

9.0 Challenges for IPC Program Development

Learning Objectives

By the end of chapter 9.0, the reader will be able to:

1. Understand common IPC challenges and how to address them
2. Understand key considerations for addressing individual high risk groups

Programmatic Challenges

Challenge: IPC methodologies tend to be too complex, manuals too wordy, activities too complicated, and too much emphasis placed on biomedical facts rather than the behavioral issues.

Solution: Focus content on behavior choices rather than facts about HIV and AIDS. Simplify manuals, guides, and support materials by including only the essential facts needed to support behavior change. Avoid wordiness and complicated formats that draw attention away from the information. Ensure they are user-friendly for the IPCs who are not literate. Before creating anything new, check existing programs for existing materials.

Challenge: Management obstacles.

Solution: Ensure that sufficient attention and resources are allocated to management, staffing, budgeting, and the creation of timelines. When insufficient attention is given to creating a supportive, structural environment, the entire program will suffer.

Challenge: Determining whether IPC should stand alone or be part of a larger project.

Solution: IPC can be complementary to a larger BCC intervention, or it can stand alone. When IPC programs stand alone, they typically are not sufficiently linked to health services. When they are part of a larger project, IPC is often perceived as a low-priority add-on. It is important to consider both circumstances.

Challenge: Ensuring that programmatic decisions are evidence based.

Solution: Allocate sufficient research resources at the beginning of the project. Create a research environment and an M&E structure that incorporates regular tracking of program activities and impact.

Challenge: Insufficient support & supervision.

Solution: To ensure that IPC agents are not left on their own and not doing their jobs, incorporate a supervision plan from the inception of the IPC program. Supervision mechanisms also provide an additional channel to obtain program feedback.

Challenge: Bringing pilot IPC programs to scale.

Solution: Small scale interventions can be so management intensive that scale-up seems impossible. Plan for scale-up during the pilot phase. Develop materials, M&E plans, management structure, and staff requirements with scale-up in mind.

Challenge: IPC discussions stray from the given topic or message.

Solution: Correct the assumption that the provision of facts will result in behavior change. During training provide IPCs with plenty of participatory activities so that they do not rely on reciting facts about HIV/AIDS. Ensure that IPC expectations are clear from the start: their primary goal is not to educate through facts, but to educate AND promote behavior change by engaging target groups in discussions that are focused on increasing risk perception, improving skills and self-efficacy to make healthier behavioral choices, and addressing barriers to adopting healthy behaviors.

Challenge: Embarrassment talking about sensitive sexual issues.

Solution: Practice discussions in trainings using role plays. Develop support materials that will help facilitate sensitive discussions.

Challenge: Message degeneration.

Solution: Allow supervisors to correct IPCs when they get off topic. Develop support materials that help IPCs guide their discussions to focus on behavior change. Develop guidelines for each IPC session so that IPCs do not try to cover too many topics.

Challenge: Conducting participatory rather than didactic trainings.

Solution: Trainings should be focused on building IPCs' skills to conduct interactive participatory discussions and activities with target group members rather than focusing solely on increasing HIV knowledge. This will help ensure that IPCs use more a reflective interactive approach to their field work.

Challenge: Developing support materials that encourage participation

Solution: Support materials such as flip charts, picture codes, cue and counseling cards that encourage target group participation are an essential tool for encouraging participation. They also make it easier for IPCs to raise sensitive topics. Focus on utilizing a variety of participatory techniques, games, and activities.

Challenge: Insufficient provision of support materials

Solution: Ensure that a sufficient portion of the budget is allocated to developing support materials. It is important to think in advance and plan so that enough materials are produced for the numbers of IPC staff.

IPC Staffing Challenges

Challenge: Because IPCs are not target group members, they may be rejected by the target group participants.

Solution: The IPC trainings should focus on communication techniques that allow outsiders to break into target groups. The program as a whole can also work to gain the support and respect of target groups, thereby making the acceptance of individual members more likely. Alternatively, peer educators can be utilized if the target group is extremely untrustworthy of outsiders.

Challenge: High staff turnover.

Solution: This is often caused by volunteers quitting when they need to find work to increase their income. Similarly, volunteer IPCs may be busy with other activities or jobs and have little time to be involved in IPC activities. One solution is to pay IPCs or provide financial or material incentives. If resources are constrained, it is important to be very up-front about volunteer time commitments before hiring volunteers. Keep IPCs motivated with incentives, supervisory support, and by regularly rotating topics and messages.

Challenge: Legal ramifications from firing staff.

Solution: Even though IPCs or PEs may be volunteers, some countries' labor laws still protect them from dismissal, even if a project is coming to a close. Legal advice should be sought when preparing contracts and outlining terms of employment.

Challenge: Unable to find qualified IPCs

Solution: Often identifying IPCs with IPC program or facilitation experience is not possible given local capacity. If this occurs, try widening your search by exploring other nearby geographic areas that may have a larger pool of applicants. If you simply can not identify qualified IPCs, it will be necessary to develop a more intensive and comprehensive training program. Furthermore, a new group of IPCs will need plenty of opportunity to practice the new skills they learn in the training. It will, therefore, be important to incorporate a mixture of training methods including role plays, case studies, and perhaps actual field practice in order to instill the appropriate skill set in your staff members.

Key issues to Consider When Reaching Specific Target Populations

Commercial sex workers

Significantly higher rates of HIV infection have been documented among sex workers and their clients as compared to most other population groups within a country. HIV often spreads among sex workers before spreading into the general population. A number of factors may heighten sex workers' vulnerability to and risk of HIV infection. Stigmatization and marginalization can result in isolation that can limit sex workers' access to legal, health, and social services. Laws and policies to protect sex workers and their clients are often non-existent or inadequately enforced. Limited information, skills, and negotiating power may lead to behavior that puts sex workers at a higher risk for HIV transmission.

Lifestyle factors such as violence, alcohol, and drug use may also increase risk. Increasing mobility among sex workers makes effective and sustainable prevention work more difficult. Understanding these challenges can help guide IPC program development.

People enter sex work for a variety of reasons. Economic need often drives people to engage in sex work; perhaps it is the only or best paying employment option. Others are forced or coerced into sex work through violence, trafficking, or debt bondage. Others freely choose sex work as their occupation. Entry into sex work can also be rooted into socio-cultural traditions, beliefs, or norms that perpetuate gender inequalities.

Sex work is not monolithic, and it is important to understand and consider the drive behind sex work when defining your target population. Certain factions of sex workers may not even identify with the term “sex worker.” It is therefore important for programmers to work with endogenous target group definitions rather than those imposed by program planners or donors.

IPC interventions that focus on individual behavior change must specifically address the traditional and cultural sexual behaviors in the local sex work environment and take into account the various forms of sex work that occur there (e.g. brothel-based, indirect or occasional sex work, male sex work, or transgender sex work). Outreach initiatives can be employed for particularly hard to reach populations. For a population that is so frequently marginalized and may be skeptical or untrusting of outsiders, peer education can be a useful strategy. While you may opt not to utilize peer education specifically, IPC programs should involve target group members in program design and implementation. Involvement and support of target group members can help improve the chances of program success.

IPC programs can also link to STI, VCT, or other health services to make such services more accessible, acceptable, and affordable to the target population. In addition, a focus on quality of care that patients receive can influence how well sex workers comply with treatment recommendations and whether they would return to the clinic or health center for future care.

Mobile Populations

Mobile people can be described as people who move from one place to another temporarily, seasonally, or permanently for a host of voluntary or involuntary reasons. Mobile populations can include truckers, seafarers, transport workers, agricultural workers, sex workers, and migrant workers. Migrants are people who take up residence or who remain for an extended stay in a foreign country. Migration and mobility are continually on the rise due to the increased availability of transport, economic imbalances between communities, the opening of closed borders, war and ethnic tensions that displace people, and the organized

trafficking of people between countries. Women can comprise nearly half of migrants, and in some regions represent the majority of mobile workers.

The process of migration and mobility is not static. It is a process comprising of the

- 1) source, or where people come from and why they leave
- 2) transit, or the places they pass through, how they travel, and how they maintain themselves while traveling
- 3) destination, or where people go, and their living and working conditions in the new place
- 4) return, or the communities to which people return, their families, and resources

Again, it is important to define which component of migration your IPC program will address, and the specific factions of people that it will impact.

There is increasing recognition that mobile populations are more vulnerable to HIV/AIDS than those who do not move. Mobile populations can experience marginalization at any point in the migration process which can influence their risk for HIV/AIDS. They may acquire HIV while on the move and take the infection with them back home without knowing it. They also face obstacles in accessing preventative health services as well as care and support. They may have limited access to health care, try to avoid attention from and contact with legal authorities, they may have limited economic resources, and in some countries, they may face forced HIV testing and deportation.

IPC interventions should take into consideration the factors that may marginalize the target mobile population. A successful intervention may be better off focusing not on a group or on individuals, but on the sites or areas where risks might occur. Alternatively, mobile populations could be reached at specific points on their travels (e.g. at truck stops, or at a lodge where migratory miners are living). IPC interventions with mobile populations should work to meet the linguistic and cultural needs of the target group, which can become difficult if people from multiple countries or ethnic groups converge in one area for seasonal labor. This underscores the importance of including migrants and mobile people in the design of the IPC program. Peer education is often successful with mobile and migrant groups, but other IPC agents can be useful as well.

Uniformed services personnel

Uniformed services personnel are a highly vulnerable group to STI and HIV infection. This is primarily due to their work environment, mobility, and age. Their risk of contracting HIV or STIs tends to be higher than that of the general population during times of peace, and in times of conflict the difference can be much higher. The military's professional ethos tends to excuse or even encourage risk-taking. Furthermore, military bases, camps, or installations of peacekeeping forces tend to attract sex workers. Finally, military duties often

necessitate lengthy periods spent away from home, making HIV/AIDS a threat to family members and other social contacts of those in the military.

Uniformed services personnel, however, offer a unique opportunity for HIV awareness and training as they are a large, “captive audience” in a disciplined and highly organized setting. Among uniformed services, youths and other youths whom they recruit exert strong influence on their peers within and outside of the service. Populations of uniformed services personnel will be literate and may have free time at their barracks where IPC can take place. Many uniformed services also have their own health services that may be interested in collaborating with an IPC program.

Injecting Drug Users (IDUs)

Sharing injection equipment to either inject or split drugs places IDUs at a higher risk for HIV infection. Sharing can occur because there are not enough needles and syringes available or they are not affordable by and accessible to IDUs. IDUs who share needles and engage in unprotected sexual activity are at a higher risk for HIV infection themselves in addition to putting their sexual partners at risk. Furthermore, men and women who exchange sex for drugs are also at an increased risk for HIV transmission. IDUs often face multiple health risks due to social, economic, and psychological factors. HIV prevention, therefore, may not be their top concern as they are also facing challenges such as addiction, poverty, incarceration, homelessness, stigma, or mental illness. IPC strategies may approach work with IDUs from a safe injection perspective, a safe sex perspective, or work to link IDUs with appropriate health or social services.

Those who choose to share injecting equipment are often very difficult to reach since they operate in exclusive communities and may not exhibit regular patterns of risk behaviors. In many countries they are well hidden, operating underground out of fear of arrest. IPC requires the utmost sensitivity and IDU peer educators are the best option. IDUs are more likely to use condoms when members of their social network discuss health concerns. If a program uses peer educators, however, support must be provided to ensure they avoid relapse. IPC programs may also want to consider collaborating with other community based prevention programs or drug treatment programs that may have experience and insight into reaching this target group. Carrying out outreach activities to raise awareness, build rapport, and promote the program itself may be a crucial component of an IPC program with IDUs.

Men who have sex with men (MSM):

Sex between men exists in most societies, and it frequently involves unprotective, penetrative anal sex, which carries a high risk of HIV transmission, especially for the receptive partner. For cultural reasons sex between men is often stigmatized by society, and men themselves may deny engaging in such behaviors. Furthermore, many MSM are married or have sex with women as well and they may not identify themselves as homosexual or even as bisexual.

This makes the challenge to develop effective IPC interventions with this population quite difficult.

In most countries, a certain proportion of sex between men is commercial. Adolescent males also may engage in sex with other males of their peer group, and in some cultures it may be common for adolescent males to have sex with older men. Therefore, when targeting MSM with IPC initiatives, it is essential to clearly define the population to be targeted by the program.

Denial on the part of policy-makers and program managers that MSM exists in a given geographic area may be an obstacle to overcome when designing an MSM IPC program. Lack of adequate or reliable epidemiological data may also present a barrier, making formative research an even more crucial component of program development. MSM can be a difficult population to reach, and because of the fleeting nature of many of their relationships, they may not consider themselves to be at risk. MSM can be stigmatized, and their behavior criminalized making them less likely to see the health services that they may need.

All of these barriers make peer education the logical choice for MSM IPC programs. MSM peers will help facilitate contact with this group, and will also serve as a trusted information source. Peer educators can be used to promote condoms and lubricants, they can conduct outreach, educate about VCT services, or they can carry out face-to-face IPC interactions to educate and improve risk perception. Anti-stigma media campaigns may also be helpful depending on the magnitude of the behavioral problem. In some parts of the world collaboration with gay community projects, if they exist, can be helpful.