

PEER SUPPORT FOR LTBI TREATMENT ADHERENCE AND COMPLETION



TRAINING CURRICULUM AND FACILITATOR'S GUIDE

CHARLES P. FELTON
NATIONAL
TUBERCULOSIS
CENTER



AT HARLEM HOSPITAL

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
DOT	directly observed therapy
HIV	human immunodeficiency virus
IMG	international medical graduate
INH	isoniazid
LTBI	latent tuberculosis infection
TB	tuberculosis
TST	tuberculin skin test
U.S.	United States

PREFACE

This guide finds its inspiration in the peer workers at Harlem Hospital Center who for many years have worked to promote healthy behaviors in their community. Collaboration between peer workers and health care professionals has strengthened Harlem Hospital's response to the community's gravest health threats, including tuberculosis (TB). In particular, the guide draws on the expertise gained and lessons learned in the peer-based Harlem Pathways to Completion Study and the Tuberculosis Adherence Partnership Alliance Study (TAPAS), both based within the Charles P. Felton National Tuberculosis Center. Our cumulative experience with peer workers may contribute to the development of innovative approaches to improving adherence and completion rates among patients receiving treatment for latent TB infection (LTBI).

Funded by the National Heart, Lung, and Blood Institute, the Pathways to Completion Study comprised two randomized clinical trials, one for patients with active tuberculosis disease and the other for patients with LTBI. The latter study tested a peer support model using peer workers who themselves had been treated for active TB. These workers did not observe patients taking LTBI medicine, but offered multifaceted support, made referrals for needed services, and provided practical help with adherence. This study concluded in 2000. Also with funding from National Heart, Lung, and Blood Institute, TAPAS is a randomized clinical trial testing a peer intervention in support of LTBI treatment adherence. TAPAS began recruitment in May 2002 and enrolled more than 250 participants over a 4-year period.

These studies used a similar intervention model, consisting of peer support to improve medication adherence combined with health education and social services to address barriers to adherence. Trained peer workers were from the Harlem community, and had successfully adhered to treatment for active TB or LTBI. Including African immigrants, Latinos, and African-Americans, they reflected their clients' ethnic background and shared other characteristics, such as a history of homelessness and substance abuse. Peers provided informal counseling and social support and practical tips for managing treatment and adherence, helped their clients navigate the health and social service systems, and facilitated communication with providers. Peer workers were trained in Harlem Hospital-based training courses, which included basic information related to TB, LTBI, and adherence and activities to build listening, communication and informal counseling skills. Training was reinforced through off-site and program-based training and workshops, as well as in biweekly case management meetings. Peers worked part-time and receive a stipend.

Based on our years of researching, developing, and implementing peer programs and peer trainings, we produced a comprehensive manual for programs providing peer support for LTBI programs. This manual, "Peer Support for LTBI Treatment Adherence: A Manual for Program Managers and Supervisors of Peer Workers," is available from the Charles P. Felton National Tuberculosis Center.

This **Training Curriculum and Facilitator's Guide** is intended to complement the earlier, program-oriented, **Peer Support for LTBI Treatment Adherence**, manual. Designed for health educators, program managers and peer supervisors with no specialized training experience, this Curriculum emphasizes the principles of adult education and participatory learning techniques to train adherence support peers. The Curriculum can be used to train peers at a particular site, or adapted for training cohorts of peers in larger settings such as TB control programs or health departments. State and local TB controllers and experts in adult education and training have contributed to the Curriculum's balance of content and training methodology. Technical information, training strategies, and modification techniques enable trainers to tailor material to a range of participant needs. Session plans include outlines, teaching points, discussion questions and suggested activities. Expert input and field-testing of training techniques and session content enhance the usefulness of this resource across a variety of settings. The Curriculum is intended to help programs overcome one barrier to training peers to support LTBI treatment adherence.

I. INTRODUCTION

Eliminating health disparities in the US is a primary goal of the CDC's 'Healthy People 2010' agenda for national health promotion and disease prevention. However, there is a growing awareness that traditional structures of healthcare delivery have not effectively addressed persistent disparities in health outcomes by race and socio-economic status in the US. Peer collaboration is a potentially powerful tool to overcome these disparities, and builds on long-established traditions of non-professional, community-based health care ranging from mid-wifery to naturopathy to palliative care. A 1994 CDC report highlighted the effectiveness of using peer workers in promoting positive health outcomes in impoverished and poorly served communities, particularly African-American communities. The report provided impetus for renewed interest in incorporating peer workers into health promotion and disease prevention efforts.

A. PEER WORKERS IN HEALTH CARE SERVICES

The range of terms used to describe community-based, non-professional health service providers reflects the wide variety of functions that they perform: peer educator, counselor, or advisor; community health worker; lay health worker; buddy; *promotores de salud*. For the sake of simplicity, this guide uses the term 'peer worker' to refer to all non-professionals in health and social service programs whose roles rest to some degree on their connection with the community they serve.

In health care, peer workers may act as a liaison between providers and clients, serve as a "navigator" to help client locate needed services, translate medical information for their clients, and provide linkages to other community services. Peers can also relay information from clients to providers so that services become more accessible and culturally relevant. Studies of peer support for various disease treatments have demonstrated their effectiveness in improving medication adherence and appointment keeping.

Peer workers have also been used to promote specific behaviors such as breastfeeding, eating healthier diets to reduce hypertension, and cancer screening. In HIV/AIDS work, peer workers have effectively delivered HIV prevention messages and materials to hard-to-reach populations. Peers acting as medication supervisors for tuberculosis clients in developing countries achieved treatment success rates similar to professional healthcare workers. Peer-based programs can provide personalized support that creates a bond between client and peer worker and catalyzes positive behavior changes. Social learning theory suggests that peer workers serve as role models, demonstrating how to adopt a beneficial health behavior and helping others overcome barriers to better health. Peers are an accessible, familiar resource for information, education, advice and referrals.

A peer worker's effectiveness stems from several factors that help to define exactly who is a peer and under what circumstances. Peers sharing a reference group with clients may be viewed as more credible than professionals, because the peer has most likely faced life constraints similar to those encountered by his or her client. This perceived commonality may be due to shared language, ethnicity, sexual orientation, medical history or chronic disease state, history of substance use, or other life experiences. Or peer workers may identify with their clients as members of the same community. All these bases of identifying and cultivating common ground with clients in order to achieve targeted health outcomes are true to the definition of peer worker. This manual focuses primarily on peers who use their own personal experience with LTBI treatment in the service of improving individual client adherence and treatment completion. However, much of the orientation given here can apply to supervising peers whose shared experience with their clients is less specific.

The variety of peer role definitions has been conceptualized as a continuum extending from the “natural helper” to the paraprofessional model. In the natural helper model, an effort is made to identify community members who are viewed by others as a focal point for information and assistance. After receiving some training, these helpers return to their normal tasks with an increased capacity to provide health education and guidance to their peers. For instance, a beauty shop owner in a community with elevated rates of high-risk Latent TB Infection might have information in her shop about the importance of being treated for infection and how to access health care. Such helpers are usually not paid and retain a fair amount of autonomy in their intervention activities.

At the other end of the continuum is the paraprofessional model, typically employed by hospital and community service-based programs. This model is characterized by stronger institutional affiliations that imply more structured supervision of peer workers, tighter definition of their activities, and regular documentation of peer activities. The paraprofessional model is often used with populations or illnesses that are stigmatized; examples include former drug users doing outreach for HIV or TB prevention and treatment, homeless individuals helping other shelter residents attend TB appointments, and former TB patients supporting LTBI clients to complete treatment.

Each variation of peer work has an appropriate niche in health care provision, and each requires its own corresponding level of supervision. This manual is designed to be useful to supervisors at any point along the continuum of peer workers, whether a few elements from the manual are adapted to monitor natural helper-style volunteers who distribute pamphlets about LTBI treatment, or it is used as a guide to supervisors of peer counselors working within the paraprofessional framework.

B. THE CHALLENGE OF ADHERENCE AND COMPLETION IN LTBI TREATMENT

Targeted treatment of LTBI is an important part of the national strategy for eliminating tuberculosis in the United States. The CDC’s Healthy People 2010 objectives for TB include increasing to 85% the proportion of high-risk persons with LTBI who complete a course of treatment. High-risk persons include those with recent infection (within 2 years); recent immigrants from countries with high rates of TB; people with HIV infection or other immunosuppressive conditions; and children under the age of five. Rates of LTBI treatment completion in the US have consistently fallen below the 85% target. Greater attention to the assessment of adherence and strategies to improve it can make an important contribution to improving LTBI treatment completion rates, thus furthering the larger goal of TB control and elimination.

Adherence is the degree to which patient behavior coincides with medical advice about medication taking, follow-up care, diet, and other lifestyle changes. Although persons who do not complete LTBI treatment are much more likely to develop active disease than those who do, poor adherence to LTBI is common. Indeed, poor adherence is a challenge to effective treatment for a multitude of diseases and conditions. Data have not shown that demographic or personality characteristics are consistently associated with adherence; however, circumstances like homelessness, active substance use, lack of social support, and untreated mental illness put patients on LTBI treatment at increased risk for non-adherence. The nature of LTBI treatment regimens themselves presents an adherence challenge, since poor adherence is generally associated with drug regimens that, like LTBI treatment, are long-term, produce side effects, or do not relieve symptoms. Patient knowledge of regimen and attitudes toward LTBI treatment, including perceived benefits of treatment and perceived ability to overcome barriers to treatment,

have been positively associated with better adherence to LTBI treatment, as have aspects of the patient-provider relationship and of the health care setting. In general, research suggests that adherence results from the interaction of several factors. Therefore, interventions to improve adherence will be most effective when they target multiple dimensions of adherence.

A multidisciplinary team of providers can offer adherence support that is both comprehensive and unified in its message. An adherence support team may consist only of an adherence-dedicated nurse, a primary care physician, and the patient. Or, the team may provide a full complement of services including pharmacy, social work, health education, case management, system navigation, outreach, mental health counseling, and social support for individual and groups. Teams also vary in degree of integration: members may exchange information continually in a shared workspace or meet only once every two weeks. In any case, smooth, consistent communication among team members, and between the team and its clients is essential.

Regardless of peer workers' specific tasks and objectives as team members, they are uniquely situated to facilitate patient-professional communication. Peers come to the team with a sense of how patients experience LTBI diagnosis, treatment and adherence, and may be better able than professionals to perceive misunderstandings and barriers to provider-client communication. Because their interactions with clients are based on empathy and shared experiences and because they frequently have more open access to clients, peer workers may glean more information about actual and potential challenges to adherence than do professional team members. For the same reasons, peer team members may also communicate the team's messages to clients most effectively.

Directly Observed Therapy (DOT) is the standard of care for TB disease, and is also a very effective way to ensure complete treatment of LTBI in the most high risk patients (immunocompromised persons or children of infectious cases who get DOT at home). The Charles P. Felton National TB Center does not advocate the exclusive use of peer workers in adherence support in these circumstances. However, for many persons at risk for progression from LTBI to TB disease – who face the burdens of prolonged treatment, possible side effects, and no perceptible health improvement – being accompanied on the treatment journey by an experienced peer worker can make a positive difference.

Capacities in which peers can effectively promote adherence to LTBI treatment include: health education, case management, patient navigation or liaison, and outreach.

Roles of Peer Workers
Improve patient-provider communication by relaying medical information in terms accessible to the patient.
Make health care providers aware of specific barriers to communication.
Help patients navigate the health care system.
Link patients to medical referrals; even escort them.
Assist patients in accomplishing treatment-related tasks.
Cultivate 'helping relationships' that bond patient and peer in a uniquely personal alliance for health-promoting behaviors.
Facilitate social and community services needed by patients for successful treatment completion.

II. OVERVIEW OF CURRICULUM AND FACILITATOR'S GUIDE

The *Peer Support for LTBI Treatment Adherence and Completion: Training Curriculum and Facilitator's Guide* is designed for use by those charged with training peers to support LTBI medication adherence. Background information on approaches to adult education and training, and evaluation, as well as suggestions for pre-training preparation provide a starting point for planning and implementing a successful training course. We recommend that even seasoned educators review these sections designed to put session plans in context and stimulate creative learning activities.

Each of the eight session outlines contains suggested format, content, and objectives. These outlines are the result of formative evaluation involving TB Controllers and education and training professionals across the United States. However, outlines can and should be modified to better meet program needs. For example, a program that has already trained peers to support LTBI treatment adherence, may choose to omit some of the basic TB content, but emphasize case studies to further develop peer skills.

The session outlines are followed by explanations of content, discussion points, basic information, and sample activities. Any included materials are designed to be easily adapted to local needs. We hope that the suggested format and activities do not constrain, but rather, inspire innovative approaches to adult education and training.

III. ADULT EDUCATION AND TRAINING

A. THE CHALLENGE OF ADULT EDUCATION

When preparing to teach new information or skills to peers, it is important to recognize and use techniques that facilitate adult learning. While it is natural to gravitate towards the more familiar lecture style encountered in high school and college, a little planning, practice and creativity enable a willing facilitator to share the responsibility of teaching and learning with training participants. Many adult learners may have bad memories of their largely passive learning experiences in high school and college, where highly technical information was delivered in lecture format. Regardless of whether this form of education was a positive or negative experience, it is the expectation of most adult learners.

Lectures alone cannot adequately prepare peers for their role in supporting medication adherence. Though the peer role requires some technical knowledge of TB infection and disease, as well as LTBI treatment and adherence, this information is useless if peers lack an open mind, interpersonal skills, problem-solving and critical thinking skills, and good judgment.

“The lecture method of teaching is the best way to transfer the teacher’s notes to the students’ notebooks without ever passing through their minds.”

—David Werner and Bill Bower, *Helping Health Workers Learn*

Peers come from a variety of backgrounds that allow them to connect with and serve the diverse members of their community. Their firsthand understanding of the context in which people struggle to adhere to LTBI treatment is the key to a peer’s capacity to help clients overcome barriers to medication adherence. In order to prepare peers to help others adhere to LTBI medication, the vital peer perspective must inform the training course.

While there is no sure-fire learning method that works for everyone, the following techniques will help facilitators to better educate and train adults:

- Build on trainees’ knowledge, understanding, and previous experience
- Communicate consistent technical information in clear, simple language that trainees can understand
- Present content in a structured way so it may be more easily integrated with what trainees already know
- Allow opportunity for active learning, whereby learners process information, solve problems, or practice skills – individually or in groups
- Match the scope and depth of material with trainees’ learning needs and capacity
- Give immediate feedback to trainees about their own learning
- Provide opportunities for the trainee to give feedback and inform future training efforts

B. PARTICIPATORY TECHNIQUES

1. Information sharing and clarification

A participatory approach to training will allow ample time for trainees to interact with and learn from experts in TB disease, peer support and counseling, and to share their personal experiences with LTBI. Facilitators should make sure that presenters answer peers' questions in words they can understand, and provide a channel for follow-up questions after the session. Experienced peers from other programs in the area may serve as valuable resources to enrich discussions with practical personal experiences and troubleshooting tips.

2. Observation

When training peers to join an existing peer adherence support program, the training course might provide an opportunity for trainees to learn by "shadowing" some of the on-the-job activities of experienced peers. This type of observation/experiential learning allows peers in training to personally view the peer role, interactions among the LTBI adherence support team, and the key role that other professionals have in providing health and social services. During shadowing sessions, trainees might be asked to complete a brief checklist to help clarify the roles of the different team members they have observed. Another way to bring examples to life is to engage peers in detailed case studies, presented in a variety of formats. A case study might be used to illustrate one client's situation, how it was managed, what went wrong, and how the situation was resolved.

3. Applying knowledge and practicing skills

When given the opportunity to apply newly acquired knowledge, the trainee interacts with information on a deeper level. Instead of simply regurgitating facts, the peer must draw on his or her understanding of key information and how it relates to the problem at hand. Exercises designed to apply technical information to 'real-life' scenarios will challenge trainees to reconsider what they know, and bring to the surface any misconceptions. Using knowledge gained during technical training while practicing the peer role will build confidence in trainees' ability to educate others and allow the facilitator the opportunity to correct information as needed.

Perhaps the most important way a peer will support LTBI treatment adherence is by helping clients overcome barriers to adherence. Complex barriers require both the peer's problem-solving skills, as well as his or her ability to lead clients through a process that reveals strategies to address adherence obstacles. Only by analyzing their personal experiences and applying problem-solving skills to complex situations, will the trainee develop the capacity to help others adhere to LTBI treatment. Training for peer adherence support is most relevant when it synthesizes technical information with practical skills in practicing problem-solving and peer counseling. Be sure that the training allows enough time for peers to master these skills.

C. SETTING THE STAGE FOR SUCCESSFUL TRAINING

1. Pre-Training Assessment

A successful training course requires careful planning to meet the training objectives of a program and the learning needs of participants. Even “tried and true” curricula and materials should be updated or modified to ensure appropriate training content and format. One way to match session plans and other activities to peer training needs is to carry out a pre-training assessment. To adequately inform training preparation, the training coordinator should try to gather information from several different sources. At minimum, the pre-training assessment should include program goals, local context and resources, and baseline participant characteristics.

A peer job description and answers to the following questions will aid the training coordinator in considering program goals, local context, and participant characteristics, vis-à-vis the peer role:

- How many peers will be working with the program?
- How many LTBI patients will a peer support at one time?
- How many times a week/month is a peer expected to contact the client?
- What is the usual form of peer-client contact (ie, in-person, telephone...)?
- What are the usual hours during which a peer will contact clients?
- How many hours is a peer expected to work each week?
- Are peers expected to have access to their own vehicle for work?
- Does the program provide transportation reimbursement to peers?
- What compensation, benefits, or incentives can peers expect?
- What are the minimum educational qualifications for peers?
- What skills are peers expected to have prior to training?
- What other peer characteristics are desired?

Program review

The content of this curriculum attempts to address the most important program training requirements for a peer-based LTBI treatment adherence support intervention. However, program goals will vary in response to disease burden, local policies, available health care services, and funding priorities. Trainers that take the time to understand the program will be able to make better use of materials that address the program’s training requirements, and identify areas where materials and content need to be developed or modified.

If the training coordinator is also the program manager, program review may seem like a simple step. In fact, the program manager usually does have the broadest perspective on his or her program, but as a result, may also have some difficulty linking more general program goals with training objectives. The more multi-faceted the program, the more likely this is true. It is worthwhile for the person in charge of the training course to identify the program goals that are to be fulfilled by the peer-based intervention, and then translate these goals into clear training goals and objectives (see Evaluation).

To get started, try answering the following general questions about the program:

- What is the purpose of the program (program goals)?
- How will the program achieve its goals?
- Besides providing peer support for LTBI treatment adherence, what are some of the other program activities?
- Describe or diagram program organization and key personnel.
- Describe or diagram the relationships between program personnel.
- How are peers supervised and supported within the program?
- When was the program established and how long is it intended to function?
- How is the program sustained (funding sources; partnerships)?
- What other training opportunities does the program provide?

Ideally, a thorough review of program goals and training objectives takes place at least one month prior to the training course. This allows time to tailor curriculum content to a program's specific training needs.

Program review may reveal that more than one training course is needed to cover content related to different program goals, or that in addition to peer training, other intervention staff require special training and support. If this is the case, the training coordinator must differentiate between what the planned training course will accomplish, and what will be the focus of future training or technical assistance.

Local context

An understanding of the context in which a program operates will increase the value of peer training by informing course content with locally relevant examples and insights. Though the peer job description might be fairly standard across similar programs, peers further define and fulfill their role in response to the physical, social and political aspects of their local context.

Physical environment is an important factor to consider when training peer workers. Depending on the geographic area covered by a program and the availability of reliable transportation, peers from different programs will encounter different challenges to fulfilling their role. A skilled trainer will integrate these challenges into the training course so that peers are better prepared to work in the field. Peers supporting LTBI patients scattered throughout a large suburban county with poor public transportation might be trained to set meetings during clinic visits or at locations that are mutually convenient to the peer and patient. Conversely, peers working in a dense metro area with good public transportation could plan to visit patients at home. Weather-related issues such as accessibility during snow storms or heavy rains also require consideration and planning so that peers can perform their job.

To get started, try answering the following questions about the physical context:

- What is the 'catchment area' for the peer adherence support program?
- Is there reliable public transportation throughout the catchment area?
- At all times? If not, when?
- How much does public transportation cost?
- Are there any parts of the catchment area that are not easily accessible throughout the year? If so, where? When? What do people in this part of town do when access is poor?
- What parts of the catchment area are most frequented by residents living in more remote areas?
- What locations do members of the target population visit on a regular basis?

Social context is intimately linked to the peer role, as peers are selected from the social milieu of the patients they support. The role of the peer usually unfolds outside program walls, in a patient's social setting, where peers typically mirror characteristics of a target population that may include former substance use, foreign birth or travel, economic disadvantage, unemployment, or homelessness. The same traits that enable peers to build helping relationships with their clients may put peers at risk. Assessing potential pitfalls such as relapse into substance use or involvement in ethnic tensions can help the trainer prepare peers to establish boundaries and examine how their own experiences relate to client needs.

Patterns of social behavior also influence the ways that peers interact with their clients. Sporting events, religious services, or other regular community activities in a small town might provide opportunities for peers to connect with their clients in a less formal setting. In more transient, urban areas where communities are less intact, peers might need to schedule meetings during their clients' clinic visits. Other pressing social issues such as racial or ethnic division or inequitable access to education, healthcare, or social services can be incorporated into training discussions of local context.

The strength of peer support lies in the unique social connection between the peer and client. Investigating the social attributes of the LTBI patient population will guide the trainer in developing peer capacity to support clients in their shared social context. Understanding the peers' social context may also shed light on issues with which peers require additional support for their role.

To get started, try answering the following questions about the social context:

- Describe the social characteristics of the target population in terms of race/ethnicity, country of origin, socioeconomic status, alcohol or substance use, education, employment, housing, etc.
- Describe the social landscape of the 'catchment area' in terms of commercial and residential areas, neighborhood divisions, zoning, health districts, key institutions, etc.
- What are the most important activities observed in the target population?
- What activities do members of the target population participate in regularly?
- What are the most pressing social issues in the catchment area? How do these issues relate to the target population?

Programs are at the mercy of funding priorities and other policies that may or may not reflect local realities. In some instances, misguided priorities result in a glut of auxiliary health services, while in other cases, minimal supportive services are not provided at all. Volunteer or paraprofessional healthcare worker regulations vary across states, as do TB control policies and practices. A trainer who understands the political forces that shape program activities will prepare peers to complement, rather than compete with or duplicate existing services, and adhere to local policies that regulate service delivery.

Less obvious than official policies and health worker regulations are the myriad informal protocols established over time. Understanding how a health jurisdiction operates takes time and the willingness to speak with several key informants. However, exploring the various means through which health services are provided will help the trainer communicate factors that facilitate and constrain the peer role in the local context.

To get started, try answering the following questions about the political context:

- Describe the relationship between the peer program and local TB control.
- Describe key relationships between the peer program and other health service organizations.

- What, if any, healthcare worker regulations apply to peers?
- Are there any healthcare policies or regulations that conflict with the peer role, as defined by the program? If so, how can the peer role be modified?
- Where does the target population receive most health services? TB-related services?
- Who is in charge of LTBI case management? How does the peer relate to the person in charge of their clients' case management?
- How do other health service providers perceive peers in general? As a source of adherence support?

Understanding the local context allows trainers to more effectively prepare peers to support patients in the 'real world,' and helps diminish the frustration and error sometimes associated with defining the peer role.

Training that critically considers the context in which peers will engage with their clients and other service providers will better prepare peers to operationalize their role. Any evaluation of local context should therefore, purposefully seek to identify resources for training and supporting peers. One recommended peer training activity involves mapping peer resources. While assessing the local context, the

facilitator may choose to work through this exercise to better understand the different institutions and personalities that the peer may encounter in the field (see mapping exercise, Session 7).

Participant characteristics

Even the most thorough pre-training assessment of a program and local context is incomplete without information about training participant (peer) characteristics. In some programs, a program manager/trainer might recruit and interview prospective peers. In contrast, a large program might send peer trainees from several different sites to a central course led by an outside facilitator. Whatever the case, it makes sense to plan on collecting baseline participant characteristics using a standard format that can be referenced for planning purposes.

If an application process is used to screen peer candidates for an interview, the application form will likely collect information concerning peer baseline criteria (see Appendix A). Building on this information, a more detailed inventory of participant knowledge, skills and experience, and interests has proven extremely useful to trainers as they prepare a peer training course.

A more complete picture of participant educational background and baseline knowledge can help the trainer determine an appropriate teaching level, and suggest supplementary materials or teaching methods. It is crucial to identify low-literacy trainees early enough to plan activities that attend to their special learning needs. Foreknowledge of individual trainee's skills and experience as well as their particular area of interest allows the trainer to draw on peer resources within the

training group – a strategy in keeping with adult learning theory, and one that conveniently models the peer role. Perhaps the most important thing a trainer can do to ensure that training content and format suit peer learning needs is to take the time to learn about the training participants.

High participation and optimal learning are the reward for adapting course content and format to participant characteristics.

2. Scheduling and Logistics

Enroll participants

Enrolling participants or selecting peer candidates to take part in a training course is a time consuming activity. Depending on the recruitment process, the program manager or training coordinator might spend days screening and interviewing applicants to decide which candidates have the capacity to support LTBI treatment adherence. Experience has shown that peers engaged in LTBI adherence support should meet the following qualifications:

- Past treatment for LTBI or active TB disease
- Local resident or familiarity with community
- Ability to reflect on and apply life experience
- Good communication skills
- Open-minded (non-judgmental)
- Committed to working with others to control TB
- Not currently using street drugs or abusing alcohol

However, unlike positions with strict educational requirements, the peer role might be based on less conventional assets such as: fluency in a specified language, experience working or living with the client population, experience dealing with one or more difficulty faced by client population,

Sometimes the key characteristics sought by adherence support programs are found in low-literacy trainees. Imposing an education or literacy requirement may exclude those peers most able to connect with the target population.

ability to relate easily to client population and program staff, acceptance of alternative perspectives and lifestyles, good communication skills, willingness to voice opinions and share information with others, and the ability to work independently. Imposing educational requirements on peer applicants may prohibit peer candidates with a great deal of potential from taking part in the training course.

Though assorted preparations such as budgeting, reserving space, purchasing materials and identifying facilitators might commence well in advance, session plans should not be finalized until all participants are known. Waiting until after trainees are enrolled to finalize session plans gives the training coordinator the opportunity to respond to the general characteristics of a training class, and to address any individual learning needs. The actual number of trainees enrolled in the course will also be important when selecting the training space and purchasing materials.

Schedule training

How the training course is structured will have a lot to do with the program resources available to train peer workers. Some programs are able to dedicate a training coordinator to oversee a weeklong course, while others will involve a variety of human resources over a longer period of time. Whoever is responsible for training the peers should determine the length of each session and the duration of the course, based on training needs and the availability of session leaders, training facilities, and participants. For example: 8 or 9 sessions in the morning or afternoon, over 2 to 4 weeks – or two full-time weekends. See page 16 for a discussion of the advantages and disadvantages of different schedules.

The eight sessions outlined in this curriculum are each approximately four hours long. Together, they represent the minimum technical content and skills practice recommended for peer adherence support trainees with little or no training in TB/LTBI. Each session can be expanded to fill an entire day by augmenting technical material and including an additional practice activity after lunch.

Once finalized, the course schedule should be distributed to training facilitators, participants, and ALL PROGRAM STAFF. It is critical that even personnel not directly involved in the training be aware of the training course and encouraged to support the peers they are likely to encounter in the workplace. Keeping program staff abreast of training activities makes everyone feel more invested in all program operations, not just individual assignments.

Identify session leaders

Not all training courses have the benefit of a dedicated training coordinator and must rely on the fairly independent contributions of several different facilitators. In fact, peer participants report that technical sessions led by medical experts are a critical part of training, because these sessions

Even when there is a dedicated training coordinator, enlisting the varying perspectives and expertise of diverse session leaders will improve training.

afford the opportunity to discuss TB issues with doctors and peers at the same time. Though different perspectives and expertise generally enhance learning, it is important that each session leader agrees to use a participatory approach, and is willing to work with the person in charge (program manager or training coordinator) to meet session objectives and ensure training continuity.

Experience with past and on-going peer programs also suggests that it is useful to involve other members of the intervention team in training. However, while some program staff will be qualified to lead sessions, others will be better included in skills practice and other learning activities that provide a chance for peers to interact with and learn from members of the adherence support team. For guidance in selecting appropriate session leaders, please see the recommended facilitator characteristics, included in each session outline.

Secure space and materials

Once the training coordinator knows how many participants will take part in the training course, it is time to begin the search for an appropriate space and procure training materials. Planning ahead is important to make sure facilitators and participants begin the training course with a sense of security and focus. A comfortable room and all needed materials can be secured well in advance of the actual training course. Attention to how the training room is ordered, and making sure that materials are complete and on-hand will create a supportive learning environment that is free from distraction.

Spatial organization is a critical feature of the training experience. First and foremost, the training coordinator must make sure that the training room is accessible to all participants. If necessary, accommodations for handicapped trainees can be made, or alternate locations identified. Restrooms and drinking water should be conveniently located near the training room, to minimize time spent away from the session. The ideal room size will comfortably allow all participants and facilitators to sit together in a semicircle, and break into 3-4 small groups for discussion. Reconfiguration into small groups is easiest when using lightweight, moveable chairs and there is minimal additional furniture in the room. If a training course will be completed in one week, it may be worthwhile to temporarily relocate unneeded tables, desks and other furniture that might be in the way. In other situations, it might be easiest to designate one person to ready the room before each training session.

Depending on available program resources, training materials may need to be purchased several weeks to several months before the training course. The training coordinator needs to ascertain which materials must be ordered or obtained from an outside source as early as possible and begin the process. It is helpful to alert administrative support or the person in charge of procurement if an unusual purchase is anticipated, and leave adequate time for that person to assist. Issues that may arise with regards to training purchases may include, determining a funding source, identifying recognized supplier, obtaining estimates, quotes, and written approvals, completing paperwork, and tracking orders. By starting early and closely following the procedure, a vigilant training coordinator can minimize potential delays between identifying and receiving needed resources.

Some training materials will vary, depending on the day's session, while others will be used consistently throughout training. The training coordinator can determine what resources should be available throughout the training, and work with session leaders to develop a list of materials needed for specific sessions.

- Resources used on a regular basis might include:
Overhead projector, multimedia or LCD projector and computer, extension cords, dry erase board and dry erase markers, chalkboard and chalk, erasers, easel, flipchart paper, markers, butcher paper, pens, pencils, notepads, nametags, disposable cups, 3-hole punch, stapler, tape, dictionary, basic TB reference materials
- Session-specific resources might include:
Overhead slides, disk, CD-ROM, copies of presentation slides, factual pamphlets or other literature, relevant statistics, worksheets, handouts, games (instructions and all components), role play scenarios, case studies, cassette player, cassette recorder(s) and tapes, diagrams, graphs, maps, medication chart, TV/CR/DVD player, videos and DVDs, related reference materials

Preparing materials in advance gives sessions the chance to succeed in every way possible. Facilitators will better focus on communicating session content and engaging participants in learning, when they are not worried about whether their materials are ready.

Scheduling class sessions

Depending on when participants and trainers are available, you can expand the course by scheduling class sessions over a longer period of time or condense the course into a couple of weeks or two weekends. There are advantages and disadvantages to both approaches.

Example of expanded 4-week training schedule

Week 1	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 1			Session 2	
Afternoon	Optional			Optional	

Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 3			Session 4	
Afternoon	Optional			Optional	

Week 3	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 5			Session 6	
Afternoon	Optional			Optional	

Week 4	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 7			Session 8	
Afternoon	Optional			Graduation	

Example of 3-week training schedule (preferred)

Week 1	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 1		Session 2	Session 3	
Afternoon	Optional		Optional	Optional	

Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 4		Session 5	Session 6	
Afternoon	Optional		Optional	Optional	

Week 3	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 7		Session 8	Graduation	
Afternoon	Optional		Optional		

Example of condensed 2-week training schedule

Week 1	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 1		Session 3		Session 5
Afternoon	Session 2		Session 4		Session 6

Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Session 7		Graduation		
Afternoon	Session 8				

Example of condensed 2-weekend training schedule

Weekend 1	Saturday	Sunday	Weekend 2	Saturday	Sunday
Morning	Session 1	Session 3	Morning	Session 5	Session 7
Afternoon	Session 2	Session 4	Afternoon	Session 6	Ses.8/Grad.

If you want, the expanded training format can accommodate additional technical content and a second practical exercise by extending each session to a full day. This pace may be the best way to meet the learning needs of low-literacy trainees as it allows additional time to present technical information and clarify participant understanding through practice and discussion. It is also a good format when a program has additional, job-specific training objectives to incorporate. In many situations, an expanded training format is not realistic, placing too great a demand on limited program resources.

A more condensed training course can be achieved by scheduling two sessions on one day. Eliminating the second evaluation report, review activity and break help reduce session length, though other time saving strategies such as take-home reading may be needed to supplement the faster pace of a condensed format. A condensed format doesn't necessarily give enough time for participants to process new information, so discussions, review, and practical exercises play a crucial role in assessing how well the training is progressing. This is especially true of the two-weekend format.

Another option is the training course, carried out session-by-session, over a longer time period. Sessions might be offered once or twice a week for one or two months. Though sessions can remain formatted in four-hour blocks, increasing the interval between sessions to more than one week is not advised. Trainees need to build on new knowledge and skills, and significant time lapses will interrupt this process. Besides being impractical from a program standpoint, the training course should never last more than two months. Peer program managers agree that to maintain critical training momentum, peers should begin working in the field as soon as possible. Basic peer training conducted infrequently and over a long period of time lacks cohesion and purpose. For this reason, our experience shows that a 3-week format works best.

Meet with session leaders

If possible, a meeting with session leaders would be useful to bring together your training team. Either individually or as a group, it is a good idea to review the following:

- The challenge of adult education (page 7)
- Using participatory training techniques (page 8)
- Findings of the pre-training assessment (pages 9-12)
- Schedule for the course, how each session fits in and builds upon the others (pages 13-17)
- Preparation of materials needed for each session (pages 18-22)
- Evaluation methods that will be used; how these can help improve this and future courses (pages 23-28)

D. CONDUCTING SUCCESSFUL TRAINING

1. Designing and Preparing Sessions with Trainers

With an understanding of pre-training needs, the training coordinator is ready to work with session leaders to prepare a course that will further program goals in the local context, and respond to the learning requirements of the training participants. There are three primary ways that this training curriculum can be tailored to match the needs of a particular training course: modifying the format, adapting materials, and integrating participant experience.

Modify format

Educators agree that adult learners reinforce newly acquired knowledge when they have the opportunity to apply it. Skills practice, likewise, improves the performance of job-related tasks. It is therefore, highly recommended that a pattern of presenting new information and synthesizing it through learning activities and skills practice be maintained throughout the peer training course. In keeping with this principle, there are several formatting options that more or less preserve the essential learning sequences in the curriculum.

For a paraprofessional training cohort with a high level of literacy, some technical material can be assigned as homework. In general, this strategy means that for each training session, the first topic could be compiled and distributed as a take-home assignment, with complimentary worksheets and questions to draw trainees' attention to key points. The most current CDC TB self-study modules are an excellent resource for this type of training format. By assigning topics for self-study, actual classroom time could be reduced to about two hours/day, spent on a complementary activity or discussion reinforcing the take-home lesson. Through group activities and discussion, participants build their confidence as peers and form an effective team. However, this option is not recommended when a full training course is possible because it diminishes contact between trainees and expert session leaders, and reduces the time that participants spend dynamically influencing their learning experience.

Low-literacy groups challenge the more conventional session design. Many expert facilitators tend to rely on overhead slides and other written material to summarize the main points of certain medical or health topics. When preparing to train low-literacy participants, the training coordinator should help session leaders revise or develop technical presentations so that they rely on simple diagrams, images, and clear, accompanying explanation. Written facts, summaries, and statistics may need to be reworked and simplified for a lower reading level, and should be considered only a back-up source of information. More than other trainees, low-literacy groups require greater emphasis on discussion during, as well as following, a technical presentation. Focused discussion can verify that information has been communicated and interpreted correctly. Reducing time spent with expert session leaders on technical material is not recommended; in fact, when possible, an expanded format should be considered (below). The responsibility to accommodate the learning needs of low-literacy peers rests with the trainers, as they endeavor to creatively share information and ideas with intelligent trainees who happen to lack the ability to read and write well.

Adapt materials

A good way to determine whether the curriculum needs major changes or simple adaptation is to compare the training goals and objectives identified in the pre-training assessment, with the session objectives in the curriculum. If the session objectives cover the program training goals and objectives, then chances are good that the training course simply needs to be tailored to the specific program and context. If there are major content gaps, additional sessions should be developed and integrated into the course, in keeping with recommended participatory techniques and format.

Examples:

- A program emphasizing outreach and education, rather than adherence support, would expand on peer counseling and education content.
- A program aiming to improve TB treatment adherence would require additional content on TB medication regimens and local TB treatment regulations, and less emphasis on LTBI.
- A program geared to the specific adherence needs of persons co-infected with HIV and TB would develop sessions with HIV content.

Where possible, training activities will benefit from concrete examples and program-specific references to help peers think about how they will actually fulfill their role, outside of the classroom. To that end, an introduction to the peer job description will set the stage for future practical exercises, and encourage the peer's critical evaluation of his or her own development in relation to the peer role. One simple way to integrate program details into the training course is to make sure that peers learn and practice adherence problem-solving strategies with other members of the adherence support team. Program staff can serve as session leaders, discussion facilitators, or resources during learning activities. Forms and other program documents should be used when practicing client record-keeping.

Consideration of the peer role in relation to scheduling, transportation issues, field safety, and ways that the peers intersect with other service agencies, prepares peers to work in their specific context. Learning activities that reinforce technical content, such as case studies, role-plays and even discussion questions, are rendered more meaningful when they reflect local realities, enriched with details of the physical, social and political landscape. The activities in this curriculum are designed to take place in anywhere in the U.S. However, we encourage trainers to be creative in adapting them to be more engaging and realistic for your local setting. The suggested activities aim to highlight key teaching points and to serve as a framework to adapt content to context. The pre-training assessment will provide plenty of inspiration to adapt materials.

Many issues such as transportation, housing, and employment can stimulate insight into activities concerning the peer-client interaction and LTBI treatment adherence issues. Try adapting a role-play to take place at a metro center bus stop, or in a fast food parking lot. A peer's visit to a dilapidated apartment building can as easily become a trek to an outlying suburban neighborhood. Incorporating characteristics of the target population into learning activities prepares trainees for the type of peer-client situations they will likely encounter. Simple changes of characters' family names, type of employment, and situational details made to case studies or role-plays will provoke more thoughtful discussion of the actual patient population. As peers share many characteristics with the target population, activities that encourage trainees to introduce their own ideas and experiences will promote dynamic learning as they make core content relevant to their work and future clients.

Integrate participant experience

Participant experience is a highly valuable training resource, not to be overlooked. This is true in any adult education setting, but especially so when it comes to training peers. By definition, peers are expected to share with their clients a common language, cultural background, similar life experiences, and a history of TB or LTBI treatment. Peers are therefore already more qualified for their role than most professionals in a position to facilitate their training. But since peer adherence support requires an understanding of basic TB/LTBI information, familiarity with adherence issues, problem-solving skills, counseling and education skills, and the self-confidence to provide support to one's peers, peer trainees require thorough training that builds their already formidable capacity. The curriculum is designed to elicit peer input and participation on multiple levels. A savvy trainer will keep this in mind as he or she refines session plans and activities to draw upon the unique resources within the trainee cohort.

With the application, interview and pre-training inventory results, the training coordinator should be familiar with participants before finalizing session plans. If different session leaders or facilitators are involved in the course, the person responsible for training the peers will need to make sure that each facilitator integrates relevant participant experience into their session(s). Time spent learning about each participant's background is wasted when this information is not used to improve the training course. Peer experience and interest can inform the training course explicitly, during scheduled presentations and peer-led activities, and through participation in discussion and skills practice.

Peers are motivated to share experience with one another, especially when they are certain that their experience will be recognized and respected. A training coordinator can sustain learner interest and participation by identifying trainees with relevant experience, skills or interests, and programming peer contributions into session plans. While participants who assist with sessions would not be expected to lead an entire presentation, they could be matched with a session facilitator to keep the presentation on track and add their perspective on a particular topic. Some peers have extensive experience with activities that relate to the peer role, having worked as community health educators, or clinic outreach workers. These participants might help stimulate discussions about the target population or communicating health information. Involving trainees with experience or interest in a particular topic will channel participant energy in a positive direction, reinforce the value of peer resources, and help minimize common training difficulties such as individual boredom or session dominance that arise when disparities in trainee experience and interest are ignored.

Another effective way to integrate peer experience into training content is to plan participant-led activities. These activities can take the form of review exercises, facilitated by any peer with an interest in the previous session's content, or they might explore a more experienced participant's perspective on a related issue. Trainee-led evaluation reports give voice to participant expectations of and experience with session content and format. When trainees perceive that their feedback has an effect on the training, they are encouraged to participate.

Peers with a strong interest in a particular topic could be encouraged to carry out independent research and share results with the other trainees. Programming on-going projects that parallel the training course provides an opportunity for peers to deepen and focus learning, in whatever subject area means most to them. This training option incorporates a wide range of participant experience and interest, as participant pairs are encouraged to select an issue relating to training content, explore the issue using independent or program resources, and present findings to the training group. Peers feel appreciated and inspired to learn when training is enriched by their personal effort and insight. If the training schedule does not allocate additional time for the pairs to work on a parallel project, participants should be advised of the extra-curricular work in advance.

Finally, the seemingly obvious involvement of trainees in discussion and skills practice is optimized by careful planning and attention to individual participant characteristics. Encouraging facilitators to review participant inventories before each session is a good way to keep trainee experience and interest at the forefront of every learning activity. In this way, facilitators are primed to elicit input from those participants with relevant experience, or to stimulate dialogue by pointing out the similar or strikingly different backgrounds of various trainees.

Role-plays, case studies and other activities can be adapted to complement participant experience. Participant inventories and interviews might suggest ways that the training coordinator can make some scenarios more challenging to ensure that a particular training cohort develops a necessary breadth of skill. Scenarios might also be adapted to mirror certain participant experiences that illustrate valuable teaching points. Trainees respond best to activities that acknowledge their unique attributes and address their specific learning needs; to the extent possible, the training course should aim to suit the participants.

2. Conducting the Training Course

Roles of Training Team Members

Conducting a training course involves many simultaneous activities and requires a range of skills. If you alone are running the course, you will have to do several tasks at once. If only one or two trainers will be working together, you will have to share the load. However, if several people are available to help out at least part time, you can divide the tasks or roles to best use the skills of each member of the training team. The following are the kinds of roles that training team members may play during a course:

Leadership and continuity	one person who has the “big picture” in mind, to take the lead and tie it all together
Management/Logistics and secretarial support	someone working behind the scenes, to manage details and coordinate materials/logistics (photocopies, room set-up, equipment, refreshments, attendance sheets, etc.)
Content experts	to bring their personal experience and professional knowledge/skills to each specific session
Instructional designer	to incorporate content into a sound educational approach, using appropriate learning methods
Group facilitators	to help guide in-class and field exercises for small groups
Ex-Participants (peers)	to inspire participants with proof that it can be done
Apprentice	a “go-for” to help with setting up, logistics, errands, or documentation (This can be a good opportunity for a young person to learn about public health training.)

Working as a group

In preparing for battle I have always found that plans are useless, but planning is indispensable
— Dwight D. Eisenhower

In order to work together effectively, it is a good idea to hold periodic training team meetings. A 1-2 hour meeting before the course starts can be useful for everyone to get to know each other and understand what the entire course will cover. Additional meetings between each session can

be used to review process evaluation findings (what is going well, what needs immediate improvement) and coordinate plans for upcoming sessions. Content experts and facilitators should go over the main points that participants will learn and be ready to lead the group in mastering skills through active learning methods. Be flexible: if the original facilitator has to cancel, sessions prepared in advance can be led by an alternate facilitator or rescheduled for another time.

Back-up plan

Even after adapting session plans to program goals, local context and participant characteristics; after determining an ideal format and scheduling the perfect session leader to ensure participatory methods and coverage of session objectives; after creatively integrating participant interest and experience, there is always the chance that all will come undone. A trainer who is ready for this eventuality will not be paralyzed when a session leader cancels, materials are misplaced or do not arrive on time, and equipment fails. Imagining every possible pitfall is impossible, yet the effort to do so may lead to some novel troubleshooting. At the very least, the training coordinator should identify someone willing to assist with last minute crises and feel confident asking for help when needed.

1. SETTING OBJECTIVES

For many, the idea of goals and objectives is rather abstract. Both have something to do with planning, direction and focus, but the distinction is elusive and formulating clear, useful objectives takes more effort than one might think. In this curriculum, session outlines list suggested training objectives. However, objectives might need to be developed or modified to better meet program needs for additional training content or emphasis. To meet this challenge, trainers must understand how objectives relate to goals, and how to identify meaningful objectives that will move them toward established goals.

Goals and Objectives

Goals usually concern a general desired outcome that can be achieved by more explicit objectives. Goals can be quite abstract and characteristically address the big picture. For example, in a program offering multi-level health and social services, an acceptable goal might be: "Improve the social and health status of women and children." In contrast, objectives concern more specific outcomes that together further the goal. Objectives can range in scope to suit a program as a whole, or a particular session during a comprehensive training course. Try thinking of objectives as significant steps toward a desired accomplishment.

The following example may help illustrate the relationship between goals and objectives:

Goal:
<ul style="list-style-type: none">• Provide Support for LTBI Treatment Adherence
Program Objectives:
<ul style="list-style-type: none">• Institute weekly adherence support team meetings• Hire 12 peers by the end of the 1st quarter• Conduct peer training course using Peer Support for LTBI Treatment Adherence Curriculum within 2 weeks of hiring peers• Initiate peer intervention in 6 districts within 1 month of peer training• Assess peer intervention after 3, 6, 9 and 12 months
Training Objectives: By the end of the training course...
<ul style="list-style-type: none">• Participants will participate in 90% of training sessions• Participants will retain 85% of TB/LTBI information presented• Participants will demonstrate 100% of skills trained• Facilitators will respond to 100% of participant feedback during the course• All participants and facilitators will help evaluate training course
Session Objectives: By the end of the session participants will...
<ul style="list-style-type: none">• Identify 3 reasons why TB is an important health issue• Define key terms associated with TB• Explain how TB is transmitted• Describe how TB infection causes TB disease• Identify risks associated with progression from latent infection to active TB disease

Selecting useful objectives

Deciding on learning objectives is often easier said than done, as acquiring knowledge or mastering a skill is not equivalent to using that knowledge or skill for their intended purpose (i.e. adherence support). Training objectives should not try to encompass outcomes that will take place beyond the boundaries of a training course. In other words, a well-formulated training objective does not address how the trainee will apply information or skills acquired during training, outside of the course setting. The intense nature of job-related training calls for objectives that are specific, measurable, achievable, relevant, and time-bound; sometimes referred to as SMART objectives.

- Specific** - state what will be achieved using action verb to describe observable behavior
- Measurable** - to determine whether or how much of objective has been achieved
- Achievable** - given circumstances and available resources
- Relevant** - to those responsible for achieving them
- Time Bound** - set with realistic time-frame or deadline

Specific Measurable Achievable Relevant Time-bound

There are several steps that help trainers select good objectives. To begin with, writing down the more general program goal(s) and objectives will help focus training objectives, ensuring the most appropriate training course. With the main, over-arching goals and objectives in mind, consider what needs to be accomplished for each technical topic or skill competency. Be as specific as possible and make sure that each objective has just one purpose. If you combine objectives, it is difficult to assess the extent to which it was fulfilled when only one of the intended outcomes succeeds. Finally, including evidence of intended outcomes and establishing a time frame will suggest ways to monitor and evaluate the degree to which the objectives were met.

For example, while a training team may agree that it aims for participants to *learn how TB is transmitted*, this statement does not qualify as a measurable objective. Why? An objective should offer enough concrete information to suggest its measurement. In this example, the active verb, learn, is open to various interpretations: people learn passively and actively, retain much or little. This vague objective also says nothing about when trainees are expected to complete it. To *explain how TB is transmitted* by the session's end is a more specific outcome, as well as one that is amenable to precise measurement. Taking the time to think about the behavior to be measured will lead to a more accurate, useful objective.

2. MEASURING OBJECTIVES

Having purposefully selected training objectives that further the more general program goal(s), a trainer can be reasonably confident that the course content suits program needs. The 'M' in SMART, distinguishes objectives from simple tasks, because a measurable objective can be tracked and evaluated. Measures, also known as 'indicators,' allow us to monitor progress and evaluate outcomes; they let us know whether or not we have achieved our objective.

When people talk about indicators, they generally mean statistics that reveal something about the objective. Indicators are typically represented by counts, rates, ratios, proportions or percentages. Indicators may refer to objectives for individual students as well as for the training session itself. For each indicator, the trainer or program manager must decide on a performance standard, that is, the expected target for each indicator.

- **Objective**
Identify 3 reasons why TB is an important health issue
- **Indicator**
Applied Knowledge
- **Performance Standard**
3 correct reasons identified in role-play (individual)
80% of participants cite 3 reasons in role-play (session)

Good measures are valid, specific, sensitive, representative, reliable, accessible, and ethical. A measure should capture only the outcome of interest, without the interference of unrelated factors. It should be able to consistently detect the desired outcome in all participants. In the case of a role-play, opportunity for non-native English speakers to be observed communicating in their native language would be important. Finally, the measure should be relatively simple and ethical, such as knowledge or skill demonstration. Field demonstration might be most realistic, but impractical and unethical with actual LTBI patients.

Monitoring

Foreknowledge of measures is essential to properly monitoring objectives. In the above example, trainers must know ahead of time that the objective, *Identify 3 reasons why TB is an important health issue*, will be measured by participants citing reasons during a role-play exercise. Thus, they will know to observe and note whether each participant has met the objective. The same objective could also be measured by a written response to an open-ended post-test question. Without a pre-determined measure, there is no way to assess with certainty, whether an objective has been met.

Objectives can be monitored and recorded throughout the training course using observation checklists and pre-post-testing (see Appendix B). Trainers may opt to designate an outsider to monitor the training sessions and record trainee progress toward objectives. Monitoring trainee progress helps meet training objectives by giving facilitators a chance to reinforce training content that was not understood or operationalized as intended. Data used for monitoring and evaluation can be collected using written tests, reports, and other records, through observation, and through verbal questioning or interview. If results from the final post-test serve as the sole indicator for training session objectives, there is no chance to improve training outcomes.

Evaluation

Clear objectives, indicators, and performance standards provide trainers with a good deal of information. Critically examining this information will answer the question, “Was the objective accomplished?” In an earlier example, the objective, *Identify 3 reasons why TB is an important health issue*, would be evaluated by observing trainees’ applied knowledge of the importance of TB as a health issue in a role-play activity, and comparing their success citing reasons with the performance standard of 3 reasons for the individual, and 80% of participants for the session overall. In this example, each participant who can correctly identify 3 reasons why TB is an important health issue during the role-play activity will have met this learning objective. If 10 out of 12 participants accurately identify 3 reasons why TB is an important health issue during the role-play activity, the evaluator could conclude that the session objective was met.

Objectives alone are not enough!

Each objective should be evaluated using measures established at the outset. For important learning objectives, multiple measures such as pre and post-testing, classroom demonstration and/or interview might be necessary to ensure trainee competence. These results might be further interpreted in their qualitative context to show how training composition, structure, and technique can influence learning outcomes.

Process evaluation

Qualitative observations made by an independent observer/evaluator, as well as those made by peer participants and session facilitators can give insight into how well the training course is going. Generally, this is known as process evaluation. In their efforts to meet defined objectives, trainers sometimes neglect to evaluate the training process and how well the training course met the objectives it set out to accomplish. Process evaluation considers how a training course (or particular session or activity) was carried out, without assessing whether or not it achieved the intended outcome. The essential question in process evaluation is “How did it go?”

Some sample Process Evaluation Questions include:

- What went well during the activity or session? Why?

- What went wrong during the activity or session? Why? What could be done differently?
- How well did the plan work for this session/activity? Compare planned session to completed session.
- Describe general satisfaction with what actually happened.
- How can session/activity improve or change next time?

Participatory Evaluation

Participatory evaluation brings the experience and feedback of those most directly involved in the program into the evaluation process. Incorporating the trainees' perspective adds new and potentially valuable dimensions to evaluation findings. When participants help evaluate the training program, they attend to the objectives in a different way and invest themselves in the process of achieving learning objectives. A participatory approach is not only good for evaluation; the approach directly benefits both the program and the participants.

Rationale for more interactive evaluation:

- Participants are "insiders" and they know more about what is going on inside the program than anyone else.
- Participants can and will learn more about themselves and the program if they conduct the evaluation.
- Participants as evaluators helps build a sense of ownership of the program
- Participants are also the best ones to give feedback and make suggestions for improvement

3. SAMPLE EVALUATION PLAN – PEER TRAINING

Trainees are asked to share in the training evaluation by choosing one session to evaluate. For each session two trainees serve as the evaluators. It's easier to do this in pairs, because each person will see things a little differently, and the evaluation will be better with both points of view together.

Participant evaluators are asked to reflect on the stated session objectives and complete a short one-page Session Evaluation Form at the end of the session (see Appendix C). They are responsible for reporting on the experience of the *entire group*, not just their own experience.

Participant Evaluation – 5 Steps:

1. Review the objectives

Before training begins, the participant evaluators should make sure they understand the session objectives and clarify any confusion. These objectives should be noted on the Session Evaluation Summary (Appendix D) and serve as a reference point in evaluating the session.

2. Plan observations of the session

Even though the same person may be teaching or facilitating, a session is often divided into several sections. These parts go along with the different stated objectives. The sample format indicates how participants are to evaluate each session 'part' and its associated objective.

3. Watch what happens in each part of the session

In each part, consider the following:

- Was the presentation of material clear? Did everyone 'get it?'
- How much did participants get involved in that part of the session: Ask questions? Participate in activities or discussion?

- Overall response to that part: Were most people involved or did they act bored? Did it seem to go on too long?
- Meet objectives: Did this part of the session meet its stated objective(s)?

4. Make notes of what happened at the end of each part of the session

Evaluators should do this on the Session Evaluation Summary. One session might require notes on three (or more) parts.

5. Evaluate each section and summarize the entire training session

- Independently, evaluators provide feedback on each section using the Session Evaluation Summary.
- Together, evaluators review the objectives and determine if the session as a whole met the objectives and summarize evaluations of the entire session: instructor, materials used, activities and presentation, involvement of the participants, how much people learned. This summary is recorded on the Session Evaluation Summary.

6. Report back to the entire group at the end of the day's training sessions

Be sure to give your notes and evaluation sheets to the training coordinator so these can be used to improve future sessions.

4. FOLLOW-UP

Evaluation includes an implicit contract to act on results. Persons involved at all levels of training can benefit from evaluation, though results are most often used to improve overall training outcomes and processes.

Evaluating training objectives and processes in concert is the most effective way to improve both. Monitoring session objectives from both the participant and the facilitator perspective provides the opportunity to revise the curriculum to reinforce difficult content and provide additional opportunity for practice. It also highlights the special needs of trainees who may be struggling with the format due to language difficulties or low-literacy. Caught early on, these challenges can be addressed so that they can attain all learning objectives. Evaluating the degree to which trainees meet training objectives creates a standard for peers working in the field and helps establish their credibility among clients, the adherence support team, and other area health and social service providers.

Process evaluation makes equally important contributions to the training course. Observations and feedback regarding how well a session is going will help the facilitator(s) adjust format or training technique to better meet the learning needs of the participants. It also suggests strategy for future training courses. Likewise, participants can benefit from similar insight into how they are engaging with the training process and their peers. Suggestions on how to take responsibility for their learning experience can help prevent trainee frustration with sometimes novel participatory methods.

Programs benefit from the lessons learned during a training course. Difficulty meeting key training objectives might suggest additional peer training, or a re-ordering of staff responsibility to ensure appropriate patient support. More often, the participants themselves shed new light on topics outlined by professionals, and their fresh ideas and perspective help shape program operations in unpredictable ways. Sometimes a very significant, overlooked objective reveals itself during a training session, for all to attain. Without evaluation, the dynamic human capacity of the training course is lost.

IV. SESSION PLANS

SESSION 1: INTRODUCTION / ROLE OF THE PEER - PART 1 (3 HOURS)

Welcome and icebreaker introduction	(30 min)
Training goals and organization	(10 min)
Training and participant evaluation methods	(10 min)
Pre-test	(20 min)
Break	(10 min)
Role of the Peer - Part 1	(90 min)
• Lecture/Discussion: How peers can improve health outcomes	
• Activity: Peer perceptions and supervisor expectations	
• Debrief: Discussion, Q&A	
Participant Observation Report	(10 min)

Session Objectives

By the end of this session, participants will be able to:

- Explain the goals of this training course
- List 3 approaches to adult learning
- Identify 3 ways that peers can help improve health outcomes
- Recognize and discuss challenges in defining and fulfilling the peer role
- Identify support peers need to function in their role

NOTES: SESSION 1

Welcome and icebreaker introductions

After welcoming participants and briefly introducing training staff, the icebreaker should also serve as introductions, allowing an opportunity for participants to share their backgrounds and get to know each other. The following are two examples of introductory icebreakers:

- Truth-Truth-Lie: After telling the group his or her name, each participant shares three pieces of information about themselves, two facts and one lie. The participants try to guess which piece of information is false. One trainer models the activity to begin.
- Interviews: Participants split up into pairs and interview each other for 5 minutes each. Then, each participant introduces his or her partner to the rest of the group.
- Hundreds of ideas for icebreaker exercises can be found online or in any handbook of training methods.

Training goals and organization / Evaluation methods

First, trainers will share with participants the goals of the training, which will remain posted in the training room throughout the training. After sharing the goals, trainers will elicit from participants and record on flip chart paper any expectations for the training course and topics of interest participants may have. When presenting the schedule of sessions, try to point out how the training will incorporate the expectations and topics of interest suggested by participants. Also, explain how the course will be evaluated and how participants will be involved in evaluation. Finally, discuss “housekeeping” issues, such as the schedule for breaks and refreshments, location of restrooms, contact phone numbers in case of absence, etc.

Pre-test

Sample test questions are provided in Appendix B. When a group is comprised of low-literacy participants, pre- and post-testing can be done without a written exam. Participants can be asked to explain concepts or demonstrate skills alone or in pairs. If results are carefully documented at the start and conclusion of the training, they can be compared to show training effects and demonstrate peer competencies.

Role of the peer – Part 1

This is the first session that explores the role of the peer in adherence support. As peers begin to understand their capacity to contribute to improved health and the goals of the adherence support intervention, they build a framework for acquiring and applying relevant knowledge and skills.

Lecture/Discussion: How peers can improve health outcomes

Lecture: Across the country, many grass roots health efforts have used peer workers in programs to reduce weight, control blood pressure, reduce heart disease, screen for cancers, improve adherence to treatment for diabetes and asthma, and fight TB.

Programs using peer workers in TB have been successful in many ways: reaching out to specific populations, providing health information to clients, dealing with stigma, conducting TST screening, accessing community resources, and providing adherence support to help clients complete LTBI treatment. After all, peer workers have insider knowledge of the community and its needs, provide flexible services, reach out to underserved groups, relate better to clients, and serve as role models.

Adherence is a complex behavioral goal that involves more than just taking pills. When social support is not available, substitute support provided by a peer using a non-judgmental approach can be effective. To enhance adherence, a multidisciplinary team is important. Peers have been employed as “natural helpers” or “paraprofessionals.” In the latter role, peers may be full-time employees in entry-level positions, or may receive stipends as part-time workers. Peer workers often do the following for their contacts:

- Communicate regularly with clients
- Discuss barriers to adherence and how to overcome them
- Offer support and empathy
- Discuss life circumstances and stresses
- Provide referrals and help with navigating the health system
- Advocate for their clients in whatever way they can

Most communication with clients is in person or occasionally by phone. This takes place in the clinic, in the field, or at storefront offices. On average one part-time peer has a case load of 10 clients.

Working with the health team, it is important that the peer worker:

- Establish an accepted role in the clinic and community
- Have access to client charts
- Maintain confidentiality
- Participate in case management meetings
- Document client contacts

Discussion: This could begin with the facilitator eliciting examples of the types of peer interventions known to participants, perhaps as a brainstorming activity, listing examples on a board or poster. Trainees could then share their impressions of and/or personal experience with peer programs.

Sample Discussion Questions:

1. Could someone start us off by sharing their experience with one of these types of peer interventions? (This will usually lead to other experiences.) Re-address: Can anyone else share an experience they have had with a peer intervention?
2. How did some of these interventions improve the health of the population served? Re-address: Are there any other ways that this intervention led to better health?
3. What other types of programs have you heard of that use peers to improve health? Where did they do this? How did they function?
4. Why do you think peer adherence support for LTBI treatment is important?
5. In our community, how do you think that a peer adherence support intervention for LTBI treatment will help improve health?

Strategy: A semi-structured format will ensure a discussion covering important points that may not enter into an entirely free-form session. Plan a few guiding questions in advance to spark dialogue about key issues. This semi-structured format will also facilitate discussion among participants who are not yet accustomed to communicating with one another.

Activity: Peer perceptions and supervisor expectations

This activity is designed to share peer perceptions and supervisor expectations concerning the peers' job descriptions. For this activity, the peer supervisor (if he or she is not the facilitator) should participate.

In a large group, trainees **brainstorm** the adherence support peer job description, listing responsibilities and related activities. The supervisor then hands out a copy of

the actual job description for trainees to review. After several minutes, the facilitator leads a discussion of the similarities and differences between the peers' perceived job description and the supervisor's description. This discussion is an opportunity for the supervisor to clarify work expectations and answer questions. Trainees should be encouraged to suggest other activities and point out perceived areas of difficulty that can be integrated into later sessions.

Trainees then divide into pairs and are given 15 minutes to come up with a supervisor's job description. The job description should have clear examples of how the supervisor will monitor peer responsibilities and activities, as well as how the supervisor will support peers. In the large group, pairs will take turns interviewing the supervisor for his or her job, asking the supervisor to describe their role and share examples of how he or she will meet the supervision and support needs of peers. After each role play, the group gives feedback while the facilitator records salient supervisor responsibilities. When each pair has interviewed the supervisor, the activity concludes with a summary of peer and supervisor job descriptions and a good faith agreement to work towards fulfilling these expectations.

Participant Observation Report

When trainees are taking part in the evaluation, the facilitator should schedule time immediately following the session for the report and group feedback. (See Evaluation.)

SESSION 2: TB 101

(3 HOURS)

Review Activity (Peer Role)	(20 min)
Overview of tuberculosis	(30 min)
<ul style="list-style-type: none">• Brief history• Global and local snapshot• Current issues	
TB Transmission, Infection, Disease - Part 1	(60 min)
<ul style="list-style-type: none">• Preventing infection, preventing disease	
Break	(15 min)
TB Transmission, Infection, Disease - Part 2	(45 min)
<ul style="list-style-type: none">• Activity: Game -TB Facts / Stump the Peer• Debrief: Discussion, Q&A	
Participant Observation Report	(10 min)

Session Objectives

By the end of this session, participants will be able to:

- Identify 3 reasons why TB is an important health issue
- Define key terms associated with TB
- Explain TB transmission, infection and prevention
- Describe how TB infection causes TB disease
- Identify risks associated with progression from latent infection to active TB disease

NOTES: SESSION 2

Review Activity

To perpetuate participants' ownership of their training experience, the facilitator can ask volunteers to lead the twenty-minute review of the previous session. A list of suggested review activities (game shows, quizzes, puzzles, hang-man, etc.) may be provided, but trainees should be encouraged to try out their own ideas.

The facilitator is responsible for making sure that all information presented in the review activity is accurate. Factual corrections should be supplied immediately. The review activity is not intended to be comprehensive; however, if a critical point from the previous session has been overlooked by the activity leader(s), the facilitator may remind participants of the session's key points at the end of the review activity.

TB Overview - Historical context and current issues; local, national and global significance

This session will help trainees appreciate the importance of TB-control and elimination. Material in the CDC's *Self-Study Module on Tuberculosis 1*, as well as current information regarding the spread of TB, local, national and global burden of TB disease, and TB-control issues should be covered. Including information gathered during the pre-training needs assessment may add interesting local relevance to the overview.

TB transmission, infection and disease – Part 1, Preventing infection, preventing disease

Lecture / Discussion

The lecture will present specific and technical information about latent TB infection and disease. Again, the CDC's *Self-Study Module on Tuberculosis 1* will be a helpful resource. Also consult your local health department and see what is new at the CDC Division of Tuberculosis Elimination website <http://www.cdc.gov/nchstp/tb/>. To make the lecture more interactive, case studies and mini-quizzes can be incorporated. Samples can be found in the module.

Activity: Game – TB Facts / Stump the Peer

Participants divide into two groups. The teams take 10 minutes to prepare 10 questions about the TB lecture. The teams take turns asking the question to the other team. If the team answers the question correctly, that team receives one point. If the team does not answer the question correctly, the team asking the question gets one point. After 20 minutes of play, the team with the most points is the winner. The session facilitators serve as referees and fact-checkers.

Debrief: Discussion, Q&A

Participant Observation Report (see Notes, Session 1)

SESSION 3: LOCAL TB CONTROL AND CONFIDENTIALITY

(3 HOURS)

Review Activity (TB Facts)	(20 min)
Local TB Control	(60 min)
Presentation: Local TB control system/structure	
• Activity: Peer collaboration with local TB control	
• Debrief: Discussion, Q&A	
Current Issues in TB control	(20 min)
Break	(10 min)
Confidentiality	(60 min)
• Presentation: Confidentiality	
• Discussion: How peers protect client confidentiality	
• Activity: Confidentiality in practice	
• Debrief: Discussion, Q&A	
Participant Observation Report	(10 min)

Session Objectives

By the end of this session, participants will be able to:

- Describe the local TB control system
- Identify 3 ways that peers can help local TB control
- Explain the purpose of confidentiality
- Discuss confidentiality regulations
- Practice confidentiality in potential peer-client situations

NOTES: SESSION 3

Review Activity

Facilitated by trainees (See Notes, Session 2)

Local TB Control

Presentation: This session introduces trainees to local TB control systems and methods, to help participants begin to think about where they will fit into the TB control network. Ideally, the session leader will be someone with a broad perspective on local TB control and prevention efforts; however, if such a person is unavailable, the facilitator should make sure to get information and input from the local health department for this session.

Activity: Peer collaboration with local TB control

Trainees break into groups of two or three to discuss cases where peers collaborate with the local TB control networks. After their small group discussion, the small groups present their case and their proposed solution/strategy to the other participants. The cases should be tailored to reflect real situations the peers are likely to face in working with local TB control programs.

Sample Case:

Your client returns to the clinic for his monthly appointment. He tells you he is experiencing side effects from the medication, but he is in a hurry and does not want to wait to see the doctor. How can you help your client?

Current Issues in TB Control

There are several ways you can identify issues to be explored: Ask participants. Check your emails. Read journals and newsletters. Ask your local health department. Browse the CDC Division of Tuberculosis Elimination website <http://www.cdc.gov/nchstp/tb/>. News is always happening, science is developing new drugs or diagnostic tests, researchers are finding new ways to work more effectively, and the epidemiology of the TB epidemic is evolving in new ways in your local area. Participants may have questions about what is going on in the world of TB control and how it relates to them, their jobs, their clients, and their community.

Work with participants to come up with a list of issues and gather the resources (people or information) you need to present these for discussion.

Confidentiality

Presentation and Discussion:

The presentation will focus on the importance of client-patient confidentiality. Laws protecting patient confidentiality should be presented, as well as common breaches of confidentiality that peers might face.

Discussion: How peers protect client confidentiality

The discussion is intended to help peers reflect on the importance of confidentiality for their clients. Following are some possible questions for discussion:

- As a patient, have you ever experienced a breach in confidentiality? How did that make you feel?
- Why is it important to protect client confidentiality?
What kinds of situations have you experienced where you had to protect a patient's confidentiality? What did you do?
- What can peers do to protect patient confidentiality?

Activity: Confidentiality in practice – Role-playing

Participants are given scenarios to act out. After each group presents their scenario, the group discusses what happened. The group suggests other ways to handle the situation. When all groups are finished presenting, the group will discuss any remaining issues, questions and concerns. These scenarios should be tailored to fit local program needs and context. See examples of scenarios on next page.

Participant Observation Report (see Notes, Session 1)

CONFIDENTIALITY IN PRACTICE ROLE PLAY ACTIVITY

Scenario 1 – The Immigration Officer

Mr. Martinez is a 25-year-old construction worker from Mexico, who lives with several fellow workers. During the past 3 months, a peer has been helping Mr. Martinez deal with some personal issues that could interfere with his medication adherence. A couple of the men that share Mr. Martinez's home want to know why the peer keeps calling and coming around. They are afraid that the peer is an immigration officer.

*One of the **Roommates** confronts the **Peer** who must explain his relationship with **Mr. Martinez** without breaking confidentiality.*

Scenario 2 – The Relationship

Miss Dupuy, a part-time college student, comes to the clinic for LTBI follow-up appointments each month. At the clinic, she regularly meets with a peer who has been helping her get into more affordable housing. Miss Dupuy has recently started a relationship with Mr. Williamson, an orderly working at the same hospital where she visits the TB clinic. The orderly and Miss Dupuy's peer happen to be members of the same softball team (church or other community group). When Mr. Williamson discovers that Miss Dupuy frequently meets with the peer at the hospital, he becomes concerned about their relationship.

*After group, the **Peer** and **Mr. Williamson** discuss the peer's relationship with **Miss Dupuy** without breaking confidentiality.*

Scenario 3 – A Relapse

Mr. Jones has been on LTBI treatment for several months. When he first met with his peer, Mr. Jones explained that he used to drink alcohol excessively, but hadn't had a drink during the six months that he has lived at a residential program. Recently, Mr. Jones has been missing his meetings with the peer and did not keep his last clinic appointment. When the peer finally catches up with Mr. Jones, he admits that he has started drinking alcohol again and has not been taking his medication regularly. The peer succeeds in convincing Mr. Jones to take part in outpatient treatment for alcoholism, but to attend, Mr. Jones must get permission to leave the residence where he lives.

*The **Peer** must call the residential program **Manager** to get permission for **Mr. Jones** to attend outpatient treatment without breaking confidentiality.*

SESSION 4: LTBI TREATMENT AND ADHERENCE

(3 HOURS)

Review Activity (Local TB Control/Confidentiality)	(20 min)
Latent TB Infection (LTBI) <ul style="list-style-type: none">• Importance of treating LTBI• Medication regimens• Treatment adherence	(60 min)
Break	(10 min)
Barriers to LTBI Treatment Adherence <ul style="list-style-type: none">• Discussion: Examining barriers to treatment adherence• Activity: Overcoming barriers to LTBI treatment with strategies that support adherence• Debrief: Discussion, Q&A	(80 min)
Participant Observation Report	(10 min)

Session Objectives
By the end of this session, participants will be able to:
<ul style="list-style-type: none">• Explain how LTBI treatment helps prevent TB disease
<ul style="list-style-type: none">• Identify 2 common medication regimens for LTBI
<ul style="list-style-type: none">• Discuss the importance of LTBI treatment adherence and the risks of non-adherence
<ul style="list-style-type: none">• Explain why medication adherence is a challenge for doctors and their patients
<ul style="list-style-type: none">• Identify 3 common barriers to treatment adherence
<ul style="list-style-type: none">• Plan solutions to counteract barriers to adherence

NOTES: SESSION 4

Review Activity Facilitated by trainees (See Notes, Session 2)

LTBI

This session presents the key technical information that the peer will need in order to offer information and support to LTBI patients. The importance of treating LTBI should emphasize TB risk and TB control, drawing on materials from the local TB control program and the *CDC Self-Study Module 4, Treatment of Tuberculosis Infection and Disease*. An overview of LTBI therapy should touch on all LTBI medication regimens used in the health jurisdiction, but explain the details of only the most common INH treatment regimen. Trainees can be instructed to seek information from their client's medical provider regarding any alternate regimen. Following are the key teaching points that peers will likely use to educate their clients: Rationale for LTBI treatment; High-priority candidates for LTBI treatment; Medication regimens for LTBI treatment; Monitoring for side effects; What to do if you have side effects; What adherence means and why it is important.

A medical practitioner is the most appropriate person to explain the why and how of LTBI treatment. If a TB doctor or nurse cannot lead this session, every effort should be made to acquire information to address potential questions concerning TB risk and LTBI treatment regimens and monitoring in advance of the session. Means of following-up unanswered questions within a 24-hour time frame should also be set up before the session.

This session should be interactive and informal. Trainees should be encouraged to ask questions. In addition, the presenter should make use of the case studies in the module to encourage trainee participation.

Barriers to LTBI Treatment Adherence

The second part of the session involves examining the reasons patients have difficulty adhering to LTBI therapy, and solutions to overcoming barriers to medication adherence. This session will help trainees synthesize LTBI treatment information with adherence support strategies.

Discussion: Examining barriers to treatment adherence

- Begin the discussion of barriers to LTBI therapy by asking participants to share some of the difficulties they encountered when taking TB/LTBI medication.
- Share adherence strategies used personally, for example putting medication next to toothbrush or setting an alarm.
- Identify barriers to adherence specific to LTBI, for example, long treatment, asymptomatic, side effects.
- Identify barriers to adherence specific to local context, for example, no clinic hours on Saturdays or long waiting times in clinic.

Activity: Overcoming barriers to LTBI treatment with strategies that support adherence

Divide into small groups of 2-3 participants. Each group is given a scenario of a client facing barriers to adherence. The group must brainstorm feasible solutions. Small groups share their solutions with the large group, who also try to add solutions.

Sample Scenarios are provided but should be tailored to mirror local conditions and issues.

Scenario 1 – Patient can't take off from work

Robert works 60 hours per week. He works from midnight to noon every weekday, and cannot attend regular clinic hours, which are from 9:00 – 12:00. He does not want to take off work because he needs the money to support his family. What can be done?

Scenario 2 – Forgetful patient

David is very busy and always forgets to take his pills. He usually remembers when he has already left the house for the day. By the time he gets home at night, he has already forgotten. What suggestions do you have for David?

Scenario 3 – Worried immigrant

Salimata is an immigrant from Africa. She lives with 8 roommates in a small apartment. She is afraid that if they find out she is taking medicine for TB, they will kick her out of the apartment. She hides her bottle of medicine, and doesn't take it when her roommates are home, which is almost all of the time. She is very worried they will find out. What can you suggest to Salimata?

Participant Observation Report (See Notes, Session 1)

SESSION 5: ROLE OF THE PEER – PART 2

(3 HOURS)

Review Activity (LTBI Treatment and Adherence)	(20 min)
Role of the Peer, Part 2	(30 min)
• Peers and adherence support	
Using Your Own Experience to Support Adherence	(45 min)
• Role Play Exercise: Sharing personal experience	
Break	(15 min)
Setting Boundaries When Sharing Personal Experience	(60 min)
• Activity and Discussion: “Inappropriate Question Guy/Gal”	
• Role Playing: Sharing Information and Setting Boundaries in Client-Peer Interactions	
• Debrief: Discussion, Q&A	
Participant Observation Report	(10 min)

Session Objectives
By the end of this session, participants will be able to:
• Explain how peer workers support medication adherence
• Differentiate between showing power and sharing power
• Identify 4 personal experiences to share with clients
• Examine personal boundaries for peer-client interactions
• Recognize when to refer client for additional support
• Prepare an effective support strategy for fictional client
• Document interactions with clients

NOTES: SESSION 5

Review Activity Facilitated by trainees (See Notes, Session 2)

Role of the Peer, Part 2

Lecture/Discussion

This session covers adherence issues and the adherence support that peers provide to their clients. A review of barriers to adherence faced by LTBI patients can be incorporated here. This session also introduces the idea of peers’ sharing their own experiences with clients to encourage adherence.

The following are some factors which have been found to have an association with adherence:

Patient-related factors

Positive associations with adherence or treatment completion have been found for:

- Recent exposure to TB
- High perceived benefits of treatment, or expectations of positive outcomes of treatment

- Social norms and values that uphold treatment for LTBI
- Knowledge and treatment of TB and LTBI

Negative associations with adherence or treatment completion have been found for:

- Substance dependency
- Concurrent illnesses and additional treatment regimens
- Low perception of susceptibility to TB disease
- Low intention to complete treatment
- Lack of social support
- Among immigrant adolescents, greater acculturation and more years in the United States

Clinic facilities may influence treatment completion and adherence to the extent that they adequately address patient needs:

- Inaccessible or inconvenient care locations may discourage treatment completion
- Lack of translators and language appropriate patient information may also be a barrier to care
- Conversely, the use of tangible incentives and enablers and reminders have been shown to increase treatment completion

Characteristics of the treatment regimen may discourage adherence and treatment completion. These include:

- Concerns about the toxicity of LTBI medications
- Fear of side effects

How Peers Support Adherence

- **Navigation:** Adherence to LTBI treatment is a complicated, variable experience, and it helps considerably to have a ‘road map’ drawn from others who have already traveled that road, offering suggestions on how to take medications, deal with side effects, and so on.
- **Emotional support:** Adherence is not easy and requires a commitment to change or adopt new behaviors and to deal with unanticipated difficulties. Support from peer workers helps build and reinforce client commitment to adherence as they lend an empathetic ear or suggest ways that clients might address their most pressing concerns.
- **Building self-efficacy:** Peers are well positioned to assist clients in developing a positive self-image. They can help clients manage adherence by breaking the process into achievable, ‘can-do’ steps. In this way, peer workers help their clients grow accustomed to succeeding.
- **Modeling:** The best way to learn is through experience and peer workers have a wealth of experience to share with clients. The peer can model problem solving, in general, and adherence behavior, in particular, while providing suggestions to help clients develop their own adherence strategies.

Using Your Own Experience to Support Adherence

Role Play Exercise: Sharing personal experience

Be sure to use scenarios similar to ones the peers can expect to encounter on the job. The following are three sample scenarios that you could use or adapt:

Scenario 1

Mr. A is an African-American man in his forties living in a city shelter. He has been on treatment for LTBI for four months. He was assigned a peer worker to assist with adherence.

Once when the peer worker was visiting the shelter, Mr. A seemed very agitated. He said that his locker had been broken into and things have been “re-arranged.” He claimed that fellow residents were spying on him and that security guards were no help. In fact, he suspected the guards were part of the problem, harassing him with questions and keeping him from the dormitory area while others went through his stuff. He is getting more and more angry.

Scenario 2

Miss B is an Asian woman in her thirties living on the outskirts of the city. She is being treated for LTBI. Miss B was assigned a peer worker to help with adherence issues.

Miss B has been consistent with her LTBI treatment but sometimes acts “bizarre.” The peer worker has tried to visit her at home several times. No one answered the door although the worker could see someone inside. One time when she finally let the peer worker in, there was a big kitchen knife sitting on the coffee table. The worker wondered why it was there and whether to be concerned for her safety.

Scenario 3

Mr. H is a Latino man in his 20s living in a neighborhood near the chest clinic. He is being treated for LTBI after being exposed to MDR-TB. The peer worker has been assigned to help with adherence because Mr. H seems to distrust the treatment.

Mr. H has completed 5 months of treatment and has been generally adherent. However recently, his mood seems different. Mr. H tells you that he doesn't like taking the medications. When he comes to the clinic, he often appears disheveled, with poor hygiene. Mr. H says that he is not eating regularly.

Setting Boundaries When Sharing Personal Experience

Activity and Discussion: “Inappropriate Question Guy/Gal”

This activity pushes comfort levels to demonstrate the importance of setting limits in sharing personal limits. A volunteer should be selected for a “role play” between the participant and one of the trainers. The volunteer is instructed that the activity is a role play between a client and peer who are meeting for the first time. The peer should NOT be warned that the trainer will be asking inappropriate questions; that is a surprise. The trainer (client) will then ask many personal questions to the peer volunteer during the interaction, such as, “Where do you live?” “Did you have TB?” “Do you have HIV?” “Give me your phone number.” “Are you married?” “What do you do on weekends?” “How much do peers get paid?” “How much do you weigh?” and other questions of a personal nature.

Following the demonstration, a discussion should delve into the following issues:

1. What happened in the activity?
2. How would you feel if one of your clients asked you such questions?
3. What kinds of information are you willing to share on a first meeting? Is this different than the information you might share when you know a client better? What types of information will you never share? Is everyone comfortable sharing the same information?
4. In the activity, what did the peer do when asked questions he/she did not feel comfortable asking?
5. What other strategies could we use to divert such questions? What kinds of things should we avoid doing? (These strategies should be written on a board or paper for reference in the next activity.)

Role Playing: Sharing Information and Setting Boundaries in Client-Peer Interactions

- Part 1: Deflecting uncomfortable questions
Peers divide into pairs and practice the strategies from the previous activity, imitating a peer-client meeting.
- Part 2: Group role plays
Participants play out scenarios in front of the group. After each scene, the participants discuss what happened, strategies used and other ways to handle a similar situation. Following are two sample scenarios. Ideally, however, scenarios would be adapted to the local context and peer group.

Scenario 1 – Client invites peer to movie

A male client invites a female peer to see a movie. When the peer refuses, the client gets upset and starts to shout and curse. How does the peer handle the situation?

Scenario 2 – Privacy of health information

A peer and a client are discussing LTBI treatment and the increased risk for people with HIV. The peer tells the client about taking LTBI treatment. The client asks the peer if he/she has HIV. The peer feels this information is none of the client's business, whether or not he/she is HIV+.

Participant Observation Report (See Notes, Session 1)

SESSION 6: PEER COUNSELING

(3 HOURS)

Review Activity (Peers and Adherence Support)	(20 min)
Introduction to Communication	(30 min)
• Values Clarification	
• Discussion	
Peer Counseling Skills	(45 min)
• Motivational Interviewing	
• Discussion	
Break	(15 min)
Counseling Skills Practicum	(60 min)
• Lecture/Demonstration: Techniques that enhance communication	
• Activity: Practicing peer counseling	
• Debrief: Discussion, Q&A	
Participant Observation Report	(10 min)

Objectives
By the end of this session, participants will be able to:
• Recognize how gender, culture and other lifestyle factors influence peer-client interactions
• Identify basic verbal and non-verbal communication skills
• Discuss peer counseling skills
• Practice engaging peers and counseling on TB risk and adherence

NOTES: SESSION 6

Review Activity Facilitated by trainees (See Notes, Session 2)

Introduction to Communication

The goal of this section is to provide the peer worker with the knowledge and skills for effective communication when offering counseling. To facilitate this session, try to find a person who him/herself will be a good model of effective communication. It is more important to demonstrate good communication skills than to talk about them. Familiarity with the role of the peer worker and good counseling skills are also important.

Values clarification

Effective communication with clients requires sensitivity and respect for others with different ideas and values. The peer worker is required to engage in personal and sometimes intimate discussions with their clients. Everyone has values – strong beliefs that may influence behavior. Values can be formed by the larger community or within the individual. A good place to start looking at one’s own values is to ask oneself, “What are the elements in my life that are truly very important to me?” The answer to that question is an example of that person’s values.

Below are a few points that may trigger thinking about values:

Values

- Are strongly held beliefs that tend not to change
- May vary from culture to culture, group to group, etc
- Are things that a person might fight over or die for
- May be so much a part of the person that he or she may take them for granted
- Are long-standing assumptions that do not change easily
- Can be something that all the information in the world may not change

Values can be formed by:

- Parents
- Teachers
- Peers
- Religious organizations/affiliations
- Media
- Community
- Life experiences
- Family

It is important to note that while values are strong beliefs, they can change because of different influences, events, people, and experiences. For example, the events of September 11, 2001, could change how one might value one's life. The death of a loved one from smoking may change one's values about smoking. Attitudes about seatbelts, gun control, and high blood pressure are just a few values that could be subject to change in one's life.

Peer workers can be more effective in counseling if they are aware of their own values and if they understand that values will vary from client to client. Most important, the peer worker must be willing to respect people who have values different from their own.

Effective peer workers are aware of their personal values and develop strategies that allow them to work with situations when their values differ from those of a person whom they are educating, or when their personal values are in conflict with the information that must be provided.

Group Discussion

- Discuss what a value is
- List influences that form values
- Discuss influences that can change a person value

Discuss with participants that values may change as different events, people, and etc influence people. You may want to include the following as examples:

- The events that occurred on September 11, 2001
- The birth of a child
- Death of a close relative or friend

- Marriage
- Graduating high school or going away to college
- Moving to another country

Peer Counseling Skills

This session is an overview of counseling, including basic skills and techniques. First, the facilitator should discuss the definition of counseling. For example, counseling is a way for people who are having problems that they can't handle to find help from a trained professional. A person goes to a counselor because he/she can't find the answers to a problem or situation.

Motivational Interviewing

Motivational Interviewing is an approach which is gaining wide acceptance in the field of counseling. It is guided by three philosophical principles: 1) that each person has a powerful potential to change; 2) that change cannot be imposed on a person; and 3) that reward and encouragement work better than punishment and judgment.

There are five components to Motivational Interviewing:

- 1) **express empathy** – the counselor should accept what the person expresses from his or her reality. Active listening techniques should be used by the counselor.
- 2) **develop discrepancy** – the counselor should point out differences between what the person is saying he or she wants and what he or she is doing.
- 3) **avoid argumentation** – the counselor should avoid labeling (e.g., trying to tell a client that he's got a problem with alcohol). This will only make the client defensive. People cannot explore their feelings about the issue if they have to defend their behavior. They will tighten up and become resistant to any discussion of change. The counselor should remember not to take a position. The client is responsible for his or her life, not the counselor.
- 4) **roll with resistance** – Using a technique found in martial arts, the counselor should gently steer things using the client's momentum. The client's resistance is a signal to the counselor to change strategies.
- 5) **support self-efficacy** – The counselor should possess hope, trust and belief in the client's capacity to change. The client has to believe in his or her ability to carry out and succeed in a task.

Counseling Skills Practicum

Lecture/Demonstration: Techniques that enhance communication

Review and model (demonstrate) basic counseling skills and techniques, including small talk, active listening, conflict and confrontation, reassurance and support, ventilation.

Small talk When first sitting down to talk with a client, the counselor should initiate conversation about everyday matters, e.g., the weather, the well-being of the client's family, etc. This helps to put the client at ease and to begin to establish rapport. While often difficult to accomplish in rushed clinical settings, it helps to establish a relationship between the counselor and client and suggests that not everything be all "business."

Active listening It is very important that the counselor listen carefully to the client, both because important information may be imparted, but also because of the effect it will have in developing rapport. Active listening involves several responses:

- say “un huh” or “go on” to keep the client talking
- ask for clarification when you don’t understand something
- repeating back what the client has just said helps to show that you are listening. It also prompts the client to give more detail about the situation.

Conflict and confrontation This is a technique to use cautiously. If the client is engaged in a dangerous or self-reinforcing behavior, it may be necessary to confront them with the consequences of their actions or the contradiction in what they say and what they are doing. Confrontation may be useful when a good relationship exists between the counselor and the client. When it does not, it will likely lead to the client’s flight or even anger and violence.

Reassurance and support When struggling with a variety of problems, many people simply want permission to feel sad, angry, etc. without being judged. The counselor should avoid trying to give fast answers on what to do, or share their own experiences, or bombard the client with technical information, or minimize the client’s problems, or tell the client they shouldn’t feel the way they’re feeling. There is a time for the counselor to offer reassurance and support. Good counseling is about listening, not talking.

Ventilation Similarly, sometimes clients just need to complain, whether it be about the treatment they’re getting, the fact of having this medical condition, society’s laws about what help you get when you’re sick, etc. The best thing for a counselor to do at these times is to listen and be sympathetic. The counselor should, however, be mindful of the client’s possible acceleration of anger and threats and be prepared to defuse such a situation. This is best done not by denying or minimizing the client’s complaints, but instead acknowledging the client’s feelings, getting them to talk, and starting a discussion about their options in dealing with the situation.

Forms of Questions

In using questions to prompt conversation and find out information from the client, the counselor may use closed-ended or open-ended questions. Each serves a purpose.

Closed-ended questions begin with words like “are,” “do,” “did,” or “is.” They generally can be answered with one word (yes/no) or a specific fact (“what is your date of birth?”). Closed-ended questions are used to obtain a specific piece of information and they tend to narrow rather than broaden discussion. They are also useful in focusing a client who is rambling or digressing.

Open-ended questions begin with “how,” “when,” “who,” “what,” or “where.” They ask for information without specifying the content. Open-ended questions require more than a “yes,” “no,” or “maybe” answer. The counselor would use open-ended to invite the client to talk at the beginning of an encounter, to get the client to elaborate on situations where more information is needed, to determine what the client knows and wants to learn, and to assess how the client organizes his or her thinking and problem-solving skills.

Focused questions serve to elicit more specific information. Often clients will answer a closed- or open-ended question with a vague or noncommittal response. Focused questions hone in on a particular detail or aspect. For example, if you asked a homeless client where he spent most of his time, he might respond, "I don't know, its hard to say." One focused question might be, "how about the morning? Where do you usually go in the morning?" Alternatively, you could ask, "when do you go to the drop-in center?"

Laundry list questions give clients a variety of possible responses. Using this technique can lead directly to information or possibly trigger the client's memory. For example, if discussing what symptoms a client with a certain medical condition had, you could list the many symptoms which can occur. In another example with a homeless client, you could list the variety of places he or she might be staying, such as shelters, SRO hotels, friends' or relatives' apartments, and public places such as parks, transit terminals, or abandoned buildings.

Paraphrasing is a way of repeating back the client's words. It has the dual purpose of demonstrating that you are listening carefully to what he or she is saying, and getting the client to elaborate more on his or her statement. For example, a client could say, "I don't know how I got TB. I eat well and have never smoked or done anything to harm my lungs." You might respond, "you feel you haven't done anything which would cause you to get TB."

Reflection (or "mirroring") is similar to paraphrasing but focuses on the emotional content of the client's statement, rather than the factual material. A client who is recommended for Directly Observed Therapy might say, "I don't see any reason why people need to see me take my medicines. I am not a child anymore." You might respond by saying, "you feel that people don't think you're responsible."

Practicing peer counseling: Divide participants into pairs to practice

- Changing the following closed-ended questions to open-ended questions: Do you work? Are you using drugs? Did the doctor talk to you about latent TB infection?
- Using focused questions: How have you been feeling recently? Where do you spend most of your time? Who do you have contact with on a regular basis?
- Probing with "laundry list questions:" Where have you gone for help with substance use? Have you had any side effects from the medicines you take? What medicines do you take now?
- Paraphrasing: Practice repeating back the client's words to show that you are listening and to get the client to elaborate.

"I don't know much about TB infection. A lot of people I know have it. The doctor told me that it would be good if I took medicines but I don't know why. It's a real drag taking medicine."

"I haven't always been positive. I think my first exposure was when I was living in a shelter where a lot of people were coming down with symptoms of TB. They had to go to doctors because of coughing and that was 3 or 4 years ago."

- Reflecting the emotional content of what a client is saying: Practice identifying the client's feelings behind his/her words.

"I am feeling very tired these days and the drugs mess up my drug use, I don't know if it is all worth it."

"You've asked me all sorts of questions already. I have answered them all, but I'm not going to give you the names of my friends. I believe in privacy."

Non-verbal Communication

The counselor must also give attention to non-verbal communication, for how we act is often just as important as what we say. Counselors who are not aware of their non-verbal cues may find that their body language contradicts their statements.

The facilitator should discuss the following forms of nonverbal communication:

Eye contact This is an area where it is important to acknowledge different practices among cultural groups. In one group, it may be appropriate for the listener to look at the speaker, to demonstrate that he or she is paying attention. In other cultures, such a direct gaze would be interpreted as defiance or disrespect. In general, the counselor should meet the client's eyes without aggressively forcing contact. Continuous staring at the client is not appropriate in any context.

Facial expressions The counselor should endeavor to present a relaxed, pleasant look. Too often, physicians or others asking questions of clients frown or have a pained look on their faces.

Posture The counselor should sit in a manner which is relaxed, yet attentive. He or she should face the client. Inappropriate postures include facing away from the client, slouching, standing over the client, or taking an aggressive stance.

Gestures It is appropriate to nod in agreement or recognition, or to make modest gestures with the hands. Counselors should avoid flailing their arms, fidgeting, or shrugging their shoulders. They should be especially cautious about touching the client, as different cultures will have very different interpretations of such actions. For one group, casual touching may indicate rapport while others will find it intrusive or a violation.

Tone of voice Counselors should speak in a strong but not loud voice. It is important to use inflection in speaking so as not to speak in a monotone. Be careful to avoid mumbling.

Loudness The counselor's voice should be loud enough for the client to hear but not so loud where it become overpowering. If the counselor speaks too softly, the client must strain to hear.

Rate of speech The rate of speech should be moderate and steady. If too fast, the client will struggle to understand; if too slow, he or she will become bored.

Distance This is another area in which there are vast cultural differences. Some groups expect closeness as an expression of rapport. Others feel hemmed in or intimidated when their conversation partner is too close. The counselor should try to assess the distance preferred by the client and accommodate him or her, depending on the counselor's comfort. It may be necessary to negotiate a speaking distance.

Discussion

Use the following statements and questions to get the group talking about non-verbal

communication:

- Body language can play an important part in non-verbal communication, both the peer worker's own body language and that of the client. What types of body language can you think of? Rank these in terms of how each affects building rapport or trust.
- What people think we mean is determined not only by what we say but how we say it. How can you use your voice to build rapport and trust?

Participant Observation Report (See Notes, Session 1)

SESSION 7: ROLE OF THE PEER WORKER – PART 3

(3 HOURS)

Review Activity (Peer Counseling)	(20 min)
Critical Aspects of the Peer-Client Relationship	(45 min)
• Presentation	
• Role plays	
• Discussion	
Break	(15 min)
Working as Part of a Multidisciplinary Team	(45 min)
• Presentation	
• Role plays	
Multidisciplinary Team Practicum	(45 min)
• Activity: Mapping resources	
• Debrief: Discussion, Q&A	
Participant Observation Report	(10 min)

Session Objectives

By the end of this session, participants will be able to:

- Examine how peers build and maintain relationships with clients
- Discuss strategies to bring the peer-client relationship to a successful conclusion
- Identify resources and strategies for referral and/or follow-up
- Create map of health and social service resources

NOTES: SESSION 7

Review Activity Facilitated by trainees (See Notes, Session 2)

Critical Aspects of the Peer-Client Relationship

Peer workers inhabit a role that is not well known to either clients or fellow workers. As a result, the peer worker may need to make extra efforts to explain what their role is and what their activities are. This situation may lead to specific problems in the relationship between the peer worker and the client. The facilitator should discuss salient issues which are often seen in the following areas:

- Disclosure
- Building relationships
- Boundaries
- Confidentiality
- Termination

Disclosure

The primary skill that peers bring to their adherence work is the ability to reflect on their own life experience and communicate it in such a way that it is helpful to individual clients. When peer workers talk about their own journey from learning they have LTBI to completing treatment, they offer role modeling, social learning, and support, while also laying the foundation of a deeply personal relationship dedicated to adherence.

At the same time, the peer worker is likely to have personal concerns about his or her own disclosure. When so many people confuse LTBI with active TB disease, which remains a stigmatizing condition in our society, those receiving LTBI treatment are understandably cautious about sharing this information. For those who have participated in self-help and other recovery programs, this caution may be reinforced by group norms about 'anonymity.' While this perspective is appropriate in certain circumstances, it is contrary to the spirit and value of the peer worker as discussed in this training. A key characteristic of peer workers is their capacity to relate to clients through common experiences and draw on life experiences to help clients through difficult times. This is not possible if peer workers keep their experience with TB/LTBI a secret.

Over time, we have found that it is important to let the peers decide when (but not if) they reveal their background to a given client. Each peer will develop a style with which they are comfortable. However, it is important for program managers to be clear about general expectations regarding disclosure.

Building Relationships

Relationship-building Techniques

- Appropriate disclosure
- Active listening
- Availability
- Meeting clients 'where they are at'
- Address the client's immediate concerns

Although peer workers engage clients in ways that are explicitly non-clinical and mimic casual or social interactions, they are nonetheless building a relationship that, over time, will facilitate the integration of adherence into their clients' lives. In order to build rapport, peer workers first take an impression of client disposition, sense of self, and existing social support networks. They establish commonalities in their past and present lives in order to

provide appropriate social support. In this way, peer workers reinforce trusting relationships by approaching adherence on the client's own terms and allowing the client, rather than healthcare professionals, to decide how adherence fits into the client's life.

Boundaries

Clear guidelines help to create a setting in which both peer workers and clients feel safe in disclosing personal histories, thoughts and feelings. Peers usually do not rely on the recognized indicators of professional health care providers, such as a white coat, degrees hanging on the wall, or initials after their last name. Without the familiar indicators of a healthcare provider, it may be more difficult for clients to understand the parameters of the relationship, and peers must be explicit about what types of interactions fall outside those boundaries.

Peer workers develop strategies for defining and honoring interpersonal boundaries in three crucial domains:

1. Peer workers must define the limits of their expertise, so that clients do not confuse sharing tips for handling side effects with medical advice, or a sympathetic ear with psychotherapy.
2. Peer workers must be clear about the amount of time and energy they can give, especially if they are available to clients outside of normal working hours.
3. Peer workers should advise and periodically remind clients of the program or other requirements that limit the duration of adherence support.

Attention given to establishing boundaries is especially important in peer work because the peer is building a relationship with the client expressly to achieve desired health outcomes, such as medication adherence. For some clients, the presence of a person who listens, who cares, and who may go the extra mile to help may be unfamiliar and confusing. These actions may be interpreted as an effort to establish an intimate (that is, sexual) relationship and that prospect may be either welcomed or rebuffed. Clients who respond to a perceived mutual interest may then feel betrayed or misled when the peer suggests that such behaviors are inappropriate.

Confidentiality

When confronted by the prospect of a peer program, professionals often voice a concern about maintaining confidentiality. This concern stems from their belief that peers do not receive professional training on confidentiality, and that by coming from the same social milieu as clients, the peers may be tempted to discover or reveal information about associates. These fears are unfounded. To the contrary, because peers have first been clients themselves, they are very sensitive to what is known and revealed. The 'Golden Rule' is very real to them and peers do not want to reveal about their clients what could be revealed about them. In contrast, many professionals are taught strict rules about confidentiality but in practice, develop a looser approach that allows them to share information freely with colleagues to more quickly access needed services.

Needless to say, while peers may be inherently cautious about revealing client information, the concept of confidentiality and related issues must be presented thoroughly during the initial training and reinforced in subsequent training and supervision. As with other professionals, peer workers may overstep boundaries in receiving and providing information, driven by their desire to help clients.

Termination

Precisely because it is based on shared experiences and mutual self-disclosure, ending the peer-client relationship can be difficult for both parties. Professional education suggests that termination should be discussed at the first meeting of helper and client. While this may not be realistic, it certainly should be discussed once a working relationship is established. It is important for the client to know, and the peer worker to remind him/herself, that there is a finite limit to their relationship. This may be an artificial limit (in the case of a research study testing a six-month intervention) or a functional limit (when treatment is completed). Frequent reminders as this limit approaches may lessen the possibility of negative feelings about bringing the relationship to a close.

Peer workers should be reminded, however, that even their best efforts to handle termination responsibly are not always well received by clients. Some clients who have suffered a multitude of losses may withdraw prematurely, seeking to avoid the emotional pain of termination. Others become angry, accusing the peer of real or imagined slights. Clients often interpret the ending of the relationship personally, despite efforts to convince them that for most clients, the end of the peer-client relationship signifies successful completion of LTBI treatment.

Peer workers too may have emotional reactions to ending the peer-client relationship with certain clients, having enjoyed the relationship established with certain individuals. Again, supervision is vital in identifying and acknowledging these feelings, while helping the peer worker to deal with them in an appropriate manner.

Role Play / Group Discussion

The following are two scenarios involving some of the issues discussed above. Two participants should volunteer or be selected to play the peer worker and the client.

Scenario 1 – Boundaries

You are a female peer worker who has been working with Mr. A for five months. You have helped him become adherent through some difficult times in his personal life. Recently these problems have subsided and your regular conversations with him have become easy and enjoyable. To your surprise, Mr. A. asks you to go out to dinner with him. How do you maintain your professional boundaries without insulting him or seeming rude?

Scenario 2 – Termination

You have been working with Ms. M. for nine months and she is nearing completion of LTBI treatment. Over the past month, you have been reminding her that when she completes treatment, your relationship with her must come to an end. You both are very proud that she has made it this far, despite a number of problems in her life. The program will be giving a “graduation” party for people who complete treatment around the time Ms. M. completes. A week before the party, Ms. M. abruptly stops returning your calls and doesn’t answer the door when you try to visit. She does not attend the graduation. When you encounter her on the street one day shortly after the graduation, she angrily claims that you don’t care about her and runs away before you can say anything. How do you feel about the situation with Ms. M. and what would you do?

Working as part of a multidisciplinary adherence support team

Whether an adherence program is created specifically to provide peer support or peer workers are incorporated into an existing program, it is essential to define their roles, responsibilities, and interaction with other members of the adherence support effort. Because the job skills and activities entailed in peer work are different in nature than professional positions, it is necessary to be more explicit in defining peer roles, responsibilities, and activities.

An effective supervisor will provide peer workers with a clear job description based on established peer objectives and expectations. Peer workers themselves might be asked to help shape the role that they are intended to fulfill, bringing attention to issues faced in the field and suggesting creative ways to address them.

In a similar fashion, programs should ensure that mechanisms for regular dialogue among peers and other team members are established and maintained. One such mechanism would be multidisciplinary case meetings where the physician, nurse, peer worker, health educator, social worker, and others discuss individual clients.

Programs intending to add a peer component to their existing services must first recognize the need to review standing operations, to prepare a context into which peer workers will integrate. It will be important to assist peer workers in practicing how to present themselves and explain their function to patients and professionals.

Scenario 1 – Plan for improving adherence

Over several months of LTBI treatment, it has become clear that Mr. R is not adherent to the regimen. He often complains about the medication making him sick. Rather than side effects, some members of the team feel that his unstable living situation is the primary reason for his non-adherence. Others feel that he is depressed.

The facilitator should assign three or four participants a different team member role and viewpoint about Mr. R's non-adherence. The purpose of the discussion should be to generate a plan for improving Mr. R's adherence.

Scenario 2 – Alternative regimen?

Ms. S. has been evaluated by the doctor and is recommended for LTBI treatment. However, a friend from her country became quite sick on the INH regimen. Ms. S. is willing to take LTBI treatment – but is adamant against taking INH. The peer worker is aware of alternative regimens (e.g., 4 months RIF). A participant playing a peer worker should discuss alternate regimens and helping this patient achieve treatment completion with two other participants playing the roles of physician and nurse.

Multidisciplinary Team Practicum

Activity: Mapping Exercise – Identifying Community Resources

This is a group exercise designed to identify and locate various resources in your community. It serves to increase awareness of those resources which do exist, while also identifying areas about which the participants know little and areas in which services do not exist. In some cases, clients may need to travel outside of community boundaries to obtain a certain service type.

Participants may choose to create a geographical map or to list services in categories. Service types to consider include:

- Clothes Distribution
- Domestic Violence Services
- Education, Job Training and Placement Assistance
- Food and Nutrition Programs
- Housing Services
- Legal Services
- Medical Services
- Mental Health Services

- Substance Abuse Treatment Programs
- Support Services for: people living with HIV/AIDS, individuals with disabilities, the lesbian, gay, bisexual, and transgender community, prisoners and former prisoners, youth, immigrants, or other high risk groups in your area

Discuss what services are available, how clients can access them, and what barriers they may encounter. How can the peer worker help clients to navigate the system and get the services they need?

Participant Observation Report (See Notes, Session 1)

SESSION 8: FIELD SAFETY AND SYNTHESIS

(3 HOURS)

Field Safety	(40 min)
<ul style="list-style-type: none">• Presentation: Field safety overview• Activity: Assessing safety in the field• Discussion: Field safety precautions	
Participant Observation Report	(10 min)
Review Session	(45 min)
<ul style="list-style-type: none">• Q&A – all sessions	
Break	(10 min)
Post-test	(30 min)
Graduation	(45 min)

Session Objectives
By the end of this session, participants will be able to:
<ul style="list-style-type: none">• Discuss potential threats to safety while working in the community
<ul style="list-style-type: none">• Practice assessing the safety of common peer-client situations
<ul style="list-style-type: none">• Identify and discuss strategies to work safely in the community

NOTES: SESSION 8

Field Safety

Presentation: Consider having a brief talk by speaker who is familiar with public health field work, perhaps an experienced disease control investigator – or a sympathetic police officer. The 18 minute video *Leaving to Return: A Safe Day in the Life of a Public Health Field Worker* provides safety tips for public health field workers. It is available from the New York State Department of Health, Bureau of Tuberculosis Control (email: tbcontrol@health.state.ny.us)

Activity: Addressing safety in the field

Participants break up in groups of two to brainstorm scenarios they may encounter in the field and appropriate reactions. The groups choose one scenario to present to the group.

Discussion: Field safety precautions

The discussion should cover field safety issues, including potential threats to safety while working in the community and minimizing personal risk.

Review Session

The review session can take any form, depending on the preferences of the participants and facilitators. However, it should be comprehensive and allow participants the opportunity to ask any remaining questions they may have about any subject or skill that has been taught in the course.

Post-Test

See Appendix B.

Graduation

This should be a brief ceremony that honors the individual and group achievements during training, and aims participants toward their jobs as peer workers working in the program and community.

APPENDICES

APPENDIX A

Adherence Support Peer Worker Training Course _____
Dates

Application Form

First name Last name Middle initial

Position title How did you hear about this course?

Mailing address:

Division, Department, and/or Program Organization

Street Apt # / Suite #

City State Zip code

Office telephone Ext. Fax E-mail address

Tell us about yourself:

How long have you worked in TB? What languages do you use in your work?

Please describe any previous experience or training in TB, public health, or peer work.

What are the main tasks you do in your job?

Does your employer want you to take this course? Supervisor's signature

APPENDIX B

Adherence Support Peer Worker Training Course

Pre / Post Test

Please write 4 letters or 4 numbers that will be used as your personal ID to match your pre-test and post-test results. ID# ____ ____ ____ ____

Please write today's date ____ / ____ / ____

Please read each question and circle the best answer.

1. The goal of the adherence support program is to provide carfare and lunch for participants.
True or False
2. The role of the Peer Worker is
 - a. To provide carfare and lunch
 - b. To assist clients in adhering to treatment for latent tuberculosis infection
 - c. To give medical advice to clients
3. It is the responsibility of the Peer Worker to respect the confidentiality of the client's medical information.
True or False
4. Peer Workers can provide a client's medical information to a licensed health care worker.
True or False
5. How can a person spread tuberculosis?
 - a. Coughing
 - b. Unsafe sex
 - c. Kissing
 - f. All of the above
6. How can tuberculosis infection be detected?
 - a. Chest X-ray
 - b. Skin test (PPD)
 - c. Blood test
 - d. Urine test
 - e. Both b and c
 - f. All of the above

7. What drug is most commonly used to treat latent tuberculosis infection?
 - a. AZT
 - b. Penicillin
 - c. INH
 - d. Vitamin C
8. Drinking alcohol is permitted while receiving treatment for latent tuberculosis infection.
True or False
9. A full treatment for latent tuberculosis infection is 90% effective in preventing tuberculosis disease in the future.
True or False
10. A person with latent tuberculosis infection can
 - a. spread TB by coughing, singing, talking, laughing
 - b. spread TB by unsafe sex
 - c. not spread TB at all
 - d. spread TB by kissing
11. The side effects from the medication used to treat latent tuberculosis infection include: (Check all that apply.)
 - a. dry mouth
 - b. ringing in ears
 - c. abdominal pain
 - d. jaundice
 - e. rash
 - f. blurred vision

This is a list of actions that a Peer Worker might do to help a client who has been prescribed medication to treat latent tuberculosis infection. Please circle the “**D**” next to actions that can help a client **DECIDE** to take treatment or the “**C**” next to actions that can help a client to **CONTINUE** to take treatment.

12. **C** **D** Help the client remember to take medication by placing it next to his or her toothbrush.
13. **C** **D** Explain the seriousness of tuberculosis disease.
14. **C** **D** Discuss the client’s risk of developing tuberculosis disease.
15. **C** **D** Make practical suggestions to help the client overcome barriers for taking medications.
16. **C** **D** Explain that the treatment for latent tuberculosis infection can be safe and effective if properly monitored with follow-up visits to the clinic.

APPENDIX C

Adherence Support Peer Worker Training Course

Session Evaluation Form

Title of session: _____ Date: ____ / ____ / ____

Please use the following numbers to tell us how you felt about this training session.

(1) Very bad (2) Bad (3) Somewhat good (4) Good (5) Very good

1. The trainer made the group feel _____
2. My level of comfort in the group was _____
3. Before this session my knowledge of the subject was _____
4. The reading materials were _____
5. Prior to this session, my understanding of the information was _____
6. After this session my knowledge of the subject is _____
7. Overall I found the training session _____

APPENDIX D

Adherence Support Peer Worker Training Course

Session Evaluation Summary

Title of session: _____ Date: ____ / ____ / ____

Session Objectives	
<i>By the end of this session, participants will be able to:</i>	<i>Instructor</i>
• Objective 1	_____
• Objective 2	_____
• Objective 3	_____
• Objective 4	_____

Objective 1

Was the presentation of material clear? _____

Did everyone 'get it?' _____

How much did participants get involved in the session? _____

Did they ask questions? _____

Did they participate in activities or discussion? _____

Were most people involved? Or did they act bored? _____

Did it seem to go on too long? _____

Did this part of the session meet its stated objectives? _____

Repeat these questions for each objective

Objective 2

Objective 3

Objective 4

Other comments:

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New York, New York, 10037
telephone: 212-939-8254
fax: 212-939-8259

Website: <http://www.harlemtbcenter.org>