacting the hospital to see if people followed up on the referral but in reality, few people test.

Strengths include:

1. There are a high number of sex workers working the visiting ships and there is a discrete association of sex workers operating on the islands. The last peer education workshop conducted in October 2008 successfully invited sex workers to attend and be trained as peer educators.
2. About ten of the peer educators are members of the MSM and Fa'afafine community and outreach to their peers.
3. There is an intention to expand the peer education project to the outer islands with the establishment of new Red Cross branches. It is hoped to double the number of contacts in 2009.
4. Peer educators outreach to public bars, and make use of the family and social networks. Condoms are distributed through these contacts.

5. Recruitment of peer educators is through others by linking into their social networks. Training workshops are constrained by funding to two per year, but an additional one has been conducted due to the great demand from many young people wishing to be trained.
6. The offer of financial remuneration does assist in attracting recruits.
7. The peer educators themselves decide what activities should take place. Language and literacy can make it difficult for young people to be involved in project design but drama has provided opportunities for some input.
8. There is a well organised network of NGOs on the island involved in peer education—Family Health Association, KANGO and AHD.

Opportunities for further development in peer education:

1. Outreach has been restricted to monthly episodes because of the financial impost of remunerations.
2. Monitoring and evaluation is poor due to the geographic spread, literacy levels, the number of peer educators, limited supervisory staff and lack of appropriate evaluation tools.
3. Outreach to PLWHA is yet to be developed due to lack of funds and there is a greater need to encourage support and advocacy. Many PLWHA remain undiagnosed or living in isolation for fear of stigmatisation.

2.3.2 Adolescent Health and Development Program

The AHD program targets young people aged 10–24-years but can be accessed by older clients seeking STI and HIV testing. Peer educators conduct promotional and awareness programs. These peer educators travel to communities to deliver awareness activities, training workshops for youth including life skills, advocacy seminars for decision makers, parents and elders, training of trainers and even radio programs.

Two FTE staff and 11 peer educators are employed of which one is a Youth Project Officer (new post this year). Four peer educator trainers are paid whilst the remainder are paid incentives of $20 per day. The project primarily targets high risk youth. The peer educators are aged 20–26-years but see people over a wide range. Peer education is conducted jointly with other agencies, and use is made of facilitators and speakers from other NGOs. The AHD program is part of the Kiribati HIV Task Force and receives good support from sponsoring agencies and some support from government.

Workshops have been held for sex workers over the last two-years, but sex worker outreach is now being managed by another NGO, KANGO. As a result the AHD program has refocussed on youth. Contact is made through the community leader, with whom the project is discussed. Youth are called together to discuss potential strategies. Young people are recruited from the community to become peer educators. Once trained they outreach to distribute condoms and provide one-to-one information.

Strengths include:

1. The National Peer Education Committee conducted a mapping exercise of high risk communities to identify areas of high risk. The program is consequently targeting those communities.
2. An M&E system was instituted in 2008. Programs were delivered to particular islands, and after six months, peer educators returned to those islands to conduct focus group discussions with parents, elders and young people to determine whether they had seen changes in particular individuals.
3. Peer educators decide on the activities to be implemented.
4. Good collaboration has evolved with NGOs, government and some churches.
5. The program conducts VCCT itself, collecting the blood and sending it for testing. Results return to the program so there is follow-up of young people.

Opportunities for further development in peer education:

1. Many more communities need to be reached.
2. Need to constantly retrain because of attrition.
3. Assess and identify vulnerable groups.
4. Peer educators have a need for greater refresher training and for more opportunities to come together with other NGOs.
5. Youth friendly services have just integrated into the public health mainstream this year for sustainability. Three community public health clinics are piloted this year; two at Bikenibeu and one at Temaiku.

2.3.3 Kiribati Family Health Association

Kiribati Family Health Association, founded in 1997, employs five FTE staff and 25 volunteers, and addresses HIV as a cross cutting issue under the IPPF strategic framework (the five As—Advocacy, Access, Abortion prevention, Adolescents and HIV/AIDS). The organisation delivers peer education.

About 20% of the organisation's activities are devoted to peer education, utilising the services of a youth officer and volunteer. The project targets: marginalized young people, young people attending school, women, people living in rural / remote communities, seafarers and partners of seafarers.

The peer education carried out is through outreach in the various communities, including those in and out of schools. It refers to a one-to-one sharing of information between a youth peer educator and a youth client. More formal peer education is conducted by KFHA to train peer educators on how to deliver information to others.

Strengths include:

1. The organisation is mentioned in the national HIV/sexual health strategy; is a member of the National HIV Task Force; and is a part of a peer education network. KFHA is a member of the Kiribati National Peer Education Committee, which consists of NGOs, GOs, and FBOs.
2. It collaborates with the MOH and Kiribati Institute of Technology and is invited as resources in the training conducted.

3. The KFHA is providing family planning and sexual and reproductive health services complementing MOH health services and therefore does not need to refer to other services.
4. There is support for peer education by the organisation and Ministry of Health.
5. The KFHA has conducted a ToT and leadership training for youth peer educators in 2008. External training has also been made available.

Opportunities for further development in peer education:

1. Other vulnerable groups identified include sex workers. There has been no specific training for these groups but rather they are grouped with other community members.
2. Youth peer educators are only paid for their return bus fares and refreshments during their visits, which is equivalent to AUD10 each per visit.
3. There was a feeling that there should be greater clarification on the general aim and purpose of peer education to engender a uniform understanding amongst those organizations utilizing this tool for community education.

2.3.4 Kiribati Association of NGOs (KANGO)

It is understood that KANGO is involved in peer education initiatives however no information about this organisation was obtained.

2.4 Regional organisations

The mapping exercise also included consultations with regional partners based in Fiji on peer education. The following raised Kiribati in their discussions.

2.4.1 Marie Stopes International

Developed initially in Fiji, the condom social marketing (CSM) program of MSIP relies upon peer distribution of condoms. Persons with previous experience in peer education (often head hunted from existing agency networks) are trained in sales and marketing and are designated as peer leaders. The training workshop is a two-day program dealing with the principles of CSM with refresher training on HIV and other STIs. The educators recruit teams of condom distributors from villages (or from vulnerable communities). This model was first developed in Fiji and is now being implemented in other countries, including Kiribati, where MSIP has partnered with a local organisation and selected trained educators to become skilled in CSM. Though initially developed as a peer education program, CSM has become more of a community education and outreach project with less focus placed on engaging and developing peers as distributors and educators.

2.4.2 Secretariat of the Pacific Community and UNFPA Adolescent and Reproductive Health Program

The Adolescent Reproductive Health (ARH) Program was implemented across the Pacific in 2001 as a UNFPA sponsored program in collaboration with SPC. UNICEF established a life skills program in 2002 which took on a broader scope of adolescent development beyond

ARH and became the Adolescent Health & Development (AHD) Program in 2005 by merging with the UNFPA-SPC project.

The life skills program utilised master trainers within existing NGOs and attached SRH to their agenda. The ARH program placed coordinators in each country but over time their role has diversified, and at times, confused as they take on a wider range of activity and responsibility.

Within the AHD program, some coordinators are placed within the MoH, some take on a support role for lead agency NGO, and others offer technical assistance to a range of NGOs. In Kiribati, the AHD program operates a drop in centre from which peer educators operate. The AHD, Family Health Association and KANGO have formed a Peer Education Coordinating Committee which has created a coordinated approach wherein each NGO is designated a particular target population. Workshops have been delivered to transactional sex workers.

The AHD program has responsibility for operating youth centres, clinics, nurses, peer educators and has moved beyond sexual and reproductive health to encompass a full range of health issues, although this remains its focus.

2.4.3 UNICEF

UNICEF is keen to redirect the AHD program so that it can focus more on the most vulnerable youth populations through the adaptation of certain aspects of its training and capacity. To commence this process, an exercise will soon commence to map vulnerable populations in three countries—Vanuatu, Solomon Islands and Kiribati. UNICEF will be closely working with the AHD program in these countries to develop their capacity to target vulnerable groups.

2.4.4 UNFPA

UNFPA has supported some pilot projects on sex worker peer education in FSM, Fiji, Marshall Islands, Vanuatu, Solomon Islands and Kiribati. In FSM, Kiribati, Solomon Islands and RMI sex worker peer educators attended training workshops to gain knowledge and skills on HIV/STIs, promotion/distribution of condoms and the benefits of VCCT. The sex work peer education initiatives have been a response to local need. UNFPA's involvement has been technical support and a small amount of funds to run some workshops. There has also been assistance to FSM, Kiribati, and the Marshall Islands with technical support regarding grant submissions in support of sex worker peer educator programs, extending the above pilot projects.

3.0 Discussion

It is evident that peer education is being utilised effectively in Kiribati. Different organisations utilise the methodology in different ways and target different vulnerable populations. Many of the components of an effective coordinated HIV peer education initiative are in place however confusion over the methodology does exist.

At times community awareness and community based education activities are given the name of peer education although the specific activity may not be 'true peer education' according to the definition cited above. Given this, there are aspects that can be more finely developed and that will greatly assist the sustainability of this methodology.

One significant area—and one that is common in many other countries—is the need for effective monitoring and evaluation. The Red Cross program is trying to encourage peer educators to conduct more one-to-one interventions rather than with general groups. In this way activity reports can be completed for individuals who can be followed up. Nonetheless forms are not very well completed due to literacy issues. Consequently, the monthly meetings are important as they allow peer educators to come together and tell their stories. But evaluation to date has comprised simple "head counting" of participants. There are no pre and post test evaluations of changes in knowledge, behaviours or attitudes, particularly after drama presentations. Therefore there is an urgent need to devise a suitable monitoring tool that can engender greater accountability of peer educators; to evaluate responses from the community; to better monitor peer education activities; and to collect information from the community.

A second area is the broadening of peer education to embrace a number of community social issues. It was noted during discussions that individuals are 'tired' of the HIV message. HIV has been the focus of peer education for a long period. Integrating HIV with other peer education sessions e.g. first aid or other Red Cross programs are methods of circumventing this lack of interest. It has the added benefit of addressing usual and inevitable funding shortfalls.

It is noted that there is a well organised network of NGO on the island involved in peer education. The network meets every month to discuss mission, vision and activities. The network coordinates activities and avoids overlapping programs by designating particular villages to particular NGOs. Each agency decides which islands will be covered. However it is also noted that much of the activity described occurs in the main centre of Kiribati and there is need to reach other parts of the country.

All NGOs who undertake youth peer education pay their peer educators the same rate. Payment for involvement in peer education is standard practice and appears to reap the benefit of continued involvement. An adverse outcome of payment for this type of activity is that the level of output may decrease as individuals are paid per session / activity rather than paid on outcome. The ratio of volunteers that are paid for the work that has been described in this mapping exercise illustrates this may of concern in Kiribati.

Sources of income are difficult to obtain and a needs assessment of young people identified that males want more income generating activities and trade skills, whilst females are seeking increased domestic skills such as sewing and cooking. This demonstrated a strong desire by young people for practical skills.

While the number of individuals living with HIV in Kiribati is significant, there is a window of opportunity to adopt a coordinated and integrated approach to HIV prevention education

based on peer education methodologies that has the chance to greatly curb rises in HIV notifications. Groundwork for effective HIV peer education is in place and organisations are networked and collaborating on many initiatives.

4.0 Recommendations

1. The national strategy should differentiate between the different vulnerable groups, particularly with respect to occupational versus social groupings and interventions should be designed to specifically address these.
2. Those who are most marginalised should be involved in the consultation in strategic planning and the implementation of programs. These should include sex workers and MSM.
3. Clarification on the aim, purpose and essential methodology of peer education should be undertaken to engender a uniform understanding amongst organizations involved in this area and to foster a standardised approach to this methodology.
4. Efforts to identify the needs of those within vulnerable groups should be undertaken. This includes an assessment of the levels of involvement capable of individuals within these populations.
5. Outreach and support to individuals living with HIV in Kiribati should be enhanced. This includes advocacy roles within organisations.
6. Greater outreach to the outer islands is warranted.
7. Specific training for sex workers needs to be considered within the context of small communities.
8. If recommendations 5, 6 & 7 are unable to be fulfilled, special consideration for the needs of particular vulnerable groups is to be included within broader community education.
9. The restrictions imposed on peer education outreach due to the financial impost of remunerations should be addressed with enhanced funding or more efficient/effective targeting of PE activities at those most in need.
10. Monitoring and evaluation processes need to be addressed, including the development of evaluation tools appropriate to the unique constraints of Kiribati (geographic spread, literacy levels, limited supervisory staff).
11. Increased opportunities for refresher and recruitment training should be considered to meet the growing demand of volunteers and rapid attrition rates.

Appendix One

Analysis of peer education within the national strategy

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008		
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	All people have the right to accurate information about HIV, AIDS, STI, voluntary counselling and testing (VCT) and sexual and reproductive health. All people and groups have the right to protection from HIV infection and to care, support and treatment if they become infected. Any person regardless of age, gender, status, or health has the right to live in a healthy and happy community. During the planning process, participants recommended that human rights be a priority area. Instead of maintaining human rights as a separate sixth priority area, three working groups incorporated human rights issues into their priority area plans: Priority Area 1, Priority Area 2 and Priority Area 5.
	Partnership and engagement with the affected community (i.e. vulnerable groups)	Stigmatisation and labelling, or discrimination towards a person living with HIV or AIDS should be considered as a breach of Christian ethics and illegal. All people be encouraged to prevent people living with HIV or AIDS from suffering humiliation and discrimination. Community members should be encouraged to support and help people living with HIV or AIDS, their spouses, families and others affected. Christian families and strong family ties should encourage and enhance genuine and compassionate love, care and pastoral care to meet the needs of PLWHA, their families and other's affected.
	Engagement of young people and their right to access education & prevention services.	Parents and families have a role to play in supervising and controlling their children for the prevention of HIV. Parents and families should have open communication with their

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008		
		children about sex, STI and HIV.
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Priority Area 2: Reducing the vulnerability of specific groups Goal: To stabilize and reduce the prevalence of HIV and other sexually transmitted infections (STI) in Kiribati within specific targeted groups Objectives: 2.1 Create an enabling environment to support behaviour change for vulnerable specific groups and the general population 2.2 Establish behavioural surveillance and research with targeted populations to assist in program design Output: 2.1.1 Improved knowledge among specific targeted risk groups on HIV, AIDS and other STI, and increased awareness on safer sex practices and the rights of those living with HIV or AIDS Activities: 2.1.1.1 Conduct workshops for specific risk groups on HIV, AIDS and STI and on safer sex practices 2.1.1.2 Conduct drama for specific risk targeted group on HIV, safer sex practices, and messages to reduce stigma and discrimination for those PLWHA, 2.1.1.3 Conduct radio spots twice weekly on safer sex practices 2.1.1.4 Negotiate condom promotion and safe sex promotion for TV 2.1.1.5 Peer educators conduct school visits on quarterly basis beginning at class six and with upper forms 2.1.1.6 Peer educator outreach to specific groups (seafarers, seafarers wives, PLWHA, prisoners, wharf labourers, officers, shipping agents, and police) Output: 2.1.9 Increased condom distribution and increased condom use by targeted vulnerable groups Output: 2.2.1 Baseline data and repeated surveillance completed with seafarers, young people and individuals having transactional sex Activities: 2.2.1.2 Identify key surveyors (10) for each surveillance targeted group 2.2.1.3 Train surveyors who have on how to conduct a survey, research ethics 2.2.1.6 Conduct baseline behavioural surveys for each targeted group 2.2.1.7 Data is input into a database, analysed and results compiled into surveillance reports 2.2.1.8 Behavioural surveillance reports are made available to stakeholders and utilized by stakeholders	

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	involved with target groups to improve their strategies and services Priority Area 3: Prevention & Control of sexually transmitted infections (STI) Goal: To reduce the number of reported cases (prevalence) of sexually transmitted infections in Kiribati Objectives: 3.1 To ensure effective treatment of STI through all health facilities and by traditional healers 3.2 To encourage VCCT amongst priority groups and people treated for STI 3.3 To conduct unlinked HIV and behavioural surveillance for people with STI 3.4 To reduce unprotected sex amongst targeted priority groups 3.5 To create a clear epidemiological picture of sexually transmitted infections by age and sex Output: 3.4.3 Increased knowledge of STI, HIV, AIDS and safe sex of targeted groups (young people, bus drivers, police) Activities: (See Output 2.1.1 and related activities) 3.4.3.4 Provide information on STI, HIV, AIDS, and safe sex 3.4.3.4 Conduct workshops by trained peer educators with targeted groups (young people, bus drivers, police)
Does the Strategy highlight the importance of peer education as an intervention?	Output: 2.1.1 Improved knowledge among specific targeted risk groups on HIV, AIDS and other STI, and increased awareness on safer sex practices and the rights of those living with HIV or AIDS Activities: 2.1.1.5 Peer educators conduct school visits on quarterly basis beginning at class six and with upper forms 2.1.1.6 Peer educator outreach to specific groups (seafarers, seafarers wives, PLWHA, prisoners, wharf labourers, officers, shipping agents, and police) Output: 2.1.2 Competent Peer educators trained from each targeted vulnerable group and involved and supported in peer education activities Activities: 2.1.2.4 Ongoing Peer education with risk groups (FSP, ARH, Marie Stopes, church youth groups) is implemented Output: 2.1.7 Two youth friendly community centres established and functioning (South Tarawa and Kiritimati) that integrate VCT, sexual health, and condom distribution (See links with Priority Area1: Output

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	1.3.1 and Priority Area 3: Output 3.2.1) Activities: 2.1.7.4 Identify peer educators, VCT counsellors and staff who are going to manage the centre 2.1.7.5 Identify and train peer educators and health education staff in IEC materials production and desktop publishing at the centre. Output: 2.1.8 All local and overseas ships where local seafarers are on board are supplied with condoms and information and have seafarer peer educator outreach Activities: 2.1.8.1 Identify key seafarer peer educators that have been trained for ship outreach program 2.1.8.2 Create IEC materials with the input of seafarer peer educators and produce these materials 2.1.8.5 Link seafarer peer educators with the Maritime Training Centre activities Output: 3.2.1 Established and funded VCCT Centre where STI treatment is available (refer to link with Priority Area 1, Output 1.3.1: Priority Area 2: Output 2.1.7) Activity: 3.2.1.7 Identify and train peer educators, health workers, and other stakeholders in VCT (including counselling on STI), their roles in the referral system for care and treatment, data recording and reporting systems, and rapid HIV testing (refer to link with Priority Area 1, Output 1.3.1) Output: 3.4.1 Well-trained and competent peer educators (for youth, police and bus drivers) Activities: (See Output 2.1.2 and related activities) 3.4.1.2 Identify venues 3.4.1.5 Create support system for peer educator outreach Output 3.4.2 Increase in BCC materials produced Activities: 3.4.2.8 Peer educators distribute materials Output: 3.4.3 Increased knowledge of STI, HIV, AIDS and safe sex of targeted groups (young people, bus drivers, police) Activities: (See Output 2.1.1 and related activities) 3.4.3.3 Identify trained peer educators to run workshops 3.4.3.4 Conduct workshops by trained peer educators with targeted groups (young people, bus drivers, police)

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008									
	Output: 5.6.1. STI, HIV and AIDS resource centre running and used Activities: 5.6.1.4 Mobilize peer educators and volunteers from partner organizations to man the resource centre as part of their outreach								
Vulnerable Groups identified in Strategy and associated Prevention Strategies/Actions identified in Strategy	Population Intervention	PLWHA	Prisoners	Seafarers & wives	Youth	Sex workers	MSM	Police	Bus Drivers
	Behaviour surveillance surveys			YES	YES	YES			
	Peer education Outreach *FSP, ARH, Marie Stopes, Red Cross AHD, KFHA, KANGO, church youth groups*	YES	YES	YES	YES	YES	YES	YES	YES
	Media campaign (Billboards) *KHATBTF including PLWHA*	YES							
	Condom Day *Peer Education committee*	YES		YES	YES	YES	YES	YES	YES
	Life skills education				YES				
	youth friendly community centres *ARH*				YES				
	IEC materials produced by peer educators *MTC, Marie Stopes*			YES					
	Safe sex workshops				YES			YES	YES
	Drama								
	BCC materials Distributed by peer educators								
	Condom distribution *ARH, MTC, FSP, Marie*			YES	YES			YES	YES

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008									
	Stopes, KHATBTF								
	BCC materials produced *HIV resource centre*								
	KHATBTF committees	YES							
Does the strategy highlight the importance of partnership/engagement with vulnerable groups? Refs .	In 1998, representatives from different sectors came together with the Ministry of Health (MOH) to create the Kiribati HIV/AIDS Task Force (KHATF). These sectors included: NGO's such as AMAK (Aia Maea Ainen Kiribati / Kiribati Women's Federation), the Red Cross, Foundation of the South Pacific (FSP), Kiribati Islands Seamen Wives Association (KISWA) and Kiribati Overseas Seamen's Union (KIOSU); the two major Church denominations of the Roman Catholic Church (RC) and the Kiribati Protestant Church (KPC); people from the business sector; and other Government representatives and Ministries. In 2000, based on the data and recommendations from the Interim Action Plan report, the Kiribati STI and HIV/AIDS Strategic Plan was developed. A multi-sectoral group led by the Kiribati Overseas Seamen's Union, with representation from government, NGOs, and the Churches developed the plan. The strategic plan presents answers and solutions to problems in Kiribati. The Kiribati HIV National Strategic Planning Workshop was held March 14 – 18 2005. Forty people participated at different times throughout the week with a range of sectors from government departments, non-government organizations including youth and a women's representative, churches, police services, members of parliament, a town council, and the representative from the Asia Pacific Leadership Forum (APLF). The development of this strategic plan has involved a variety of stakeholders including government ministries, local and international non-government organizations, church and community based organizations. Output: 1.2.4 IEC materials on care and support for PLWHA and on positive living are developed, produced and distributed Activities: 1.2.4.1 Establish a committee from the KHATBTF and involving PLWHA to develop and produce IEC materials on clinical and home care, VCT, positive living, anti-stigma and discrimination Output: 1.4.1 PLWHA are readily accepted in the community and in the health system								

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	Activity 1.4.1.3. Support the development of a network of positive people Output: 2.1.3 Media campaign with five billboards completed in high-risk areas within South Tarawa with messages on ways to protect oneself from HIV infection and to decrease stigma and discrimination Activity 2.1.3.4 Create a committee of stakeholders of the KHATBTF including PLWHA to develop the key messages and review billboard designs prior to their production (see link with Priority Area 1: Output 1.2.3, Activity 1.2.3.1) Output: 2.1.4 A condom day is established as part of World AIDS day activities with special attention to high-risk groups Activities: 2.1.4.2 Peer Education committee to take lead in creating a Condom Day 2.1.4.4 Invite all high-risk groups to participate in the condom day Output: 2.1.6 A Behaviour Change Communication Strategy is created with stakeholders Activities: 2.1.6.1 Plan training workshop for stakeholders on building Behaviour Change Communication and building BCC strategies 2.1.6.2 Identify key people to train the workshop (expertise support) 2.1.6.5 Participants develop a BCC strategy Output: 2.1.8 All local and overseas ships where local seafarers are on board are supplied with condoms and information and have seafarer peer educator outreach Activities: 2.1.8.2 Create IEC materials with the input of seafarer peer educators and produce these materials Output: 2.1.9 Increased condom distribution and increased condom use by targeted vulnerable groups Activities: (See also Output 3.4.4 and relevant activities) 2.1.9.1Conduct a consultation workshop for stakeholders to get agreement from partners to distribute free condoms and sell Try Time, create a system for record keeping, create clear information on condom use, and develop strategies for condom promotion and ongoing condom distribution 2.1.9.2 Condom promotion and distribution system created with stakeholders and guidelines are endorsed by the Task force and distributed to all stakeholders involved in condom distribution 2.1.9.3 Create a condom committee with stakeholders involved in condom distribution to analyse condom

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	distribution monitoring data and supplies of in-country stock Output: 2.2.1 Baseline data and repeated surveillance completed with seafarers, young people and individuals having transactional sex Activities: 2.2.1.2 Identify key surveyors (10) for each surveillance targeted group 2.2.1.3 Train surveyors who have on how to conduct a survey, research ethics 2.2.1.8 Behavioural surveillance reports are made available to stakeholders and utilized by stakeholders involved with target groups to improve their strategies and services Output 2.3.1 HIV management legislation to protect the rights of people living with HIV, their families and communities is endorsed by Parliament Activities 2.3.1.1 Consultation workshop with key stakeholders and create a working committee including PLWHA Output 3.4.2 Increase in BCC materials produced Activities: 3.4.2.1 Create a BCC committee with stakeholders Outcomes: Priority 5 5.1 A functioning coordination mechanism and secretariat is established for the KHATBTF 5.2 Improved organizational structure, membership and constitution for the KHATBTF 5.3 Improved capacity of organizations and stakeholders involved in the response 5.4 Strengthened political advocacy on HIV/AIDS related issues 5.5 NSP is coordinated, implemented, monitored, and evaluated by the KHATBTF 5.6 Improved access to STI, HIV and AIDS resource materials 5.7 Improved funding and support for NSP activities in Tarawa and Outer Islands by donors, UN agencies and international NGOs 5.8 Improved management of the KHATBTF and advisory body established 5.9 Reduced stigma and discrimination of PLWHA Output: 5.2.2 Membership of the KHATBTF expanded for a broader response Activities: 5.2.2.1 Membership of the task force is reviewed

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	5.2.2.2 Government and NGO and CSO are identified that could play a role in the HIV response in Tarawa and Outer Islands 5.2.2.3 Information pamphlet on KHATBTF is created and produced 5.2.2.4 Consultations are made with potential stakeholders in South Tarawa and Outer Islands and pamphlets are sent to other provincial governments and groups 5.2.2.5 New members are invited to KHATBTF meetings and trainings where appropriate Output: 5.9.1 PLWHA actively participate in KHATBTF committees, prevention, and treatment and care activities and anti-stigma and discrimination media campaigns Activities: 5.9.1.1 KHATBTF members are given sensitisation training about living positively and about human rights issues. 5.9.1.2 KHATBTF members encourage the involvement of PLWHA in activities, planning, campaigns and committees 5.9.1.2 Involvement of PLWHA is coordinated by the secretariat
Does the strategy highlight the importance of training for peer workers? Refs.	Output: 2.1.2 Competent Peer educators trained from each targeted vulnerable group and involved and supported in peer education activities Activities: 2.1.2.1 Identify participants from targeted populations for peer education training 2.1.2.2 Develop a peer educator-training package that considers the needs and approach of the targeted populations 2.1.2.3 Conduct training for peer educators (youth, seafarers, seafarer's wives, sex workers, MSM, young people) from targeted populations 2.1.2.4 Ongoing Peer education with risk groups (FSP, ARH, Marie Stopes, church youth groups) is implemented 2.1.2.5 Give ongoing support to peer educators and create a monitoring system Output: 2.1.5 Life Skills education is given to in and out of schools adolescents (South Tarawa and Outer Islands) Activities: 2.1.5.3 Invite trainers from development partners to conduct life skills training workshop

Country: Kiribati Strategy Document: STI and HIV/AIDS Strategic Plan 2005–2008	
	2.1.5.4 Conduct a Training of Trainers workshop TOT 2.1.5.5 Trained trainers to train their peers in life skills 2.1.5.6 Develop a support system for life skills trainers Output: 2.1.7 Two youth friendly community centres established and functioning (South Tarawa and Kiritimati) that integrate VCT, sexual health, and condom distribution (See links with Priority Area1: Output 1.3.1 and Priority Area 3: Output 3.2.1) Activities: 2.1.7.5 Identify and train peer educators and health education staff in IEC materials production and desktop publishing at the centre. Output: 3.2.1 Established and funded VCCT Centre where STI treatment is available (refer to link with Priority Area 1, Output 1.3.1: Priority Area 2: Output 2.1.7) Activity: 3.2.1.7 Identify and train peer educators, health workers, and other stakeholders in VCT (including counselling on STI), their roles in the referral system for care and treatment, data recording and reporting systems, and rapid HIV testing (refer to link with Priority Area 1, Output 1.3.1) Output: 3.4.1 Well-trained and competent peer educators (for youth, police and bus drivers) Activities: (See Output 2.1.2 and related activities) 3.4.1.1 Develop training (resource persons, manual and specific material for targeted groups) 3.4.1.2 Identify venues 3.4.1.3 Plan budgets for training workshops 4.3.1.4 Conduct peer educator training 3.4.1.5 Create support system for peer educator outreach Output: 3.4.3 Increased knowledge of STI, HIV, AIDS and safe sex of targeted groups (young people, bus drivers, police) Activities: (See Output 2.1.1 and related activities) 3.4.3.3 Identify trained peer educators to run workshops 3.4.3.4 Conduct workshops by trained peer educators with targeted groups (young people, bus drivers, police)

Appendix Two

Summary of interviews with local organisations

Red Cross

Red Cross office employs two paid FTE and one HIV officer which commenced funding in October. Twenty-one active peer educators are engaged with more available as needed.

The organisation commenced in 1979. Currently there are no formal documents e.g. constitution (although one is currently under development), volunteer policy, no formal definition of peer education.

The Secretary General commenced work in mid 2005, occupies both a paid and voluntary position and works approximately 40 hours per week.

A personal definition of peer education is “same age working with same age”, “one age group working together”.

The project does outreach to communities, hotels and bars on a monthly basis with condom distribution and drama productions. They also do outreach to sporting events, secondary schools and work with youth groups to train up youth leaders within those groups who can then network into schools. Peer educators are provided $10 remuneration for their outreach work. The peer educators are also active as first aid trainers.

The project targets marginalised youth, young people in schools (primary, secondary & tertiary), seafarers and their partners, fishing trainees, sex workers, police, transgender and MSM. The project is currently considering targeting antenatal mothers. Injecting Drug use levels are unknown to date.

There are a high number of sex workers working the visiting ships and there is a discrete association of sex workers operating on the islands. The last peer education workshop conducted in October 2008 successfully invited sex workers to attend and be trained as peer educators. The project is planning to repeat this exercise.

About 10 of the peer educators are members of the MSM and Fa’afafine community and outreach to their peers.

Monthly meetings are held for the review of activities of PE with the HIV officer. Participation in those meetings is remunerated at $10, and transport and meals are provided. Sex workers participate in these meetings.

Activities undertaken by peers as part of this project include one-to-one education, group education, education sessions, social support, advocacy, drama productions, media presentations such as radio shows, condom distribution, resource distribution, content knowledge and skill training. Experts from the Family Health Association and KANGO provide technical training on communication skills.

The drama group comprises of young people aged 18–28-years, mostly unemployed who outreach to communities. They request approval from the community leaders before presenting. Unfortunately outreach has been restricted to monthly episodes because of funding constraints. Integrating HIV with other peer education sessions e.g. first aid or other Red Cross programs are methods of circumventing the funding shortfall.

The HIV program targets young people—marginalised, in school, church groups and community.

The aim of the project is to reduce HIV infection and reduce discrimination against PLWHA. There are about 40 diagnoses and 20 have passed away. Only two have come out about their status.

Monitoring and evaluation is considered one of the more difficult challenges due to the geographic spread, the number of peer educators, limited supervisory staff and lack of evaluation tools. Currently peer educators are asked to complete an activity form and report back to the HIV coordinator. The program is trying to encourage peer educators to conduct more one-to-one interventions than with general groups. In this way activity reports can be completed for individuals who can be followed up. Nonetheless forms are not very well completed due to literacy issues. Consequently, the monthly meetings are important as they allow peer educators to come together and tell their stories. But evaluation to date has comprised simple "head counting" of participants. There are no pre and post test evaluations of changes in knowledge, behaviours or attitudes, particularly after drama presentations. Therefore there is an urgent need to devise a suitable monitoring tool that can engender greater accountability. There is a need to evaluate responses from the community, to better monitor activities and to collect information from the community.

Whilst the project can't measure whether it has been successful, there is an acknowledgement that greater awareness has been generated through the project. This has been identified through informal discussion with community members.

It is believed that the project contacted approx 4,000 people in 2008. There is an intention to expand the project to the outer islands with the establishment of new Red Cross branches. It is hoped to double the numbers reach in 2009.

In order to establish contact, peer educators outreach to public bars, and make use of the family and social networks. Condoms are distributed through these contacts. Community education is arranged through contact with village leaders a few days prior.

Recruitment is through other peer educators linking into their social networks. Training workshops are constrained by funding to two per year, but an additional one has been conducted due to the great demand from many young people wishing to be trained. Approximately 10–20 people are trained. The offer of financial remuneration does assist in attracting recruits.

The peer educators themselves decide what activities should take place. Language and literacy can make it difficult for young people to be involved in project design but drama has provided opportunities for some input. Nonetheless any drama content needs to be checked with the HIV task force for accuracy.

With respect to the needs of young people, the most urgent are to increase awareness, to increase their sense of trust in the confidentiality of clinical services, to reduce embarrassment concerning STI testing and VCCT, and to increase their sense of security and confidence in the project.

The most important needs of the target group are to make them feel secure by stressing the confidentiality in peer interactions. There is a critical need to make the person feel comfortable and safe.

It has been hard to monitor the behaviour of peer educators during outreach and incidents can occur from time to time. It is important to stress the code of conduct at regular intervals, reminding peer educators of their commitment and public reputation. At times, meetings with the peer educators have involved members of the Board to emphasize with them their code of conduct.

What has worked well has been the effectiveness of the outreach of information across the community. The deficiency in the program has been the inability to measure the effectiveness of peer education. Monitoring and evaluation has not worked well and the program is trying harder to make peer educators accountable with an effective measuring tool. At present, there is an over reliance on trust.

There is a well organised network of NGOs who are involved in peer education—Family Health Association, KANGO and AHD. The network meets every month to discuss mission, vision and activities. The network coordinates activities and avoids overlapping programs by designating particular villages to particular NGOs. Each agency decides which islands will be covered and communicates with each other e.g., the outer islands will be allocated to the Red Cross following the establishment of branches there. HIV programs will be integrated with first aid and other sessions due to limits in funding. All NGOs undertake youth peer education and pay their peer educators the same rate.

Referrals are made of young people to the hospital for testing. These referrals can be followed up by contacting the hospital to see if people followed up on the referral but in reality, few people go the testing. Consequently, the program relies heavily on drawing groups of young people to the blood bank and provides HIV testing through there.

Refresher training is provided as required and is more flexible in its scheduling despite budget constraints. Peer educators also attend external training offered by other partners in the network.

Elements of a good peer educator include:

- Ability to communicate messages appropriately
- Accurate knowledge
- Good role modelling of behaviour (good moral conduct).

Vulnerable populations that are yet to be targeted include women in antenatal care (though KFHA may be targeting them already as they are better resourced with nursing staff). Outreach to PLWHA was also highlighted as it is a program not currently funded for and there was a greater need to encourage greater support and advocacy for them. Many PLWHA remain undiagnosed or living in isolation for fear of stigmatisation. Further to this, workplace policies and issues for PLWHA need to be looked at to ensure that persons are deprived of their livelihood.

No gaps could be identified in the training of PE as the current program appears to fulfil the aims of the project. There is an identified need for more refresher training.

One concern with respect to support and collaboration was the possibility of competition emerging among the partners of the peer education network the more resourced agency seeks to take on the role of lead agency.

Greatest needs identified were:

- More support for activities that were planned
- More refresher training
- More recruitment training for new peer educators
- Increased funding to allow for greater outreach to PLWHA
- Increased funding to allow more outreach to the outer islands, particularly with respect to PLWHA
- Improved methods of monitoring and evaluation.

Adolescent Health and Development Program

The AHD program targets young people aged 10–24 years but can be accessed by older clients seeking STI and HIV testing.

Peer education is conducted through training young people to be peer educators and work with the program in conducting promotional and awareness programs. They travel to communities to deliver awareness activities, training workshops for youth including life skills, advocacy seminars for decision makers, parents and elders, training of trainers and even radio programs.

One AHD coordinator and 11 peer educators are employed of which four are paid while the remainder are paid incentives of $20/day. One public health nurse is employed by the Ministry. The project primarily targets high risk youth. The peer educators are aged 20–26-years but see people from a wide range. The National Peer Education Committee conducted a mapping exercise of high risk communities to identify areas of high risk. The program is consequently targeting those communities. In addition, workshops have been held for sex workers over the last two-years but sex worker outreach is now being managed by another NGO, KANGO. As a result, AHD program has refocussed on youth.

An M&E system was instituted in 2008. Programs were delivered to particular islands, and after six months, peer educators returned to those islands to conduct focus groups for parents, elders and young people. Questionnaires were circulated and members of the three groups were interviewed to determine whether they had seen changes in particular individuals.

It is believed that the project has made a difference, evidenced by some changes seen in behaviour e.g. decrease in drinking, but such change has been slow. As well, numbers of persons accessing clinical services following an education session has been measured, with some increase identified.

Contact is made through the community leader, with whom the project is discussed. Youth are called together to discuss potential strategies. Young people are recruited from the community to become peer educators. Once trained they outreach and distribute condoms and provide one-to-one information. However, many more communities need to be outreached.

Peer educators decide on the activities to be implemented. A needs assessment of young people identified that males want more income generating activities and trade skills, whilst females are seeking increased domestic skills such as sewing and cooking. This demonstrated a strong desire by young people for practical skills.

The perception is that education seems to have had a real impact on some behaviour. Good collaboration has evolved with NGOs, the government and some churches. NGOs used to plan and conduct programs separately, but now there is a coordinated approach. PE is conducted jointly with other agencies, and use is made of facilitators and speakers from other NGOs. The AHD program is part of the Kiribati HIV Task Force and receives good support from sponsoring agencies and some support from government, though more funding is necessary.

The program conducts VCCT itself, collecting the blood and sending it for testing. Results return to the program so there is follow up of young people.

Every year, 1–2 peer education training workshops are conducted, but there is a need to constantly retrain because of attrition. The program conducts training for other NGOs. Some peer educators

have received training from the SPC previously in 2004 but more recently, other NGOs will incite representatives of the AHD to participate in their training.

More work needs to be undertaken to assess and identify vulnerable groups. More funding, and better qualified trainers are needed. Coordination between NGOs can be improved at times and the need for more youth friendly services was highlighted. Peer educators have a need for greater refresher training and for more opportunities to come together with other NGOs.

Collaboration between NGOs is improving. However, peer education is not fully recognised by the Government, nor on its own agenda as it is directly supported by SPC. Consequently there is no supplementary funding from the government.

Peer educators meet on a monthly basis which provides opportunities for issues of misbehaviour to be discussed. If problems persist, peer educators are seen individually.

Kiribati Family Health Association

Kiribati Family Health Association, founded in 1997, employs five FTE staff and 25 volunteers addresses HIV as a cross cutting issue under the IPPF Strategic Framework (the five As—Advocacy, Access, Abortion prevention, Adolescents and HIV/AIDS). The organisation delivers peer education. The interviewee commented that there was no formal definition of peer education but it was something that was needed. A personal definition was "Capacity building of peer educators (youth volunteers of KFHA) with the sustainability knowledge and skills that will include STIs including HIV/AIDS to be able to share same information and skills to other youths for their safety. These peer educators are therefore expected to practice and live a life of what they are preaching."

About 20% of the organisation's activities are devoted to peer education, utilising the services of a Youth Officer and volunteer. The project targets: marginalized young people; young people attending school; women; people living in rural / remote communities; seafarers and partners of seafarers. MSM were recognised as very hard to identify, injecting drug users as non-existent, and only two individuals with HIV have identified themselves.

The education carried out is through the peer-to-peer outreach by the youth peer educators to reach out to other youths in the various communities, which includes those in and out of schools.

Activities conducted include:

- Direct one-on-one education in HIV and sexual health by peers
- Group based education by peers
- Advocacy for peer education as an effective intervention measure
- Condom distribution by peers to peers
- Resource distribution by peers to peers
- Resource production by peers
- Knowledge training (in HIV & sexual health) for peer education workers
- Skill training (e.g. in communication) for peer education workers
- Training for trainers of peer educators

The organisation is mentioned in the national HIV/sexual health strategy (though the interviewee states that no national strategies exist), is a member of the National HIV Task Force, but it is not part of a peer education network. However it does collaborate with the MOH, Kiribati Institute of Technology invited as resources in the training conducted.

The KFHA is providing family planning and sexual and reproductive health services complimenting MOH health services and therefore does not need to refer to other services. There is support for peer education by the organisation and Ministry of Health. The KFHA has conducted a ToT and leadership training for youth peer educators in 2008. External training has also been made available.

The following qualities were identified as integral for effective peer education:

- Moral and character training
- To know and understand themselves as human and sexual beings
- Capacity building in the area of human sexuality
- Capacity building on the STI's and HIV/AIDS and how these are transmitted and preventive measures that to be taken
- Sustainable livelihood skills
- Negotiation and communication skills.
- Training for trainers
- Leadership trainings.

Other vulnerable groups identified include sex workers. There had been no specific training for these groups but rather they are grouped with other community members.

Education or peer education is referring to a one-to-one sharing of information between a youth peer educator and a youth client. Youth peer educators are only paid for their return bus fare and refreshment during their visits, which is equivalent to AUD10 per visit. The only peer education as we call it is the training that was conducted by KFHA to train peer educators on how to deliver information to others.

There was a feeling that there should there should be greater clarification on the general aim and purpose of peer education to engender a uniform understanding amongst those organizations utilizing this tool for community education.

The lack of known well trained peer educators and the outreach with information and condoms are confined to our own program only.