THE ROAD TO GOOD HEALTH

FACILITATOR’S GUIDE

Guidance on effective implementation of the Road to Good Health
wish to re-use a component of the work, it is your responsibility to determine whether permission is needed for that re-use and to obtain permission from the copyright owner. Examples of components can include, but are not limited to, tables, figures, or images.


Cover photo by J. Erondu
Cover design by Emily Tritsch
EXPECTATIONS FOR FACILITATORS
ON THE ROAD TO GOOD HEALTH

Your role as a facilitator in the RTGH Campaign is less about lecturing or teaching than it is about facilitating discussions on the topics included in this guide. The success of the RTGH Campaign depends on stakeholder buy-in and a collaborative approach to problem-solving. Stakeholder participation is important at every stage of the RTGH Campaign process – from baseline assessments to monitoring and evaluation, throughout the project and at its completion.

As a RTGH Campaign facilitator, you are expected to have experience addressing HIV in the project country, an understanding of the key target groups, experience in participatory training, and knowledge about behavior change communication programs.

This Facilitator’s Guide is intended to provide suggestions and solutions for you as you deliver the RTGH Toolkit program to its intended audiences. Included in this guide are:

- An introduction to the target groups (the groups that are the focus of this campaign)
- Information about the training tools employed by the RTGH Toolkit, and suggestions for how to lead successful sessions
- More specific details about coordinating with local agencies and stakeholders, implementing the campaign, monitoring and evaluating program success
- Specific training tools and activities for each target group (see Parts 1 - 4 of the toolkit)

As a facilitator, you are expected to employ the training techniques included in this guide to support a meaningful and engaging education program for the populations targeted by this toolkit. You are encouraged to modify specific training tools and activities based on your knowledge of a participant group’s specific experience and your understanding of local conditions, while continuing to support a participatory and interactive learning environment.
Who are the target groups in the *Road to Good Health*?

There are four primary audiences for the RTGH Campaign, all focused around persons who may be affected by a World Bank funded transportation project. These are:

- Managers and Supervisors,
- Construction Workers,
- Community Residents, or those residing in proximity to a transportation development project, and
- Commercial Sex Workers

### Who are the Managers and Supervisors?

- World Bank Task Team Leaders who have primary responsibility for loans to governments,
- Ministry of Transport (or equivalent) staff that have responsibility for loans,
- Contractors who provide service, including project managers, and
- Engineering consultants who work with contractors, Ministry, and Bank Staff

**Managers and Supervisors are responsible for ensuring that:**

- HIV education is required in contract bidding documents,
- Contractors fulfill contractual obligations to provide HIV education to workers and community residents through a contract with an approved service provider (the facilitator),
- Quality HIV education is delivered to all target populations, and
- Monitoring and evaluating the RTGH Campaign is completed throughout the duration of the project.

**Risk Factors for Managers and Supervisors:**

- Managers and supervisors may be at greater risk for HIV transmission than lower-paid, less mobile workers (such as construction workers)
- Risk factors for this group include high mobility, including a vehicle and/or driver, and higher income, which can provide means to buy alcohol and engage in commercial sex.
Who are the Construction Workers?

- Many are migrant workers who may spend months to a year away from home on a construction site
- Majority are young and male
- Some have migrated from another country for work
- In general, workers include skilled laborers, local staff, and migrant workers

Risk Factors for Construction Workers:

- Social and emotional isolation: sense of loneliness, distance from family including partners (girlfriend, wife), separation from workers’ socio-cultural norms that typically regular sexual behavior in their own communities
- Availability of disposable income and temptation of sexual relations within communities near the project site and worker camps
- Often a limited or lack of access to quality, affordable condoms and HIV counseling and testing services
- Transmission across communities may be high as workers return to their home villages or cities at the end of their construction contract
- The temporary nature of employment on construction sites may require workers to go from one site to another while returning home between contracts or on leave. This may contribute to exposing worker families and home communities to HIV and other STIs
Who are the Community Residents?

- Project-adjacent residents who may be affected by nearby construction work
- Community residents may find work on a construction project so they may fall into both the Construction Worker and Community Resident category

Risk Factors for Community Residents:

- Infrastructure projects increases the number of outsiders into a community who may bring the influence of alcohol, drugs, or sex; construction of transport projects in particular introduces a risk of linking low- and high- HIV prevalence areas, such as rural villages with larger cities
- Girls and women may be targeted for sexual relationships by construction workers and others
- Displaced residents may lose their economic security, creating higher risks of trafficking and sex work as a means of creating income
- While all members of communities are at risk, young people and women are especially at risk, particularly those without access to well-paying jobs that may turn to commercial sex work to earn money
Who are the Commercial Sex Workers?

- Brothel or street-based sex workers, and
- Workers at beer or food venues (such as karaoke bars and beer shops) who occasionally sell sex

Note: While there are both male and female sex workers, the Road to Good Health focuses on female sex workers

Risk Factors for Commercial Sex Workers:

- Clients who offer more money for sex without a condom
- Limited access to condoms or testing for sexually transmitted infections, including HIV
- Stigma against women who purchase condoms
- Stigma and discrimination by health care workers in testing for sexually transmitted infections
- Forced sex
- Decreased willingness by both men and women to use condoms in relationships based on affection
To effectively communicate with these populations, you must recognize that all target groups and their individual members are unique within each country, region, district, and community. All outreach and training efforts must be based on ongoing two-way communication within each group and a dedicated effort must be made to understand the complex factors that make up each person’s life (the social, cultural, psychological, emotional, spiritual, and physical aspects). This can provide information on how each person relates to HIV-related issues as well as how they might learn best.

Social and Cultural Factors
Throughout the world, there is tremendous diversity both within and between countries. All programs to address HIV must be sensitive to differences in languages, cultural norms, and social factors. Many countries have numerous ethnic minorities, each with a unique language. While the use of materials with strong visual components may be helpful, a great deal of information can be lost or misinterpreted without sufficient explanation. Facilitators should be encouraged to identify and train peer educators who speak local languages. Local trainers and facilitators will support adaptation of these sessions and the IEC materials to country-specific needs, conditions, and level of epidemic. The following tools and techniques will help in delivering a clear, complete, and effective training program.

Training Tools
The RTGH Toolkit draws on social learning and community mobilization techniques to foster and build community solutions. It builds upon recent information, education, and community (IEC) tools, behavior change communication (BCC) techniques, and social learning experiences used in HIV/AIDS responses to maximize the benefits and minimize barriers for improved health-seeking behavior. This section provides more information on some of these techniques.

Participatory Training
Participatory training is the active involvement of individuals in their learning; this method has proven more effective than having students sit quietly and listen to a lecture. Learners are found to understand and retain more information when they are engaged with the learning material. For meaningful participatory training, consider using a diversity of tools and techniques in reaching out to participants, such as: pictures, stories, role plays (scripted scenes), demonstrations, small group discussions, and games.

Peer Education
Peer education means training between people of the same peer group, or between individuals who have something in common; this includes people of similar social standing, employment, economic
status, living situation, educational level, or hometown. Peer educators are typically non-professional teachers who are trained to talk to, work with, and motivate their friends, coworkers, neighbors, or other peers. In HIV prevention and care, peer educators provide information about HIV transmission and explore issues of decision-making and behaviors through one-on-one or small group activities. Peer education has been shown to be an effective tool for behavior change. In addition, peer educators can also build local capacity; at the end of an HIV awareness program, these individuals can continue to pass on messages through casual conversations with friends, family members, and their wider peer group.

**When developing a peer education program or recruiting peer educators, consider the following:**

- Peer educators can be easily organized but require training
- They need supportive supervision
- Peer educators are useful in both giving and receiving information. Qualitative data they collect about the local epidemic or related issues can be fed into the monitoring and evaluation framework
- Peer education does not need to be costly, though some compensation should be provided
- Individuals in the peer groups, such as construction managers or workers, may not have a lot of time to participate in training. Facilitators should try to find time to share the information these individuals would need to know.
- Sharing personal information may not be culturally acceptable in some communities and will require time to establish trust.
- Messages spread via word-of-mouth may diminish its accuracy.

**Recommendations for Successful Peer Education**

- Integrate HIV peer education with other interventions
  Peer education generates demand for services and should therefore be linked to existing or early interventions that provide access to condoms, medical care, voluntary counseling and testing services, and sexually transmitted infection care.
- Carefully select, train, and retrain peer educators
  Consult with target populations and stakeholders to develop clear criteria for selection of peer educators. Each program should determine when it is more appropriate to use persons with greater power or status for communicating certain messages rather than true peers. Peer educator training should focus on communicating correct HIV information and participatory techniques to engage the audience. Many experts strongly recommend providing peer educators with
some kind of compensation. Supervision of peer educators needs to take place in the field, and supervisors should be technically competent, motivational, and supportive.

- **Design program activities to foster behavior change**

  Set realistic goals for behavior change that reflect challenges faced by target audiences. Modify, focus, or expand program activities to meet the needs of target audiences and encourage their participation. Continue to adjust content and delivery of activities based on continuous evaluation and feedback.

- **Involve stakeholders from the beginning**

  Utilize stakeholders to better reach and connect with target populations; these can include construction managers, community leaders, bar owners, women’s or youth groups, as well as others with a vested interest in the peer education program.

  Encourage continuous coordination of peer groups throughout the RTGH Campaign:
  
  - Promote construction worker conversations about HIV prevention within small groups or one-on-one;
  - Encourage women’s group members to make house calls to distribute information and talk with women about HIV prevention;
  - Organize youth groups to provide informal demonstrations for other young people; and
  - Urge commercial sex workers to promote condom usage and negotiation strategies with their peers.

- **Plan for program sustainability**

  Peer education is regarded by some as an inexpensive strategy because it may rely on volunteers. Yet the costs of implementing high-quality peer education can be high, due to the ongoing need for funds to adequately train, support, and supervise peer educators, to minimally compensate them, and to equip them with resource materials.

---

**How to be an effective peer educator**

Peer educators should:

- Teach peers about sexually transmitted infections and HIV
- Teach peers how to avoid becoming infected
- Recognize risks and risky situations specific to their lifestyles
- Refer peers to health care workers, condom dispensers, and others
- Empower peers to make informed lifestyle decisions
- Emphasize decision-making, assertiveness, and relationship skills
- Support the maintenance of behavior change
- Foster supportive and understanding attitudes toward people living with HIV
- Teach peers how to care for people living with HIV
Behavior Change Communication

Behavior Change Communication (BCC) is a process for promoting and sustaining healthy changes in the behavior of individuals and communities. The process attempts to convey targeted health messages and techniques through a variety of communication channels, such as through training, activities, media, discussions, and events. BCC attempts to bridge the gap between information and behavior. This approach addresses the attitudes and practices of target groups as they relate to reducing risk behavior related to HIV. Within a participatory communication framework, individuals gain the knowledge and skills that motivate them to develop positive and healthy practices, and avoid risk behaviors. BCC requires a good understanding of target audiences, and the use of an appropriate mix of communication channels, such as interpersonal, group, community, and mass media. BCC is most effective when combined with local advocacy and with social mobilization strategies.

### Providing Information is Easy, Changing Behavior is Difficult

Across the region, awareness about HIV can be very good and, where information is lacking, basic educational sessions can quickly fill in the gaps. Getting people to change their sexual behavior and/or address involvement in risky activities in much more complicated and requires an educational approach that engages participants in deeper ways to promote changes in attitudes, values, and norms. The need to address gender inequalities is fundamental to enable women and girls to be able to effectively control their own risk to HIV transmission.

### What else do you need to know about BCC?

In the context of the AIDS epidemic, BCC is an essential part of a comprehensive program that includes both goods (such as condoms) and services (including both counseling and testing services as well as social, spiritual, and/or psychological support).

The foundation of effective BCC campaigns is the complementary use of print and other materials with pictures that convey vital information and stimulate discussion on issues related to risky and protective behaviors, sex and sexuality. In a comprehensive BCC strategy, multiple educational techniques are used to ensure consistent messages are delivered and then reinforced through different media. BCC is most successful when there is an expectation of a positive outcome (for example, good health and access to quality services), and individuals have confidence in their ability to change or maintain new behaviors.
Effective BCC can:

- Increase knowledge of the basic facts of HIV/AIDS and sexually transmitted infections (STIs);
- Stimulate dialogue on the underlying factors that contribute to the epidemic;
- Promote essential attitude changes, such as perceived personal risk of HIV infection and a nonjudgmental attitude towards persons living with HIV;
- Reduce stigma and discrimination;
- Create a demand for information, goods, and services;
- Advocate for policy changes, such as the decriminalization of vulnerable groups;
- Promote services for prevention, care, and support; and
- Improve skills and sense of self-efficacy.

**IEC Materials**

Effective Information, Education, and Communication (IEC) materials are an important component of a comprehensive HIV education campaign. The most effective IEC materials are relevant and leverage interests of the local population. In addition, materials should be clear, communicate specific messages, and are easy to remember.

It may be beneficial to conduct a needs assessment (see Part 1 of the toolkit) before starting an IEC campaign. This will provide information about the target populations and the kinds of materials they will respond to. For example, in places that are ethnically diverse or have limited literacy, more highly visual materials can be used to reduce the need for text. In all cases, it is important to identify trainers and peer leaders who speak local languages and, ideally, are from target populations. These individuals will also be most effective at adapting IEC materials and the training session plans for local groups.

*IEC materials are most effective when they reflect the interests and preferences of the local population*

You might find that in culturally and/or religiously conservative contexts, it is considered inappropriate to display information about anything pertaining to sex. In these situations, it may be possible to identify local persons who are highly respected in their communities but also willing to open doors to taboo subjects. These individuals can achieve surprising results by introducing ideas, activities, and materials that an outsider may not be able to.

In the same way, although some materials are developed within a particular country context, they may find ready acceptance in another country if introduced. Engaging the right members of the community in identifying what materials will work will save time and money.
An IEC campaign cannot be effective alone and should include other training techniques, such as those described above. To complement the messages of the IEC materials, face-to-face education should be provided to include information on how to condoms, counseling and testing, and care and treatment services.

**General Suggestions for Leading Effective Training**

**Create a comfortable, safe, and positive training environment**

Participants are more likely to learn and share their experiences when they feel comfortable and safe in their training environment. To create an effective learning space, consider the size, layout, access, cleanliness, and temperature of the training room. Having a good understanding of your audience is important in creating an environment that supports learning. Consider gender, culture, ethnicity, hierarchy, language, tensions between subgroups, and typical ways of learning for each group in planning and delivering your training. The social environment should feel safe and positive for all participants. Every learner brings fears and expectations to a new learning situation. You and the training team can make participants comfortable with a welcoming atmosphere of open communication, respect and learning.

**All participants are equal**

The tools included in this guide have been developed so that all participants can be involved in the activity and discussion. Participation by everyone in the group is important to effective learning. In addition, the facilitator must be seen to be on the same level as the participants. You should therefore not present yourself as an authority figure. Rather you are guiding the discussion of the group. Good listening skills, the ability to draw out quiet participants, and enthusiasm will contribute to your effectiveness as a facilitator.

**There is no one right answer**

The activities in this toolkit are open-ended and have no “correct” answer or result, though there are myths and misinformation surrounding HIV and AIDS that the facilitator should make a point to correct every time they arise in discussion. In general, decisions made by the group about the activities and discussions included in this guide reflect what is right for the group.

**Please note:**

The terms “trainer” and “facilitator” are used interchangeable throughout the guide and refers to the person leading the session.

The words “tools” and “activities” both refer to the training sessions described in Part 2 of the guide and provided in Part 4.
Suggestions for coping with dominant (outspoken) personalities

The methodology used in the RTGH Toolkit is designed to stimulate full group participation and to make it difficult for strong personalities to dominate activities and discussions. There will occasionally be times when a group process may be interrupted because of one individual trying to control a discussion or the group’s thinking. If this happens, find out if the dominant individual is a designated leader or simply an aggressive person with little or no influence in the group. If the individual is a community leader, approach them formally or privately early in the planning phase, explain the purpose of the process and gain their support. Hopefully you will be able to convince them that allowing equal participation among all community members will result in the best outcome for everyone. If the dominant personality comes from an aggressive person, take them aside and convince them of the importance of the group process. Otherwise, give them separate tasks to occupy them while the group continues on.

General guidance for all activities

*Maintain the order of the activities as they are presented in the RTGH Toolkit is recommended* as this sequence was designed to support learning and skills development. The content of this guide goes beyond HIV prevention and includes also reducing high risk behavior and minimize vulnerabilities.

*Review the entire RTGH Toolkit and prepare materials ahead of time.* The construction project contractor has been advised to make available resources to allow you to implement the Road to Good Health; this includes accommodating any photocopying, IEC material procurement, or material development needs to assist you in successfully carrying out the activities including this guide.

*More than one trainer may be required to lead the activities.* The number and duration of activities, as well as language needs, may require multiple trainers.

*Ensure activity instructions are understood by participants.* Consider providing instructions at the beginning of each activity and checking for participant understanding by asking someone in the group to repeat them back.

*Other considerations for successful implementation of the toolkit:*
  - Make sure the materials are large enough to be seen by all participants
  - Try to limit the size of your group to no more than 40 persons
  - Make sure that people can talk to each other and hear everyone easily; organize seats in a circle where possible
• Be guided by the requirements of the group when facilitating activities. The tie given for each activity is only an estimate
• Encourage and welcome individual inputs
• Facilitate the group, do not direct it
• Encourage active participation of each participant. Be careful not to find fault or make critical comments when responding to participants
• Take into account the participants’ level of literacy and find ways for them to keep track of what is discussed in the sessions
• At the end of each session or training day, congratulate the group on their efforts and explain briefly what will be covered next
• At the end of each day, ask participants to evaluate the day’s activities on the basis of what they have learned, what they liked, and what they didn’t like. A sample Daily Evaluation worksheet is provided in Part 3 of this toolkit (Monitoring and Evaluation).

More Information

Feel free to consult the following resources for more information on the training techniques discussed in this section. (These resources are available in English and may require translation).

**Participatory Training**


**Peer Education**


**Behavior Change Communication**


**Information, Education and Communication (IEC)**