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Lessons Learned

OUT's Peer Education Programme for MSM / LGBT's in Tshwane, Pretoria

SUMMARY

The OUT Peer Education Programme was initiated in January 2010 and is still going strong. The aim of the programme is to offer peer education to MSM (and in a broader sense, LGBT clients) in the greater Tshwane (Pretoria) region.

The programme is funded by the South African Department of Health (hereafter referred to as DOH). Peer Educators are trained and mentored by OUT to achieve the required target of 12 000 MSM / LGBTs per year, through the following HIV prevention peer work: Talking about sex and safer sex; Challenge and change risk-promoting norms; Strengthen connections, centred on shared responsibility, care and support; Assist peers and other to understand Human Sexuality; Assist peers to gain insight into their own risk-taking behaviour; Help them to make a conscious link between substance use and STI/HIV transmission; Help them to make informed choices about reducing their risks; Help them to become aware of the importance of knowing their current health status; Develop the necessary communication and problem-solving skills; Assist in access to needed health, treatment and psychosocial support services on a regular basis; and Distribution of barrier methods.

Peer Educators '*get their prevention messages across*' through various kinds of informal one-to-one chats at private parties, in taxis, at church or varsity etc. Or through organised group outreach events in night clubs, stalls at various open and awareness days, mainstream Peer Educator trainings, community dialogues, Pride events, political and other marches and get-togethers.

For the past years, OUT has learned about the challenges in developing, implementing and the management of this intervention, which forms an important part of providing minimum services to sexual minorities and or key populations.

These include working with DOH as the funder, developing training materials, sourcing, selecting and training appropriate Peer Educators, reaching targets, mentoring, coaching and management of Peer Educators, Monitoring and Evaluation and report writing.

THE ACTIVITY

'*Peer Education*' refers to a strategically planned, high-quality informal method of education whereby specially trained and motivated young people provide on-going information and support to their peers in order to change negative peer norms and develop the motivation and skills to make informed choices and adopt health-promoting behaviour.

This is one of OUT's most successful programmes, which started in January 2010, reaching thousands of people directly and indirectly. After several years of implementation, there is a need to critically look at the programme - what is working and has impact and what is less productive.

Objective of the programme

Peer Education aims to pass on information in an informal and unstructured manner through one-to-one and group discussions in order to change behaviour patterns e.g. risky sexual behaviours, to enhance skill development and promote the sexual well-being of Men who have Sex with Men (MSM) and the Lesbian, Gay, Bisexual and Transgender (LGBT) community at large. Health information includes the following topics: Understanding Human Sexuality; HIV/AIDS; Protection for men; Protection for women; Substance use; Risk reduction strategies; and Screening and Testing.

Promotional items to motivate clients to participate in the programme and the hand out of fact sheets were part of the programme in the first two years only, in line with the budget.

Targets

For the first two years, the targets identified by the funder, DOH was 8000 per year. The target was increased to 12 000 in the third year of implementation.

Target group

According to the funder, the Department of Health (DOH), MSM living in and around Tshwane is the target group. Knowing the challenge to reach non-homosexual identified MSM, the target has been broadened to LGBT's.

Through reaching MSM indirectly, even health care providers in certain clinics in the identified zones, were included.

Location and level of the intervention

There are four identified zones in the greater Tshwane (Pretoria): Mamelodi, Soshanguve, Hatfield / city centre, and Hammanskraal. Pretoria is the political capital of South Africa and situated in Gauteng, one of nine South African provinces.

The context

South Africa has the highest number of people living with HIV in the world; 5.7 million people, with an adult prevalence rate of 17, 8%.

Among MSM alone, the prevalence is estimated to be 30%.

The HIV risk factors for MSM specifically include: Unprotected anal sex, other high-risk behaviours, including multiple partners and sex work, limited knowledge around linkages between substance use and HIV transmission, and social discrimination, stigma and homophobia making it less likely for MSM to access health services.

Although the South African Constitution (Bill of Rights) protects all citizens, irrespective of their gender and sexual orientation, against discrimination, and the provision of non-discriminative health care to all is accepted as a basic right, LGBT and MSM individuals experience various forms of discrimination in their own families, communities and from public health services. Homophobia is still thrive as proved by the 80% of South Africans that believe same sex sexual behaviour is always wrong.[i]

There are certain gaps in health service provision:

* Condoms and condom compatible lubricants are not available and / or accessible in public health facilities.
* There is no national health programme that targets MSM or LGBT's specifically.
* There are limited MSM / LGBT affirmative or sensitive public health services available.

The Peer Education Programme is designed to fill the abovementioned gaps and act as a link between the broader MSM / LGBT community and services offered by OUT Wellbeing.

Other activities implemented in the past in order to address this specific problem

OUT LGBT Wellbeing has been in existence since 1994. The organisation started with a telephone helpline and an HIV support group. In 2004, OUT offered a project called HIV schools. The aim and content of these 'schools' was similar to that of the current Peer Educator Programme. The difference was that it was a week of training, conducted in a township. It was costly and only a maximum of 15 MSM were reached per monthly training.

OUT offered various support groups over the past 8 years. These support groups, touched on the same themes covered by the current Peer Education Programme. The biggest challenge was to get the community to actively and consistently attend these support groups. Some groups died a natural death due to lack of interest. Also, by attending a support group once or twice a month was the only time people could get hold of barrier methods.

Implementation of the activity

By the end of 2009, DOH indicated interest in funding OUT for a Peer Educator Programme.

During January 2010, a project team got together and named it the ***"One2One - Connect. Talk. Empower"*** project.

The project team included OUT's Health Manager, the Training and Development Manager, the Project Coordinator and the Professional Nurse. DOH confirmed funding in March 2010.

After identifying the aims and objectives of the Peer Education programme, a Peer Educator Training Manual was designed, compiled, reviewed and printed as from April 2010 to June 2010.

It included compiling a Peer Educator Assessment Booklet. It was reviewed by internal and external HIV/ AIDS and LGBT Specialists.

The following modules were included:

* The Basics of Peer Education
* The Determinants of Risk-taking Behaviour
* HIV / AIDS and Sexually Transmitted infections
* Barrier Methods
* Substance Use
* Screening and Testing
* Risk Reduction Strategy
* Resources and Services
* About OUT LGBT Wellbeing

Recruitment of Peer Educators for the programme was exceptionally difficult not only because of the stigma and discrimination attached to OUT's line of work but because of the need to select Peer Educators who have the capacity to be able to talk freely and confidently about the nature of the work. An advertisement was sent out. They were given a guideline informational pamphlet outlining the expectations.

It was important that all Peer Educators had most of the following characteristics:

- ✓ **Credibility:** Must have a good standing with and be trusted by their peers;
- ✓ **Member of MSM/LGBT sub-population:** Be a member of a particular social or sexual network and demonstrate a deep understanding and appreciation of the issues facing MSM and gay, lesbian, bisexual and/or transgendered people;
- ✓ **Self-awareness:** Be reflective, maintain own beliefs/ principles, be aware of boundaries and demonstrate a willingness to respect these.
- ✓ **Commitment:** Be dedicated to the aims of the programme and well-being of others;
- ✓ **Role-model:** Set a good example for others in line with aims of the programme;
- ✓ **Flexibility:** Be spontaneous and able to improvise;
- ✓ **Cognitive capacity:** Be analytical, creative, and able to "think on the spot";
- ✓ **Interpersonal skills:** Be a good listener, empathic, engaging, friendly, open and outgoing;
- ✓ **Ethics:** Demonstrate a genuine desire to assist, maintain confidentiality, first do no harm, respect the autonomy of others, trustworthy and authentic reporting;
- ✓ **Observant:** Be one step ahead and pay attention;
- ✓ **Persuasive:** Be able to get a point across without being aggressive or pushy and ensure by-in.
- ✓ **A go-getter:** Demonstrate considerable energy, enthusiasm, and initiative.

During May to July 2010, about twenty candidates were screened and interviewed.

The Peer Educators were supposed to have been trained with the PSG model, which is a Peer Education training model provided by SAHATA, a DOH appointed training provider. Constant follow ups were made but no response was received from the training planners.

OUT continued with the implementation of the programme.

The candidates represented the four identified zones to be serviced for the duration of the implementation of the programme. In October 2010, fifteen were trained. Eleven passed the assessment and met the minimum requirements and were appointed as Peer Educators.

The training took place at the OUT office, over three days. The training pack included the Centre for the Study of AIDS (CSA) from the University of Pretoria's "*HIV/AIDS in South Africa: Course Companion to the CSA Entry Level Course and General Information Resource*" also called the "*Blue Book*" and OUT's "*What you need to know about drugs*" booklet. The training was conducted by a professional nurse, one of OUT's staff members.

The training was also supported by a one day "*Understanding Human Sexuality*" training. This training assisted the Peer Educators to understand themselves as sexual beings, their peers, diversity, sexual identity and fluidity, especially in the light of access to non-heterosexual identified MSM.

Play Safe Packs, a pack with responsible sex messaging cards, OUT info cards and barrier methods (condoms and OUT branded water-based lubricant) was made available by OUT's PRISM Project.

One2One Fact sheets (HIV/AIDS, STI's, Protection for Men, Protection for Women, Substance Use, Screening Testing and Other Resources, Risk Reduction Strategies) to assist Peer Educators in their task of providing the correct information, was designed and printed. The initial funding covered the cost of One2One branded stress balls, lanyards and T-shirts, to be handed out to peers to attract them to the programme.

In terms of Monitoring and Evaluation, documentation was designed to assist the Peer Educators in planning their one-to-one and community group interventions and indicate their need for Play Safe Packs and other commodities. Another form was designed to report on interventions completed, called the Activity Planning Record and the Activity Report Record.

Planning and reporting meetings were to take place every two weeks, on a Tuesday, from 11h00 to 15h00. Peer Educators were to be compensated for transport to OUT at R50 (about €3,50) per meeting. Lunch was to be provided. Some of these meetings included follow-up trainings.

The chosen approach: Health Belief Model

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program.

Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviours, including sexual risk behaviours and the transmission of HIV/AIDS[ii].

The HBM is based on the understanding that a person will take a health-related action (i.e., use condoms) if that person:

1. Feels that a negative health condition (i.e. HIV) can be avoided,
2. Has a positive expectation that by taking a recommended action, he will avoid a negative health condition (i.e., using condoms will be effective at preventing HIV), and
3. Believes that he can successfully take a recommended health action (i.e. he can use condoms and water based lubricant comfortably and with confidence).

This is an example from a sexual health action for MSM.

Concept	Condom & Lubricant Use Education Example	STI Screening or HIV Testing
1. Perceived Susceptibility	MSM believe they can get STIs or HIV	MSM believe they may have been exposed to STIs or HIV.
2. Perceived Severity	MSM believe that the consequences of getting STIs or HIV are significant enough to try to avoid.	MSM believe the consequences of having STIs or HIV without knowledge or treatment is significant enough to try to avoid.
3. Perceived Benefits	MSM believe that the recommended action of using condoms would protect them from getting STIs or HIV.	MSM believe that the recommended action of getting tested for STIs and HIV would benefit them — possibly by allowing them to get early treatment or preventing them from infecting others.
4. Perceived Barriers	MSM identify their personal barriers to using condoms (i.e. no access to water-based lubricant or difficulty negotiating condom use) and explore ways to eliminate or reduce these barriers (i.e., get free lubricant or teach them to practice condom communication skills to decrease their embarrassment level).	MSM identify their personal barriers to getting tested (i.e., being discriminated against or confidentiality broken) and explore ways to eliminate or reduce these barriers (i.e. access to MSM affirmative clinics or sensitisation sessions with clinic).
5. Cues to Action	MSM receive reminder cues for action in the form of incentives (such as OUT Play Safe Packs) or reminder messages (from OUT through Peer Educators, Face book, Twitter, SMS).	MSM receive reminder cues for action in the form of incentives (a lanyard / stress ball) or reminder messages (Fact Sheets: Protection for Men or Risk Reduction Strategies).
6. Self-Efficacy	MSM confident in using a condoms and lubricant correctly when having receptive or penetrative anal sex.	MSM receive guidance (such as information on where to get tested) or training (such as understanding sexual fluidity, how to use water-based lubricant).

The Health Belief Model helps explain why MSM / LGBT individuals may accept or reject preventative health services or adopt healthy behaviours. Social psychologists originally developed the Health Belief Model to predict the likelihood of a person taking recommended preventative health action and to understand a person's motivation and decision-making about seeking health services. The Health Belief Model proposes that people will respond best to messages about health promotion or disease prevention, in OUT's case, Peer Education and Outreach, when the following ***four conditions*** for change exist:[iii]

- The person believes that he or she is at risk of developing a specific condition.
- The person believes that the risk is serious and the consequences of developing the condition are undesirable.
- The person believes that the risk will be reduced by a specific behaviour change.
- The person believes that barriers to the behaviour change can be overcome and managed.

The HBM approach is based on the belief that Peer Education and Outreach is an evidence informed intervention with proven efficacy, based on a strong theoretical basis.

Resources

The initial 2010 funding of about R300.000 (about €20.000), covered the monthly stipends of R1000 (about €70) per peer educator per month, a part of the salaries of the Programme Manager, Project Coordinator and Administrator, material development and printing costs, training costs, meeting costs, stationary costs and a percentage for overheads and admin costs. OUT was fortunate in that it had the knowledge and competent human resources in house to design, implement and manage the programme. There was no need to appoint new or additional staff members.

Changes over time

Since the inception of the programme three years ago, eight peer educators stayed in the programme. Eight others entered and left the programme throughout the three years.

Four of the eight left because of greener pastures and permanent job positions. The other four were requested to leave the programme for an inability to form part of and work as a team and not reaching targets, even after being given a growth and mentoring period to rectify this.

Thus, once a year, there was a search for four new Peer Educators, specifically for the identified zones. This is not always an easy task, since Peer Educators have to have very specific characteristics, as mentioned before, in order for them to be able to work as part of a team, reach targets and add meaningfully to the programme.

Also, in year two, the Peer Educators became bored with their work, as indicated by general apathy and lack of meeting targets. The meetings' content shifted slightly, to include sessions about their own personal and spiritual growth. After the initial manager left the programme and OUT mid-2010, she became their mentor and coach in the second and third year. Once a month, one of the following exercises / sessions was included:

- Body Mapping
- Don't Sweat the Small Stuff Exercises
- Spot Checks on Wellness
- 30 Day Challenge (Behavioural change challenge)
- Meditation
- Ego vs. Spirit
- One-to-one mentoring meetings
- Ethical Behaviour
- Creativity
- Identifying and Keeping Boundaries
- Crisis Management
- Writing a CV

In 2012, zone leaders were identified within the group to increase efficiency and productivity and acting as a direct link between the project coordinator and the rest of the Peer Educators. They are responsible for coordinating events and managing the Peer Educators within zones. Zone leaders are identified by the Peer Educators themselves. Also, the stipends were increased to R1200, 00 per person, with a zone leader getting R1500, 00 per month for the three months taking charge of the zone.

Major turning points in the process

Change of OUT staff: The Health Manager, in charge of the programme, changed three times in three years. The Project Coordinator changed twice.

Targets: As from 2012, the targets increased significantly from 8000 to 12000 per year.

Peer Educators' needs: A year into the programme, the needs of the Peer Educators shifted. In order to retain them, group and individual emotional and spiritual mentoring and coaching were added.

Major internal and external factors that shaped the development of the activity

Internally, OUT needed to be more involved within the local MSM and LGBT community, especially in terms of HIV prevention. Thus, the most important aim of the programme was to create a direct link between OUT, its services, and the MSM / LGBT community. The Peer Educators literally became OUT, out there in the field.

Externally, a more intense need arose - to create behaviour change on the long run, where MSM and LGBT people make informed decisions about their sexual health and wellbeing in general.

Results

More than 20 000 MSM, LGBT's and others were reached directly during 2011 and 2012.

More than 35 000 Play Safe packs, condoms, lubricants, and marketing, education and training materials were distributed.

A total of sixteen young MSM role models were trained and mentored.

Monthly and quarterly reports and financial reports, submitted to DOH.

By the end of 2012, during a programme evaluation, all Peer Educators reported that they stayed in the programme for three main reasons:

- ✓ Touching and healing the lives of others
- ✓ Sharing experiences with other Peer Educators
- ✓ Personal growth sessions with the mentor

Peer Educators' Stories

All of the things I have learned were somewhat a burden at first because of the issues I had with my sexuality, but not so much anymore. ***Karabo***

Being a peer educator is both enriching and fulfilling as I get to learn and teach the world on tolerance and human sexuality. ***Gene***

It really feels like a ground breaking programme as I always break new ground in my community by sparking up unusual discussion with confidence. ***Happy***

I do this on a daily basis as I live my life, and in a way it makes me stand out because once you dedicate your life to sharing the love you have for your work, yourself and the community at large you graduate from being the gay guy everyone wants to hurt or swear at, then became a beacon of hope for those who struggle. ***Edwin***

A lot of the outreach work included going to night clubs. Most of these people are MSMs who are closeted and have issues with coming out to their families and friends. ***Bongani***

My experience as a peer educator has afforded me the opportunity to profoundly comprehend my own self existence and that my creativity emulates the true essence of my being. ***Elliot***

The process of changing stereotypes and prejudice is not an easy one you have to self-reflect and change your views on how you see other people before you can try and plant a seed to someone's mind about their stereotypes. ***Fortune***

Because they have people like us who give guidance, and help them make the right choices and thus gaining the confidence they need to become better people. ***Tshepang***

Now I know how to handle myself as a person. I'm more grounded, observant, persuasive and responsible. For that it has changed my life positively. ***Sam***

Mentor's Story

It's more than ensuring their competence! To be able to do the job, they must be emotionally OK beings, equipped to deliver lifesaving messages, in sometimes very challenging circumstances. Facilitating their journeys, especially their emotional and spiritual growth, for the past three years, has been profound in so many ways. I'm proud of every single one of them and excited about our future journey! ***Delene***

Unexpected results

Four of the Peer Educators are good in co-facilitating the Binaries & Boxes Sensitisation Training for Health Care Providers. Opportunities aroused for some Peer Educators to attend conferences and trainings to expand their own knowledge, share experiences and be more visible in the LGBT sector as a whole.

OUT was requested to provide training to other LGBT organisations, locally and in the region, with regard to Peer Education and Outreach.

Very important to acknowledge, is that these young men developed, over three years, into well integrated, informed, consciously aware, creative and dedicated MSM and LGBT activists.

Targets were not reached

Most targets were reached, but challenges were experienced. During the first year, it took most of the year to start the programme, and Peer Educators actually only started working in the field during November 2010. Also, some months fewer targets were reached, but during the Pride Months, the numbers tripled up again and made up for the average.

The main difficulties faced

Running out of barrier method stock. The Peer Education Programme do not fund OUT's barrier methods and is therefore dependant on other project's funding. Logistical challenges made the packing of Play Safe Packs difficult. The waiting period for one order of water based lubricant took was three months.

Keeping the Peer Educators energised and motivated. During the second year of the programme, the Peer Educators lost interest in their day to day work.

Miscommunication between OUT management and Peer Educators. During the evaluation, they indicated a need for increased communication between the Peer Educators and the OUT's management, in order to have a thorough understanding of the expectations between the two parties.

To some extent, the monitoring and evaluation of the programme. There's always a question if the targets reached by individuals, are a true reflection of the reality.

Communication. The communication and expectations between SAHATA, the DOH appointed Peer Educator Trainers was not flawless.

This service provider expected the Peer Educators to attend a 10day training, which was only possible for six of the Peer Educators. Their curriculum did not include any training on working with sexual minorities and the OUT Peer Educators, who realised it and knew the importance of understanding human sexuality as a Peer Educator, ended up sensitising the bigger group.

ANALYSIS AND LESSONS LEARNED

Thousands of people in and around Pretoria were reached, directly and indirectly. There has been a steady increase in the number of MSM taking up HIV Counselling and Testing services at the OUT Clinic, as well as the psychosocial support services. Currently there are 10 OUT ambassadors working in the field, directly with clients, especially those who struggle in the uptake of services at a LGBT Clinic. These Peer Educators are well known in their communities, especially for having information and condoms and lubricant readily available.

They offer support during crisis and general life challenges, like escorting someone to the clinic for HIV Counselling and Testing. They are seen as LGBT activists and leaders.

According to the programme evaluation conducted, all Peer Educators reported having an impact in their communities, acting as a link between OUT and the community, as well as providing on the spot barrier methods. It is not yet known if there is a dramatic change in MSM's risky sexual behaviour as of yet, especially since the evaluation report also include the biggest challenge that Peer Educators experience in the field – that of MSM still practising barebacking, especially under the influence of alcohol and or drugs.

The most important part of success of the programme was in the planning phase. Having first the funding in place, secondly having all the training materials ready and thirdly, selecting, training and appointing the right kind of people for the job. The success of the programme is due to 90% planning and 10% execution and not the other way around.

In the long run, the success is also due to working very close with the Peer Educators, bi-monthly, especially through supporting them on all levels, ensuring their emotional, spiritual and professional development.

What we have learnt

Personal development of the Peer Educators. Although selected for their specific characteristics and personal qualities, they are young men, not older than 26, each confronted with their own life challenges. These include issues around internalised homophobia and self-acceptance, self-image, losses of loved ones, traumas, living with HIV, general anxiety up to more serious challenges like depression and Post Traumatic Stress Disorder.

If these issues are not appropriately acknowledged and addressed, through individual and group mentoring and coaching sessions, the group dynamics become counterproductive, apathetic and full of drama and interpersonal conflict. The mentor should be someone they trust, with ample experience working with youth and HIV programming, be creative, supportive, and intuitive, and have wisdom and patience and a profound awareness of boundaries. Passion and a love for the work is of utmost importance, it rubs off! This person should not be the Manager or the Project Coordinator.

Professional development of Peer Educators. A once off training is not enough to equip them professionally. Refresher trainings and assessments, at least every two months, is very important. These should include facilitation skills, conflict management, latest trends in HIV and other STI prevention and management, human sexuality and HIV Counselling and Testing services.

A career path development for each young man adds meaning to their future at OUT. Most of them are interested in becoming a trainer or project coordinator at the organisation. These opportunities should be utilized as far as possible, including sending them on available short courses like HIV Counselling and Testing courses. It is important to ensure that they complete the practical part of each course as well. Most of the times they need a lot of encouragement to finish it.

Management of the programme. Good communication between the Management of OUT and the Peer Educators is of utmost importance. Both parties should be a 100% clear on the expectations of each, objectives of the programme and challenges experienced. Stipends should be paid on time, and if not, Peer Educators should be informed well in advance. If there are any changes, especially with regard to dates and times of meetings, Peer Educators should be informed at least 2 days in advance; especially since the meeting dates for the year are published in January of every year.

Monitoring and Evaluation. This is quite a challenging task. The reporting documentation designed and used, is not necessarily a true reflection of actual targets reached, especially the one to one sessions, since we rely heavily on the integrity of the Peer Educators.

It seems as if the contacts are reluctant to give their personal and contact details out of fear of being identified.

What we would do differently in the development and implementation of the activity

OUT would like to develop and implement a new effective and efficient monitoring and evaluation system – both quantitative and qualitative - to ensure accurate reporting on targets achieved as well as to determine the impact the programme has on MSM and LGBT in the communities.

WAY FORWARD

Ideas for future actions

- ✓ The Peer Educators expressed a need for some funding to be made available for community outreach events. There is no funding in the DOH contract for such events. OUT need to source funding from another funder.
- ✓ Training for Management on M&E of Peer Education and Outreach Programmes. OUT has been part of a process driven by ICF International to implement Quality Assurance Standards for Peer Education. This process, to develop and evaluate minimum quality assurance standards for Peer Education, started in 2012.
- ✓ One meeting per month dedicated to communication between management and the group.
- ✓ Journal keeping, with specific guidelines, monitored monthly.
- ✓ Developing and implementing an impact study, thus trying to pinpoint the true impact of the intervention, as well as addressing areas of concern.
- ✓ Expand and add another zone, e.g. Attridgeville.

Communication with the funder (DOH) is a challenge from time to time. More effective ways of ensuring effective communication will be explored in the near future.

First steps in applying what we have learned

Revise the current Peer Educator Training Manual and add two more sections, one on Human Sexuality and a third section on Personal Growth Exercises.

Usefulness and relevance of this lessons learned documentation process for OUT

It has given OUT the opportunity to take time to reflect on what have worked, and what did not work, in a programme that OUT is proud of. Knowing that it is not perfect, and with a few intentional tweaks, can grow to be a programme that is acknowledged as the one of the most successful Peer Education and Outreach interventions designed specifically for sexual minorities in South Africa and the region.

In future, OUT would include a qualitative component (one-on-one interviews) as part of a programme evaluation process, in order to obtain other unique information which is sometimes missed out on with a quantitative approach only.

ORGANISATIONAL BACKGROUND

OUT Wellbeing provides direct health services to the gay, bisexual and transgender (LGBT) community including HIV testing, counselling, treatment and general lifestyle advice and support.

OUT is situated in South Africa's capital city, Pretoria and has been in existence for more than 20 years. OUT is dedicated to the building of healthy and empowered LGBT communities in South Africa and internationally, while reducing heterosexism and homophobia in society.

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i http://www.hsrc.ac.za/HSRC_Review_Article-121.phtml

ii http://www.utwente.nl/cw/theorieenoverzicht/Theory%20Clusters/Health%20Communication/Health_Belief_Model.doc/

iii http://www.euromedinfo.eu/the-health-belief-model.html/

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6. My body, your body, our sex: A Sexual Health Needs Assessment For Lesbians and Women Who Have Sex With Women, Durban, South Africa
5. Working with buddy groups in Zimbabwe
4. 'MAN TO MAN', a joint approach on sexual health of MSM in the Netherlands via the Internet
3. Lessons learned from project "Visual information on sexual health and the exercise of citizenship by the GLBTI beneficiaries of the Organization in Quito, Ecuador".
2. Coffee afternoons: Prevention Project aimed at young gay men from Tegucigalpa (Honduras)
1. Womyn2Womyn (W2W) quarterly open day, for lesbian and bisexual (LB) women at the Prism Lifestyle Centre in Hatfield, Pretoria (South Africa)

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