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Peer education - from mutual support and solidarity to professionalization and formal recognition

In this article, originally published in the OFM on 1 December to mark World AIDS Day, we reflect on the foundations of peer education and hear from various peers talking about their roles, motivations, the challenges they face, and their aspirations. Aidspan is infinitely grateful to them for sharing their testimonies and through this modest contribution would like to pay tribute to their work, their professional and personal commitment, and the central role they play in the response to HIV and AIDS.

Introduction

The peer education approach is based on similarities between the person carrying out the educational role and the beneficiary. It also focuses on establishing a connection that differs from the usual professional approach to interventions. This approach makes it possible to rethink the purpose of the ‘relationship’, grounded in a mutual bond that can contribute to rebuilding a community, be it young people, mobile, migrant or key populations.

The peer education approach was developed in the 1990s. Much research has been undertaken to attempt to describe and analyze this approach.

In addition to similarities in terms of duties, status, role, or social position, the idea of a ‘peer’ educator is part and parcel of the ‘community’ concept, i.e., a group of people who live in the same place, share the same ideas or pursue a common goal. These people share the same values, often based on mutual support, solidarity, and connection. The peer education approach formalizes this relationship by allocating specific roles to peer educators as part of an intervention. This is based on three fundamental principles:

Close relationships

Peer education is based on an idea of proximity that differs from that of professional and institutional interventions. While providing/receiving support is at the center of the relationship in a standard intervention, in a peer education intervention, human beings are at the center of the relationship. When a local person becomes a peer educator in a peer education intervention, what matters most is their sense of shared identity and their connection to their community. The fact that they provide support is a secondary consideration. In this sense, the recognition of someone as a peer in their community is based primarily on their quality as a person, which is based on their shared belonging to a community, rather than on their qualities as a person carrying out an intervention or providing support. In fact, the majority of peer educators are former service users who felt a desire or need to provide a greater commitment by taking on additional responsibilities with their peers.

My name is Jean and I have been a peer educator for a year. Initially, I came to Espace Confiance for my own was always treated very well. There is always a warm welcome; we are directed by the educators to the socia and receive guidance at every stage of the care process. Then, I decided I wanted to become a peer educato that by working closely with people, we help them to express themselves and we stop people feeling stressed discouraged, stigmatized and isolated. The trust that builds up enables us to monitor the patient and make su taking their treatment. It is clear that we are a factor in the success of HIV testing and management.

Reciprocity and sharing

The focus of the peer education approach is on the person and on the relationship rather than on creating, or co-creating, a level of accountability of the patient towards the facility. The approach is a three-stage cycle, based on giving-receiving-giving back, which are inseparable and inherently linked. It is not about providing a free service (although peer educators currently receive little or no payment), it is rather about a voluntary commitment and a sense of moral obligation and responsibility, that often stems from the desire to give back what they themselves have received. Peer support relationships are a ‘basic social instinct’ that enables the establishment of relationships based on solidarity and mutual support. These relationships are what transform beings and individuals into people.

Peer educators, therefore, have a connecting role as ‘linking people’ who provide support in a natural way and are able to reach out to people within their environment.

My name is Carole, I am from the Democratic Republic of Congo. I started at ALCS as a volunteer in 2011, th became a staff member, then a community advisor in charge of awareness-raising and testing, before being a as prevention focal point for the Migrants project. Activities on migrant sites are difficult and dangerous: assau thefts happen, and no one can go into these areas without the help of someone who lives there. That is why w community actors, are very useful: we know the sites, we provide advice and advise if we feel that it isn’t safe for us to talk about prevention and testing with our migrant brothers and sisters as we live in the same situatio misery, hunger, and cold. It’s hard to get the attention of someone who is hungry and begging for something t we listen, we reassure, but we talk about serious subjects that are not welcome subjects, such as sexually tra infections (STIs), gender-based violence (GBV), and hygiene.

Social influence and the peer educator as a role model

Peer education involves some level of social influence. Interventions of this type focus on education and learning. Peer educators are seen as influencers for their fellow community members. They sometimes play the role of a credible information provider and other times play the role of outreach educator. When it

comes to prevention interventions, peer education supports the communication of prevention messages to specific target groups and promotes shifts in social norms and positive changes in terms of attitudes, values, or behaviors. Peer educators are also a social resource for other association workers, particularly for health care teams. The testimony below, documented by L'Initiative during training on sexual and reproductive health (SRH) for project leads, illustrates the influence of peer education on health care providers:

A peer educator working with Fatou, a young girl involved in sex work

Midwife: "When the SRH unit for adolescents and young people living with HIV (PLHIV) opened at CESAC in we carried out STI consultations, family planning, etc. There was a 17-year-old girl called Fatou, who came re STI consultations. We treated Fatou but she came back every 15 days with a new infection. During an individu interview with her, I tried to understand where all these infections were coming from, but Fatou didn't want to c me.
It just so happened that an appointment for one of our peer educators coming to get her ARV treatment coinci one of Fatou's many visits. We decided it was necessary to arrange a meeting with the peer educator to try ar understand the problem that we hadn't managed to work out. That day, in 15 minutes, the peer educator was with Fatou and she found out that she was involved in sex work.
Peer educator: We continued to support Fatou to considerably reduce the number of repeat infections and to s from transmitting HIV to her sexual partners. We talked about prevention methods during our meetings, as we the adolescent youth adherence club. Fatou has told us she doesn't take risks anymore, and she has much fe infections.
Fatou's mother: "Thanks to the home visits and advice given by the peer educators, my daughter is more stab more respectful to everybody. I approve of the peer education support as they share experiences with our chil give them self-esteem.".

Source: Collective learning and sharing, SRH challenges, practical briefs, L'Initiative.

Yet many challenges remain

Lack of official recognition of peer educator status

The legal status of peer education roles is not recognized by government Ministries. The status given to them by organizations is not secure, as they pay peer educators according to their own internal salary scales. As a result, there are big differences between organizations and the status of peer educators is uncertain: they receive an allowance rather than a salary, some have a contract, but others have no contractual relationship that outlines their work duties, and they have no social protection or health insurance. Despite community workers receiving good quality initial and ongoing training, and often closer supervision than in the public sector, they remain marginalized. Recognition of their status should be accompanied by standardized training and certification. This would also make it possible to integrate these community workers into Ministry of Health community development plans (which already include community health workers) and systematically set out the role and responsibilities of community workers at all stages of the care pathway.

Few opportunities to improve or change their status

There is a certain amount of flexibility that enables progression and increased responsibilities when carrying out awareness-raising, prevention, and testing activities (see box below).

A large variety of roles

Facilitator: Facilitators are recruited to organize awareness and prevention sessions in health care centers an neighborhoods or hot spots.
Peer educator: Person recruited and trained to carry out awareness-raising activities, testing and referrals to h facilities if someone tests positive for HIV. Peer educators receive initial training on STIs, HIV, protective meas counseling related to testing. They then receive regular refresher training and are supported by a supervisor. S in health care centers, others carry out visits at home and in hot spots, others run online chat platforms or hotl
Peer navigator: Person recruited and trained to monitor a cohort of patients from the point of testing up to mor treatment. Peer navigators remind patients about their appointments, carry out home visits if people are unwe provide treatment where necessary. They are in direct contact with referral doctors and social workers.
Psychosocial counselor: Psychosocial counselors work with peer educators to provide counseling and testing However, they receive more in-depth training on treatment literacy and family and social mediation.
Focal point/ supervisor: Person that supervises one or more peer educators in their work, they are also respon recruiting new peer educators. They are usually former peer educators and are well experienced.
Paralegal officer: This position is often filled by a peer educator who, in addition to training on STIs and HIV, h dedicated training on the legal framework, on the context for key and vulnerable populations in the country, ar information on support services for survivors of abuse and violence, and the potential avenues to follow. They cases they are aware of and inform and provide guidance to survivors. Where possible they also monitor how handled and the process of seeking redress.

The key principle at the heart of peer education is that service users go on to become peer educators. This is often their first opportunity for work and for socio-professional integration in contexts where people living with HIV are stigmatized and discriminated against. Being involved in these projects is the first step on the ladder of working life for many people, and involves increased skills in terms of knowledge about STIs, mediation and psychosocial support skills, planning, and reporting activities. Most roles that involve educator supervision are held by former educators, and from the experiences gathered, we understand that this gradual progression works. However, this progression seems to stagnate beyond this point, and most importantly, it does not lead to different careers in social work, neither within the organization nor externally. However, some of the peer educators interviewed did talk about their plans for the future: Carole would like to go back to being a physiotherapist, which she stopped after leaving the DRC; Jean would like to set up his own non-government organization (NGO) providing services for key and vulnerable populations (KVPs), particularly men who have sex with men (MSM). They imagine themselves outside their organizations and would like to be supported in their plans through training and support to access credit or employment.

Distress when facing complex situations that peer education alone cannot overcome

Community actors, particularly those working withKVPs, are confronted on a daily basis with situations of violence, poverty, and insecurity, and cannot always provide solutions to respond to social problems. For people who have experienced violence or are in particularly volatile situations (thrown out of their homes, undocumented migrants), seeking care is crucial, but their needs go far beyond what community actors can provide. This sense of helplessness has been reported by many peer educators who see these situations as personal failures, as they empathize with users, but cannot access psychological help. The issue of regular psychological support for these frontline activists must be addressed if organizations want to maintain their human resources and improve their working conditions and mental health.

Dr. Rhoufrani: Migrants who arrived the most recently are also the most vulnerable because they have not yet opportunity to build a network, so our role is important. On the ground, it is the ‘chairmen’ who rule (heads of c particular among Nigerians), which are often very violent for women and men. Our program to combat GBV re significant proportion of male victims of abuse (30% of the total), which shows that violence is not only directe women.
Carole: Migrants live in poverty with very poor hygiene conditions. People share toilets, which explains how di transmitted. Asylum seekers are asking for shelter and food, it is very difficult to talk to them about STI preven HIV testing when their most basic needs are not being met. Sometimes people can’t go home because there i violence.
Ramatoulaye: I identify the hot spots in Bamako where sex workers gather, I do sensitization work in brothels, “maquis” (local bars). Young girls experience constant violence from clients, pimps, police officers, as people money out of them. They are often rejected by their families who throw them out of their homes. A while ago, one of those girls, who was only six months old, was abused by a vagrant. The mother had gone out to work a baby alone in a room. This story really made me sad.
Mamoudou: There is a story that I cannot forget. A young MSM was being monitored by ARCAD, who were p him with treatment. The family found the medication, realized he was HIV positive, and poisoned him. He died his family didn’t think he deserved to live. I was arrested by the police, I did not dare to report the family, but I struggling because I know that a crime has been committed and no justice has been done. I couldn’t do anyth Sometimes when someone is thrown out, we try to contribute to help them to get somewhere to stay, but that enough of a response.

Peer education on the Espace Confiance online platform in Côte d’Ivoire

N’GOUAN is a website that allows users to make appointments for health services in Côte d’Ivoire. N’GOUANadministers a simple 10-question risk assessment that recommends users to services that are adapted to their needs. Once users have booked an appointment, they go to the clinic at the specified date and time to receive services and advice from a doctor on what to do next. N’GOUAN requires a valid mobile phone number for each client in order to make an appointment. The phone number is used to send clients their appointment confirmation by text message and to receive free follow-up services from a confidential case manager. The phone number is only shared with the clinic where the appointment is made. Once HIV test results are available, the phone number is shared with a case manager and/or a field worker.

Dr. Abro (right) and Jean, a peer educator from the N’Gouan platform

The team of paralegal officers at ARCAD Santé Plus

Supervised by Cheick Hamala, Chair of RENAPOC (National Network of Key Populations of Mali), this small team has just been trained to become paralegal officers. Up until now, they worked on their own initiative to report situations of violence and distress. Thanks to Global Fund NFM3 funding, the team is starting to feed back information in a more systematic way to inform the observatory that is being established and which still needs to build up its network of partners to protect survivors of violence, provide legal advice and ensure social reintegration.

Top from left to right: Dioncounda from RENAPOC, Mamoudou from Les Halles sexual health clinic, Aly who works at Mopti.

Below: Cheick Hamala from RENAPOC and Ramatoulaye known as Mama Clinique des Halles

The team of community workers from ALCS in Morocco

The Migrants Project started in 2004, when Morocco was a transit country for sub-Saharan migrants to Europe. With the tightening of border control measures, many asylum seekers now remain stranded for four to ten years and settle in Morocco, living in poverty and in particularly precarious conditions. ALCS has been running a prevention, testing, and care program for PLHIV for more than 15 years. In 2013, ALCS added a component focusing on prevention, identification, and care for victims of sexual violence. Thirty-one (31) community actors were employed to run the project in the eight cities targeted by the project (Agadir, Casablanca, Fez, Marrakech, Nador, Oujda, Rabat, Tangier,). Several different types of roles co-exist within the team: volunteer peer educators (who receive transport allowances), paid peer educators, staff members, and focal points. The last two positions sign a contract with ALCS, they must meet targets (indicators) and they supervise peer educators. The others do not have a legal relationship with the organization. The allowance they receive varies but it is rarely enough to provide a monthly income, which explains the high turnover (30% of those trained leave within a year). A task force attempts to organize discussions and advocacy around the recognition of the status of community actors (who are recognized by the National AIDS Control Program [NACP] but do not receive a salary).

Above: Awareness session at ALCS head office, testing, and counseling sessions.

Below from left to right: The Peer Education Team; and Carole, the prevention focal point for the Migrants Project, who was previously a peer educator and then a community advisor.

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