No. 5

Field experience from Thai-Myanmar border camps

MOBILE REFUGEE MALES AND HIV VULNERABILITY: TIPS AND TOOLS FOR BEHAVIOR CHANGE COMMUNICATION (BCC) FORMATIVE ASSESSMENT AND BEYOND.

UNHCR
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This document forms part of a series of publications that document field experience in HIV and AIDS. This work was undertaken by Franklin John-Leader, Australian Volunteer International HIV Programme Officer with UNHCR in Bangkok, Thailand and Ann Burton, Senior Regional HIV Coordinator, UNHCR, Bangkok, Thailand.

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Other titles in the HIV/AIDS Field experience series:

Assessment of HIV/AIDS Behaviour Change Communication Strategies employed by NGOs in Kakuma Refugee Camp, Kenya (December 2002)

Evaluation of the Introduction of Post Exposure Prophylaxis in the Clinical Management of Rape Survivors in Kibondo Refugee Camp, Tanzania (October 2005)

Community Conversations in Response to HIV/AIDS: A capacity building project with refugees and the host population. Republic of Congo (December 2005)

Introducing the Female Condom in Refugee Settings: A Guide for Implementation. Kenya. (March 2006)

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TABLE OF CONTENTS

FOREWORD

The link between mobility and HIV/AIDS is often related to the characteristics of the migration process and is widely understood to be an important factor in the facilitation of HIV/STI transmission. Men living away from their families and their home communities are more likely to have multiple sex partners. Being away from close ones such as family and friends and the forces of economic pressures; poor education; lack of HIV knowledge, language barriers, limited entertainment options; easy access to alcohol and commercial sex; limited awareness and access to STI/health services all increase mobile refugee men's vulnerability to STIs and HIV.

There is very little information regarding the HIV knowledge, attitude and behaviour of mobile refugee males. The scale and patterns of mobility, particularly amongst those who work and live away from camps for longer periods of time (a month or more) is not widely understood either. Reaching mobile populations with consistent HIV prevention messages is a formidable challenge and the complexities of reaching them when they are geographically dispersed complicate any intervention efforts further.

This manual is designed for UNHCR staff and partners who are interested in undertaking such assessments in refugee settings in their own country /community. Major steps involved in a Formative Assessment; challenges encountered during various phases of assessment and useful tips to consider are listed or explained. A set of essential, ready-to-use tools (easily adaptable to suit local situations) such as interview guides will help assessors save significant time and resources. This manual also includes some steps that go beyond the scope of formative assessment. These additional steps are briefly explained through a strategic framework for developing a BCC implementation plan. This strategic framework illustrates how assessment findings are used in the development of subsequent BCC interventions.

LIST OF ACRONYMS

AMI	Aide Medicale Internationale
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
FGD	Focus Group Discussion
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IDD	In-Depth Interviews
IDU	Injecting Drug Use or Injecting Drug User
IRC	International Rescue Committee
PLHIV	Person Living with HIV
IEC	Information, Education Communication
KII	Key Informant Interviews
NGO	Non-government Organization
STI	Sexually Transmitted Infections
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counseling and Testing

EXECUTIVE SUMMARY

The link between mobility and HIV/AIDS is often related to the characteristics of the migration process and is widely understood to be a major factor in facilitating HIV/STI transmission. Available evidence indicates that a significant proportion of HIV cases in Thai refugee camps occur amongst men who have spent time outside the camp for long periods, and their sexual partners.

There is very little information on the HIV knowledge, attitude and behaviour of the mobile male population. The scale and patterns of mobility, particularly for those who work and live away from camps for a month or more at a time are poorly understood. There is growing recognition that not everyone is at equal risk of HIV and, particularly in low level and concentrated epidemic settings, there is a need to target those at greater risk. A number of factors amplify mobile males' vulnerability to HIV. Reaching mobile populations with consistent HIV prevention messages is a formidable challenge[1]; the complexities of reaching them when they are geographically dispersed further complicates any intervention efforts.

Formative assessments were conducted in three camps along Thai-Myanmar border. These assessments were designed to enable UNHCR and their partners to develop targeted HIV/BCC interventions for camp-based mobile male refugee groups in Thailand as well as providing an insight into their HIV vulnerability.

Objectives of the assessment were to:

- Determine the magnitude of mobility amongst refugee males (16 to 40 years)
- Map patterns of mobility and social networks amongst refugee men whilst outside the camp environment
- Explore the current/ potential HIV risks and vulnerabilities of mobile men: their knowledge of HIV and AIDS; access to HIV services (both inside and outside of refugee camps); and extent of high risk activities (unprotected sex/ Injecting Drug Use (IDU)
- Investigate existing and potential BCC enablers (popular opinion leaders/partners) and challenges (stigma/negative attitudes, power dynamics) and
- Identify and assess existing resources (information education and communication (IEC), human resources and social, recreational facilities) and opportunities for future BCC interventions aimed at mobile men.

1 Family Health International. *Protecting People on the Move: Applying Lessons Learned in Asia to Improve HIV/AIDS Interventions of Mobile People.* Bangkok. 2006

These assessments show that about one third of refugees travel outside their camps, mainly to work. A majority of them are males who often live away from their camp for long periods (one month or more). Further refinement of target segmentation based on the formative assessment identified males between the ages of 18-28 (working males) as the primary target for BCC interventions along with students 16 and over currently attending school.

Three of the nine refugee camps in Thai-Myanmar border, were selected for the assessment. The methodology consisted of a mix of techniques including Focus Group Discussions (FGD), Key Informant Interviews (KII) and In-Depth Interviews (IDI) along with observation and site inventory. A number of informal meetings with camp executives and religious leaders were also undertaken. In-depth data were collected particularly targeting non-student youth and men who are away from camps for a month or more at a time. Relevant secondary data were collected during 2007/08. Both data and method triangulation techniques were used to analyze the information collected.

In most camps men and young males, particularly young working males, clearly lack sufficient HIV and AIDS information to be able to protect themselves. Fear of PLHIV and reported incidences of HIV-related discrimination were also evident in some camps. Talking about sex/sexuality and sexual transmission of HIV is still a taboo subject in the camps. Promotion and use of condoms is actively discouraged by influential leaders. The reported availability and use of condoms in villages where most men work was very low despite larger agricultural villages possessing commercial sex premises. However, there is noticeable willingness from various segments of the community such as camp leaders and religious leaders to work towards building a community that is free from fear, stigma and discrimination.

Many men showed an inclination to learn more about HIV and be able to educate their peers and thus peer group education and word-of-mouth strategies are considered to be the best options for communication amongst working men.

Four approaches of reaching boys and men are explained based on the physical location and nature of their mobility: Before leaving school, before leaving camps (where strategies include distribution of travel kits), when they return to camps during festivals and ceremonies and whilst they are out of the camps through targeted peer education and outreach strategies where feasible.

The importance of identifying and developing partnerships with local health and community organizations is also highlighted.

Although the scope of the assessment did not include the subsequent steps of developing and pre-testing BCC messages; BCC implementation, monitoring and evaluation; a strategic framework was

developed that explains key aspects of an effective BCC strategy for implementation. However the findings of the formative assessment are used in designing an overarching BCC strategy that clearly identifies:

- Risk factors (current risk behaviors, attitudes and environment)
- Behaviour change objectives (desired behaviours)
- Barriers and positive influentials
- Communication channels and media
- Behaviour change communication objectives (how to achieve desired behaviours through communication)
- Intervention strategies (peer educators, training camp leaders)

INTRODUCTION:

Mobility is associated with an increased vulnerability to HIV infection. Available evidence indicates that a significant proportion of HIV cases in Thai refugee camps occur among men who have spent long periods outside their camp and in their sexual partners. There is scant information on their HIV knowledge, attitude and behaviours to guide HIV programming. Information regarding the scale and patterns of mobility is also negligible, particularly for those who work and live away from camps for a month or more at a time. It is a formidable challenge to reach mobile populations with consistent HIV prevention messages and this is further complicated when they are geographically dispersed.

Behaviour Change Communication (BCC) formative assessments were conducted in three camps along the Thai-Myanmar border. These assessments were designed to provide further insight into the HIV vulnerability of camp-based refugee males and enable UNHCR and its partners to develop targeted HIV/BCC interventions. This field experience explains the steps undertaken and provides tips for undertaking a BCC formative assessment as well as briefly illustrating how assessment findings are used to develop a BCC intervention. Specific field examples are given throughout the document in italics.

Behavior change (BC):

Behavior change is a comprehensive process in which one passes through the stages of:
Unaware >> Aware >> Concerned >> Knowledgeable >> Motivated to change >> Practicing trial behavior change >> Sustained behavior change.

It is important to note that changing behaviours and attitudes is a process that takes time and any target audience requires a range of messages and support at each stage. It is possible for most people in this process to move both forward and backward depending on their individual and environmental circumstances.

Behavior change communication (BCC):

Behavior Change Communication (BCC):

- is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change
- employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation
- uses multiple channels to transmit and reinforce messages that address the needs of target audiences as well as creating a supportive social environment that helps people adopt and maintain safer behaviors

Through BCC audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives.

BCC activities for HIV prevention use multiple channels to transmit and reinforce messages that address the needs of target audiences. By encouraging changes in cultural attitudes, social norms, and government and institutional policies, BCC campaigns can create an environment that supports individual HIV risk reduction by giving individuals the skills and tools required to prevent HIV transmission while creating a supportive social environment that assists the adoption and maintenance of safer behaviors.

Effective BCC can:

- Increase knowledge by ensuring that people are given the basic facts about HIV and AIDS in a language or medium that they can understand and apply to themselves

- Stimulate community dialogue by encouraging community and national discussions on the basic facts of HIV and AIDS and the underlying factors that contribute to the epidemic, such as risk behaviors and risk settings, environments and cultural practices related to sex, sexuality and drug use.

- Promote essential attitude change by leading to self refection about such areas as perceived personal risk of HIV infection, the importance of compassionate and non-judgmental services, open-mindedness concerning gender roles, and the basic rights of those vulnerable to and affected by HIV and AIDS

- Reduce stigma and discrimination through communication about HIV prevention and AIDS mitigation that addresses stigma and discrimination and attempts to influence social responses to them.

- Create a demand for information and services by urging individuals and communities to demand information on HIV and AIDS and appropriate services

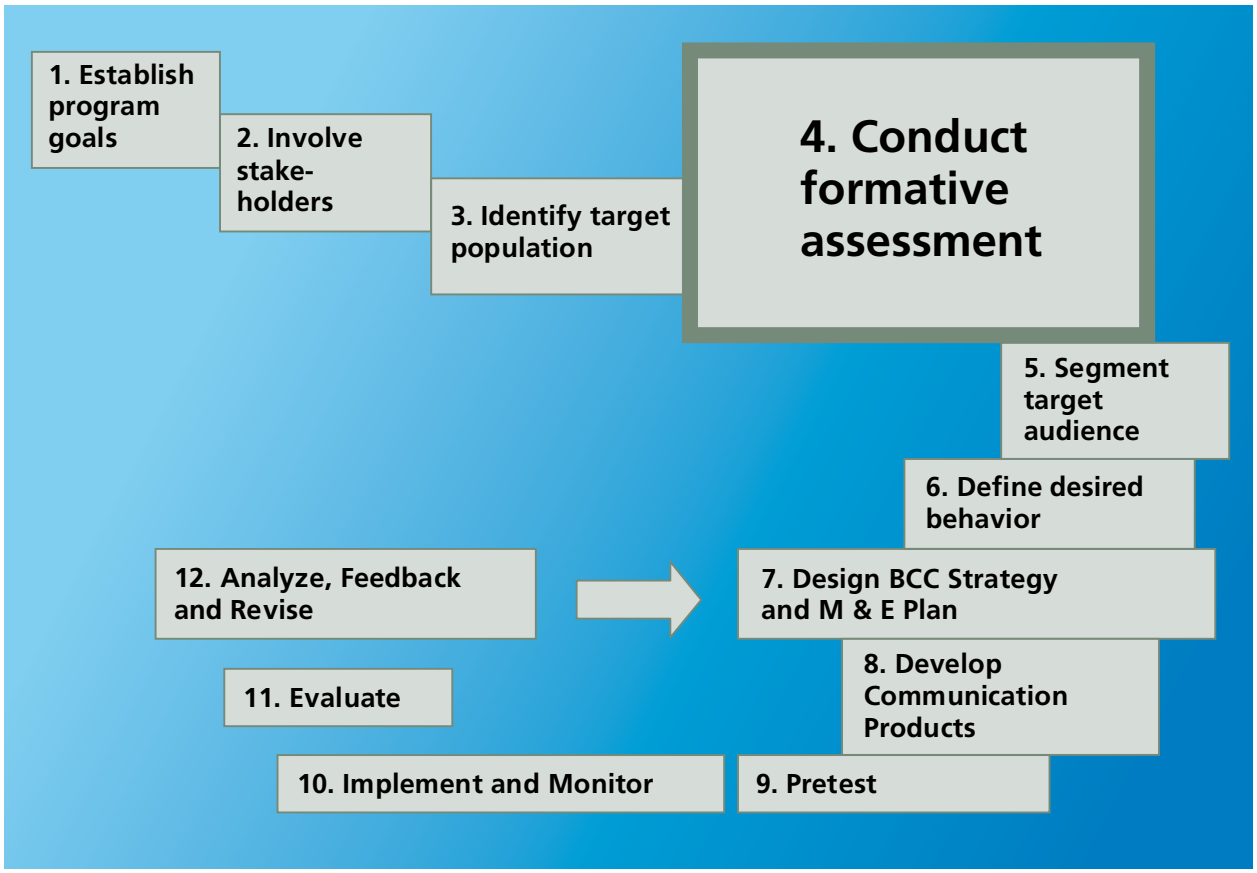
- Lead policymakers and opinion leaders toward effective approaches to the epidemic

- Increase uptake of services for HIV prevention, care and support such as Voluntary Counseling and Testing (VCT), Prevention of Mother-to-Child Transmission (PMTCT) and STI services

- Improve skills and sense of self-efficacy (perceptions about an individual's ability to perform a promoted behavior effectively) by focusing on teaching or reinforcing new skills and behaviors, such as condom use, negotiating safer sex, and safe injection practices. This can contribute to a sense of confidence in making and acting on decisions.

How does formative assessment relate to BCC strategy development?

Formative assessment is a process where you engage your target group and speak with them directly to find out more about the above key questions. This can be done through Key Informant Interviews (KII), Focus Group Discussions (FGD), In-Depth Interviews (IDI), observation and site inventory and mapping. This information can guide you to place information needs in perspective, allowing you to understand what information you really need and give hints in the selection of sites for your BCC activities.



Source: Family Health International

1. Step 1: Initial planning

It is crucial for BCC planners to state the purpose of the assessment and develop assessment objectives at the start. This can be achieved by explaining why you need to do this assessment; listing what you already know about refugee males and HIV vulnerability and what you need to know.

Reviewing information from previously conducted work and narrowing the topic is a critical first step. This helps avoid repetition of work that has already been carried out. For example, surveys, studies conducted by local, national or international bodies such as local NGOs, host government or UN agencies could be identified and reviewed.

In the next phase of step 1 you need to identify what information you need to obtain through the assessment.

Key broad questions to address should include:

1. What are the mobile refugee males behaviours and attitudes related to HIV and what are their likes, dislikes, hopes and concerns for the future;
2. Risk situations including what influences the decisions and settings for risk
3. Why individuals and groups practice the behaviors they do, and why they might be motivated to change (or unable to change) to the desired behaviors
4. Which target groups are most vulnerable;
5. Which risk / vulnerability factors are most important;
6. What persons or groups constitute their social networks and key influencers?
7. What factors influences their behavior?
8. What are the insights of opinion leaders
9. What are the opportunities, positive influencers (a leader/ peer educator etc) and resources for developing and implementing a successful BCC program? (media and entertainment habits, health care-seeking behaviors, positive deviants or those most willing to model change)
10. Which factors may be related to the impact of conflict and displacement;

1.1 Objectives:

Based on the above information, you can develop objectives for the formative assessment. Here, it is important to identify the target audience as narrowly as possible to avoid gathering irrelevant information that is not specific enough to influence the target audience; for example, targeting males who are potentially more sexually active who travel/work/live outside refugee camps for a month or more at a time.

Objectives of the assessment were to:

- Determine the magnitude of mobility amongst refugee males (16 to 40yrs)
- Map patterns of mobility and social networks amongst refugee men whilst outside the camp environment
- Explore the current/ potential HIV risks and vulnerabilities of mobile men: their knowledge of HIV and AIDS; access to HIV services (both inside and outside of refugee camps); and extent of high risk activities (unprotected sex/ Injecting Drug Use)
- Investigate existing and potential BCC enablers (popular ppinion leaders (POLs) /partners) and challenges (stigma/negative attitudes, power dynamics) and
- Identify and assess existing resources (IEC, Human Resources and social, recreational facilities) and opportunities for future BCC intervention aimed at mobile men.

1.2 Partnership development and scoping

This is an important step to identify and select key stakeholders (both organizations and individuals) for the assessment; engage them in discussions about programmatic BCC intervention strategies, including the assessment and establish common ground. In this step, articulate and refine the scope of the study and explain how information collected will be used for future interventions. It is important to include all players not just those who you are comfortable working with.

Pre-assessment visits to the area of the assessment (e.g. a particular camp) are very important even if you are familiar with the site. This gives an opportunity to identify and develop partnerships and build trust amongst key individuals who may exert influence on any future programmatic intervention in that community. It is vital to identify influential leaders within the community, these individuals many not necessarily hold any formal positions.

> *For example, during a routine camp visit by the HIV Programme Officer the need for a BCC intervention was introduced to key leaders and partners and their active involvement and support solicited. This helped the HIV Programme Officer and UNHCR field staff, (focal points for the assessment) get the support and openness necessary to organize the assessment mission.*

1.3 Methodology

In this stage, define the scope of the study based on available information and identified gaps. Specific methodologies including selection of assessment sites are finalized based on the research objectives, available resources and support from various partners. Also any secondary data, specific to the study area are collected and analyzed to avoid repeating research for which adequate information or data already exist.

> *For example, out of nine refugee camps along the Thai-Myanmar border, three were selected for the assessment. The methodology consisted of a mix of techniques including Focus Groups (FG), Key Informant Interviews KII), In-Depth Interviews (IDI) along with observation and site inventory and mapping (see sections 1.4.5/6). A number of informal meetings with camp executives and religious leaders were also undertaken.*
>
> *In-depth data were collected particularly targeting non-student youth and men who were away from camps for a month or more at a time. Relevant secondary data were collected during 2007/08. Both data and method triangulation techniques were used to analyse information collected (see Step 5).*

1.4 Assessment methods and selection of participants

Participants for FGs, KIIs and IDIs need to be selected based on information collected during the target identification process prior to Formative Assessment planning. *In this study information on who was getting HIV and main modes of transmission were sought through secondary data* [2].

It is important to obtain participants consent before commencing any interviews. A consent form should be used that details the purpose of the discussions, confidentiality and how the information collected will be used and for what purpose (see annex 2). It should highlight the fact that a participant is not obliged to participate or answer any particular questions if they do not want to.

It is important to acknowledge during the introduction that the assessment has no connection to resettlement or any other functions of UNHCR and information will only be used for programmatic implementation and no identifiable information will be collected, documented or used. This will help both participants and interviewer minimize any communication barriers and false expectations.

Assessment methods and how participants are selected are explained below.

1.4.1 Focus groups:

For group discussions:

- ensure the group's homogeneity (age group and gender or relevant sub-groupings such as ethnicity) where possible
- ideally have 6-8 people per group (this gives everybody a chance to talk, allows adequate exchange during discussions and opinions to be given; and many participants may not feel comfortable interacting if the group is larger than eight or 10).

Focus group discussions are designed to obtain high-quality information in a setting where people can consider their own views in light of the views of others. Ideally, the moderator should make sure that participants feel free to give their thoughts and opinions openly, that all of the topics in the FGD guide are presented and that the discussion are broad and deep. Honest and open discussion of participants' knowledge, attitudes and behaviors is the aim and the facilitator's ability and experience in stimulating interaction between participants cannot be underestimated.

Providing an informal, welcoming atmosphere in a private setting with some ground rules such as confidentiality and mutual respect are key to getting the most out of FGDs. Participants were not paid to participate however, their important contribution was acknowledged and refreshments

2 Any form of data that **originates** from a **source other than the personal research** of the researcher is considered to be **"secondary data"**.

were provided. However, in other settings people may need to be compensated for travel costs or other costs of participation such as lost earnings.

Time required: 90 minutes to 120 minutes.

The focus group parameters in this study were as follows:

- *Young males at school (16yrs-18 yrs)*
- *Young males not currently attending school (16yrs-18 yrs)*
- *Young males (19yrs-24 yrs)*
- *Men who worked/lived outside camp (25yrs-40yrs)*
- *Community Health workers (male and females)*

1.4.2 Key Informants Interviews (KII) and Informal Interviews

Previous knowledge of the camp population and influential persons can make the selection of individuals easier. Careful planning and communication is needed to make sure that a range of informed persons who know about mobile male populations are consulted and engaged for the assessment.

Key informants for this assessment were identified by the local focal points for the study with support from Camp Committee.

Key informants can be:

- "Expert" members of the target population who know the subject matter well
- Formal and informal community leaders
- Persons working in health
- Persons working with HIV/AIDS/health programs
- Leaders in community-based HIV prevention programs
- Government officials such as Provincial Public Health Coordinator
- Counselors working in HIV programs
- Social service agency representatives
- Educators, school administrators and school health coordinators
- Representatives from target population organizations
- Religious leaders
- Advocacy group leaders

In the interests of being inclusive and reducing the risk of future obstacles it is recommended that informal interviews or discussions with key persons who may not have details about mobile males be also undertaken. It is important to engage them at the beginning of any intervention in order to gain their support and respect which can significantly reduce any potential socio, political, cultural or religious barriers often exerted by these key leaders.

"We (religious leaders) have concerns about certain aspects of this issue but that does not mean that we are totally against any plans that can protect our people"
Christian leader,
Mae La camp, Thailand.

KII's usually take 60 minutes and the duration of informal meetings can vary from 10 minutes to 30 minutes depending on both party's availability and their ability to contribute to the objectives of the study.

1.4.3 In-Depth Interviews (IDI):

In-Depth Interviews are designed to gain in-depth answers to various aspects of risk behavior, beliefs, motivations, and reasons behind such behaviors. It also helps the interviewer to find out what might motivate the target population to adopt desired behaviors.
Participants of IDIs can be identified in a number of ways. One way to recruit them is through FGDs when the facilitators identify certain participants with in-depth information and experience of the subject.

The following groups were identified for IDI in Thailand.

- *HIV positive males*
- *Female partners of men who worked outside camp*
- *Men who work outside the camp for one month or more at a time*

In this formative assessment conducted the 'snow-balling' technique used was most effective in identifying and recruiting high quality informants.

With the **snowballing technique**, once you identify one or more good informants (who have relevant knowledge and experience) you can request them to identify other contacts who can also give information on the subject you are dealing with. This is a good way to identify informants particularly in a camp. Once you gain the respect and trust of an informant, they are happy to refer you to other sources and the quality of information can be very high where informants usually share very personal experiences that may not be easily attained if they were identified or recruited by the camp committee or local staff.

The saturation point is reached once you gain enough high quality information from informants (usually 10-15) that a pattern emerges and no more new information can be obtained. At this point there is no need for further interviews.

While IDIs are primarily employed to gather information, they also assure key target populations that they are being consulted and this consultation facilitates target populations becoming allies or partners in any future activity.

1.4.3.1 Selection of PLHIVs and partners

Care must be taken when identifying and engaging PLHIVs, especially in settings where people are not public about their HIV status. Camp health/VCT workers can be contacted to organize the interviews and interviewers must make sure that the interviewee is happy to talk to the interviewer (and interpreter if necessary).

> **In certain settings, it may be possible to use recording (audio/video) equipment, but care must be taken to make sure that participants are not self conscious of the recording as this can often restrict their free and honest participation.**

1.4.5 Observation

The aim of observation is to gain information about the social networks, the settings for risk and influences that lead to risky sexual behavior for a target population. In addition to field notes (diary), you can also use audio and/or videotape and use the observations of others, journal notes or anything else which will reveal cultural and other key aspects of the target population. A sample guide is available (see annex 15) and could be modified according to your own specific observation objectives and questions to reflect the local situation.

1.4.6 Site inventory and mapping

Site Inventory is a list of services and facilities that are relevant to your BCC intervention and can be identified and recorded during your assessment.

What to look for:

- VCT services: location- can they offer services in private?
- STI services: number of clinics, treatment and care facilities
- Condoms: where they are placed, are they under 'lock and key', who distributes them, their

level of comfort and attitude towards condom use especially by unmarried people.

- IEC provision: availability, quality of materials (fear, value-based and misleading images and messages such as "AIDS kills immoral people" vs. IEC that are informative and supportive to facilitate positive behavioral change. Eg: "You can't get HIV by caring for a friend or family member with AIDS"), places where materials are displayed or distributed; are they free; are they relevant (target specific, culturally appropriate) and whether the information is up to date.

In addition to HIV-related services within the camp, you can also develop an inventory of places where refugee men work and live.

For example, a detailed list of agricultural villages and small towns where Thai refugee men work/live with additional information such as sex work, alcohol and condoms was generated during the formative assessment in Thailand. This inventory can be useful for any BCC interventions outside Thai camps.

1.5 Development of assessment tools.

It is important to ask the right question to get information you can use. A checklist is also available to help you develop interview guides (see annex 5).

In the assessment of mobile male refugees from The Thai-Burmese border camps a set of specific data collection tools were developed in consultation with key partners, pre-tested (relevance, appropriateness and usability) and refined and incorporated into the assessment.

Tools are developed to answer the following five overarching questions:

- What is the target populations' knowledge, attitude and behaviors in terms of their risks and vulnerability to HIV;
- What are their likes and dislikes in terms of their preferred learning styles;
- What are their hopes and fears for the future;
- What are their social networks and risk settings
- What opportunities and resources are available to undertake BCC interventions

2. Step 2. Deciding on logistics for the assessment

Here, a specific action plan is developed with a clear timeline and communicated to relevant stakeholders. Key assessment focal points are identified (field staff, IPs and other), engaged and roles are defined and agreed; resources including budget are finalized and matched against the research/ action plan logistics. This plan should explain:

- Who should be involved in the assessment to get the best information
- What is the most suitable time to conduct the assessment in terms of availability of informants, staff (UNHCR and partners), transportation, weather, available facilities (interview rooms/technology etc) and interpreters if necessary
- How many days are required to conduct a full assessment? This includes the number of FGDs and interviews and time to conduct all site checks and observation.

Also in this phase:

- Assessment tools are distributed amongst relevant UNHCR field staff and partners who have been directly assigned to support the assessment as well as any interpreters so that they can become familiar with the questions before any interviews.
- A consent form is developed and tested (see annex 2)
- A letter, drafted in appropriate local language can be sent to the camp leadership (where appropriate- take advice from local UNHCR office or partner regarding the need for any such official correspondence (see annex 3)

3. Step 3: Final checks

This is an important step that any good program manager or logistician would never omit. This step is undertaken in the days leading up to the assessment. The action plan is carefully reviewed and all parties involved are contacted to make sure that everyone understands the process and that all agreed tasks are being carried out by relevant personnel. All assessment logistics (travel, appropriate technologies, camp pass etc) are confirmed.

4. Step 4: The assessment

Assessment is carried out based on the action plan (see annex 4, sample used in Thailand). Usually five full days are required to undertake a full assessment in one site. A number of 'high quality' informants are identified or traced during the first few days through KIIs, FGDs, IDIs and observation. For this reason it is highly recommended all FGDs and most KIIs and IDIs be completed during the first two to three days. This keeps the fourth and fifth days free of structured appointments and assists the assessor when scheduling new informant interviews particularly through IDI referrals and leaves time to deal with any unexpected changes that may occur in the schedule.

Important issues to consider:

- Make sure you have regular contact with informant organizers at the local level. It is most important to communicate clearly to all informants the place and time of the interviews. This will reduce any undesirable outcomes such as informants waiting for you in the wrong place.
- If possible, have a back up communication system with key contacts within the camp such as a satellite phone as mobile phones may not work in many remote camps. This will save a lot of time determining why an informant or a group is not there where/when you organized. However careful planning and clear communication should significantly reduce the likelihood of this.
- All appointments may not occur as planned for a myriad of reasons such as lack of transport, miscommunication, other commitments and varied understanding of punctuality and time by local organizers as well as informants. It is crucial to be in regular contact with local focal points and make sure you have sufficient informants for various activities planned.
- Situations where more than one KIIs or IDIs turn up at the same time is not uncommon. It is not recommended to undertake KIIs or IDIs with multiple respondents at the same time as the quality of information could be compromised if such situations occur. Rescheduling appointments with apologies and explanation is the recommended option (this is where the unstructured last two days is useful).

4.1 Engaging Interpreters

It is likely that in many camp settings you will need the service of an interpreter. Careful selection of interpreters is extremely important for a number of reasons:

- Their ability to interpret clearly and effectively
- Their ability to elicit interviewee's trust for the interview
- Their skills to transfer sensitive information without negatively affecting the interview process (for example, visible sign of discomfort when relaying information from the interviewee)
- Their understanding and commitment that all information must be confidential and not shared with anyone other than the interviewer
- Respect to interviewees irrespective of the nature of their information or opinion
- Their gender: this can be an important factor as some men may not be comfortable to share information with the interviewer in the presence of a female interpreter or vice versa.
- Camp affiliation of the interpreter. If the interpreter is a refugee, from the same camp where the assessment takes place, it may be difficult for the respondents to open up freely. This will depend on a number of factors including the level of trust that the interpreter has with the interviewee. *However, in the Thai assessment a refugee interpreter was engaged in an assessment in a Thai camp and the response was overwhelmingly positive. This was mainly*

due to the fact that this camp was large enough (over 40,000 people) to maintain anonymity and almost all refugees trusted and respected the interpreter.

- Ethnic differences and any historical conflicts or negative opinions: this is a crucial aspect when selecting interpreters. It is recommended to take advice from local focal points while selecting interpreters.
- Varying languages and dialects. Often many camps feature refugees from a variety of linguistic and cultural backgrounds. It is crucial to select interpreters who can communicate fluently with the interviewee. Again, discussing these aspects with key focal points who select informants and interpreters during the selection process can avoid undesirable outcomes.

5. Step 5: Data Analysis

Record all findings/data at the end of each day of interview/data collection. This will help avoid the possibility of losing certain key points that may not have been recorded during interviews.

Both data and method triangulation techniques were used to analyse information collected through the formative assessment conducted in Thailand.

Triangulation is a technique combining analysis from two or more sources of data which point toward a common conclusion. For example, three methods may indicate one conclusion while a fourth method indicates a different conclusion. It is likely that the first conclusion is the most reasonable one.

Triangulation should be done in two steps: first, data triangulation, and then method triangulation.

5.1 Data triangulation:

Data triangulation involves comparing data/information from all different informants or groups. For example you can compare information from all IDI participants and make a conclusion about a particular topic such as condom availability in the camp.

Sample: Data triangulation table				
	FGD 1	**FGD 2**	**FGD 3**	**FGD 4**
Target population's behavior Why practice a risk behavior? How to achieve a desired behavior?				
Social networks and risk settings Influencers of their decision-making.				
Opportunities and resources for BCC intervention What resources are available and required for BCC strategy?				

5.2 Method triangulation:

This is done once you complete data triangulation. This involves comparing and triangulating data from all the different methods such as KIIs, FGDs, IDIs and Obesrvation.

Sample: Method triangulation table				
	KII	**FGD**	**IDI**	**Observation**
Target population's behavior Why practice a risk behavior? How to achieve a desired behavior?				
Social networks and risk settings Influencers of their decision-making.				
Opportunities and resources for BCC intervention What resources are available and required for BCC strategy?				

Using the information that emerges from these triangulations, you can develop generalized statements answering the three key broad questions listed in Step 1.

6. Step 6: Key Findings

As data in a formative assessment are collected using qualitative methods the way in which data are presented will be different from an assessment using quantitative methods. Information is presented in a narrative form including statements and observations that create a picture of the behavior patterns of a group revealing its distinct themes so that appropriate BCC techniques can be developed and employed.

Key findings in the Thai - Myanmar border study

The following are the key findings from the formative assessment amongst the mobile male refugee population from the refugee camps along the Thai-Myanmar border.

Implications:

- *Peer group education strategies.*
- *Strategic distribution of travel kits with condoms, lubes and IEC.*

6.1 Mobility

- At least one third of the camp population goes outside the camp for work
- A significant number of males travel outside the camps for long periods of time, irrespective of their geographical isolation

> "a lot of men and boys go out and work from this camp. Men who are physically fit to work will go out and work as there is nothing much to do. I hardly know any households around here with someone not being away (for work) as we speak" (former health educator).

6.2 Social profile:

- Both married and unmarried men work and live away from the camps for a month or more at a time, including males as young as 13 years.
- The majority of men who work and live away for more than one month at a time (some up to 2 years) are between the ages of 16 and 40.
- More than half of the men interviewed had some education (grade 3-6); the rest did not have any education and were unable to write or read.
- Most non-student youth have very low levels of literacy and men who are in certain occupations such as the mahouts (elephant handlers) are unable to write or read.
- Most men interviewed had lived in the camp for an average of 12 years.
- Respondents religion varied but most were Buddhist, Animist, Catholic or Baptists.

6.3 HIV Knowledge

- Men and young males, particularly working young males in most camps lack sufficient information about HIV and AIDS to be able to protect themselves.
- A majority of young males did not know how HIV is transmitted and some believed mosquitoes could spread the disease.
- About half of the focus group participants and the majority of KIIs and IDIs were aware of persons with HIV in the community.

Implications:

- *IEC must be suitable for illiterate audience*
- *Strengthen STI/VCT referral systems including privacy.*
- *Develop or strengthen community based art projects on HIV and related discrimination.*

"Two years ago, we learned about condoms though a workshop in the camp. But they did not show us any condoms" male 23.

6.4 Community behaviour:

- Talking about sex/sexuality and sexual transmission of HIV is still a taboo subject in the camps. Religion is a major determinant in the behavior of most refugees in almost all camps in Thailand. Promotion and use of condoms is actively discouraged by influential camp leaders.

- However, there is a willingness from various segments of the community such as camp leaders and religious leaders to work towards building a community that is free from fear, stigma and discrimination.

6.5 Stigma

- Although some segments of the community, such as health workers, are aware of basic facts on HIV, there is a clear need for more information on HIV in many camps to better address the needs of PLHIV
- A number of people interviewed said that they were worried about people with HIV living in their neighborhood.
- HIV positive men interviewed in a northern camp said they are not at all comfortable disclosing their HIV status to anyone in the camp due to the fear of discrimination.
- Alleged discrimination against people living with HIV has been documented in one camp.
- Mae La is the only camp where HIV positive males expressed their intention to come out in public and support HIV-BCC activities.

6.6 Entertainment, substance use and unsafe practices

- Men use sex workers' services in major villages and towns
- Men who live in villages have access to cheap alcohol and sex.
- Alcohol is the preferred substance
- No injecting drug use was reported
- Refugee men pay sex workers 100-150 baht in villages and about 350-400 in Chiang Mai
- Tattooing is a common practice amongst a number of males, particularly non-student teens.
- Transactional sex is not uncommon in some camps but no known commercial sex premises in the camps.
- Male to male sex (MSM) reported within camps.

"Sometimes my friends bring girls to the hut (sex workers from local village) and they pay them 200-350 baht a night. Local Thai whisky is also available in the villages which is about 30-40 baht a bottle". Male 28.

Implications:

- *Develop targeted communication strategies for partner reduction, condom use and STI awareness.*
- *Improve awareness in schools re: dangers of sharing body piercing equipments.*
- *Strengthen safer entertainment opportunities in camps.*
- *Identify and support HIV advocates including PLHIV.*

6.7 Condom availability and use:

Availability and uptake of condoms, both inside and outside refugee camps were very low except in camps in Tak province which was significantly higher than other camps in Thailand.

6.7.1 Condom availability and use inside camp

- Access to condoms including information about how to use them is very limited in all camps except Mae La.
- There is a lot of resistance from various camp leaders who control the promotion of condoms particularly amongst unmarried people.
- A number of clinics and VCT facilities keep condoms under "lock and key". It was reported that staff often ask for the name, age and section details if people want condoms from clinics.

Implications:

- *Implement condom strategy: Improve condom availability and use; increase skills for consistent and enhance negotiation skills.*
- *Strengthen communication between relevant organizations to support condom strategy.*

"My husband often goes away for 2-3 months for work as we need money to support our family (five children, under 12 years). I have seen condoms but we never use them. I don't discuss these things (sex/condom) with my husband" (female 32, who had poor knowledge of HIV).

6.7.2 Condom availability and use: outside camp

- A number of men interviewed did not know that condoms are an effective way of preventing HIV and other STI's.
- Most working young males did not seemed concerned about the importance of consistent and correct use of condoms in order to prevent STI's.
- Condoms are reportedly available free of charge in most karaoke bars and commercial sex facilities in places like Chiang Mai, Pai and Bangkok. Also sex workers carry them, particularly Thai workers, and often insist on their clients using condom.
- However, in the case of villages where most men work, the reported availability and use of condoms was very low.

A number of large agricultural villages have commercial sex premises. "These discreet places (huts) are very basic and may have 3-8 people working - mostly from Burma. Not many people use condoms in theses places and certainly there is no information (HIV) available here"- (male 26).

6.8 Key individuals and organizations for future BCC intervention

- A number of influential leaders were consulted and or identified during BCC assessment missions (for details, see camp-specific BCC reports).
- Leaders included influential elders, camp judicial members (judge), camp committee officials, youth leaders, religious leaders and popular opinion leaders.

6.9 Available Facilities, Opportunities and Technology for BCC

6.9.1 Facilities

There are limited recreational facilities (art/sport/ physical activity) available in the camps and very limited youth friendly facilities available, particularly for non-student youth. However, facilities/ groups such as Men in Peacebuilding (MIP) in Ban Mai Nai Soi are a valuable avenue for targeted BCC intervention for young males.

6.9.2 Mode of communications

- Peer group education and word-of-mouth strategies were identified as the best option for communication amongst working men.
- Many men showed a willingness to learn more about HIV and be able to educate their peers.
- None of the HIV positive males interviewed were willing to talk about HIV to others due to

fear of discrimination and personal safety (except most PLHIVs interviewed in Mae La).

- Many key informants, young people and community health staff suggested that locally produced short documentaries would be a powerful way to reach many working young men both inside and outside of camps.
- There are no public TV news or entertainment facilities in most camps; radio is not a viable avenue for any BCC strategy in most camps as ownership is very low.

6.10 When to reach mobile males:

a) Before leaving school: Career or entertainment focused skills identification and training. Peer group training: identify and train them (include motivational, and retention strategies).

b) Before leaving camp: Most unmarried men do not inform many within the camp. Engaging youth-friendly organizations (Eg: MIP) and provide IEC/condoms can be effective. Also peer education and organizing targeted (16-28 yrs olds), section-based briefing program and introduction of Travel Kits*

Travel Kits:

The feasibility of developing travel packs targeting working refugee men should be explored. Handy travel kits could contain basic toiletries, condoms, lubricants , lists and how to access relevant services and facilities (clinics, VCT, Condoms), HIV services both in and outside camps and IEC including DVDs that are suitable for a population with low literacy levels. Kits can be designed to conceal condoms. Consideration should be given to other 'travel kit' ideas by organizations such as IOM.

c) When returning to camp: Community art events during selected festivals (varies) and films shows can be very popular. Community artforms to focus on reduction of stigma/ discrimination through real life stories. Note: a number of refugee males do not attend these festivals due to their work commitments (usually seasonal) and fear of getting caught by Thai authorities.

d) Out-of-camps: Peer group education is most suitable and outreach education where possible could be effective as well. Active involvement of PLHIVs where possible would be a great advantage to IEC, referral and care strategies. Outreach activities may include use of short presentations with support of relevant IEC/Video/experience sharing and distribution of DVD/ IEC (targeted prevention and direct messages Eg. How to use condoms, condom negotiation skills and promoting treatment, care seeking behaviours). Identify local health community organizations outside camps and assess their interventions' impact on refugee men.

7. Step 7: Feedback to key partners and leaders

Although this step is technically the last step of a formative assessment it is a crucial step and yet it is often overlooked by many BCC programme planners. It is important to share key findings with your program partners, leaders and appropriate target representatives so that they feel included in the process. It is crucial for them to play an active role in the BCC strategy development, implementation, monitoring, evaluation and maintenance of BCC activities.

8. Step 8: Target Segmentation and Refinement

It is always good practice to refine your target group before developing specific communication strategies and messages. Here, the target groups are segmented and analyzed in detail based on their risk factors (current risk behaviours identified).

For example, target segmentation based on the formative assessment in Thailand identified males between the ages of 18-28 (working males) as the primary target for BCC interventions along with students 16 and over currently attending school.

9. Step 9: Development of a BCC Strategy

During this step it is important for BCC program planners to engage key partners, representatives from the primary target as well as key gatekeepers before developing an action plan with an M and E component and clear, realistic budget and timelines.

Here, the findings of the formative assessment are used to design a BCC strategy that clearly identifies:

- Risk factors (current risk behaviors, attitudes and environment)
- Behaviour change objectives (desired behaviours)
- Barriers and positive influencers
- Communication channels and media
- Behaviour change communication objectives (how to achieve desired behaviours through communication)
- Intervention strategies (peer educators, training camp leaders)

Although the scope of the assessment did not include the further step of a full BCC strategy a strategic framework was developed (see annex 17) that explains key aspects of an effective BCC strategy for implementation.

The BCC strategy needs to explain:

- The importance of developing a creative strategy: development of messages, images and themes that clearly resonate the feelings, needs and behaviors of the target group through careful pre-tests;
- A distribution strategy that details the best way to reach the audience (when/where/how/how often) that are identified in the formative assessment; and
- A monitoring and evaluation plan to track the progress.

It is also important to take account of target populations hopes, concerns and aspirations that can help improve impact of messages and motivational themes during communication.

For example, a remarkable sense of hope, confidence and drive for the future was observed amongst the target group in most camps in Thailand. This is a good opportunity for communication planners to develop messages that resonate with the target group's motivation to make the 'shift' and adopt positive, health seeking behaviors.

10. Limitations of the assessment

Due to time restriction it was not possible to visit certain villages to observe and verify the information shared by informants.

11. Conclusions

There was very little information available regarding mobile refugee males' HIV knowledge, attitude, and behaviours. Formative assessment conducted in Thailand show that about one third of refugees travel outside their camps, mainly to work, a majority of whom are males who often live away from camps for long periods (one month or more). A set of essential, ready-to-use tools such as interview guides will help assessors save significant time and resources. A strategic framework, developed based on the formative assessments illustrates how assessment findings are used in the development of subsequent BCC interventions.

Useful resources for BCC intervention planning and implementation

- FHI through its AIDSCAP project developed a series of useful handbooks on behavior change and HIV. These can be downloaded from: http://www.fhi.org/en/HIVAIDS/pub/guide/BCC+Handbooks/index.htm

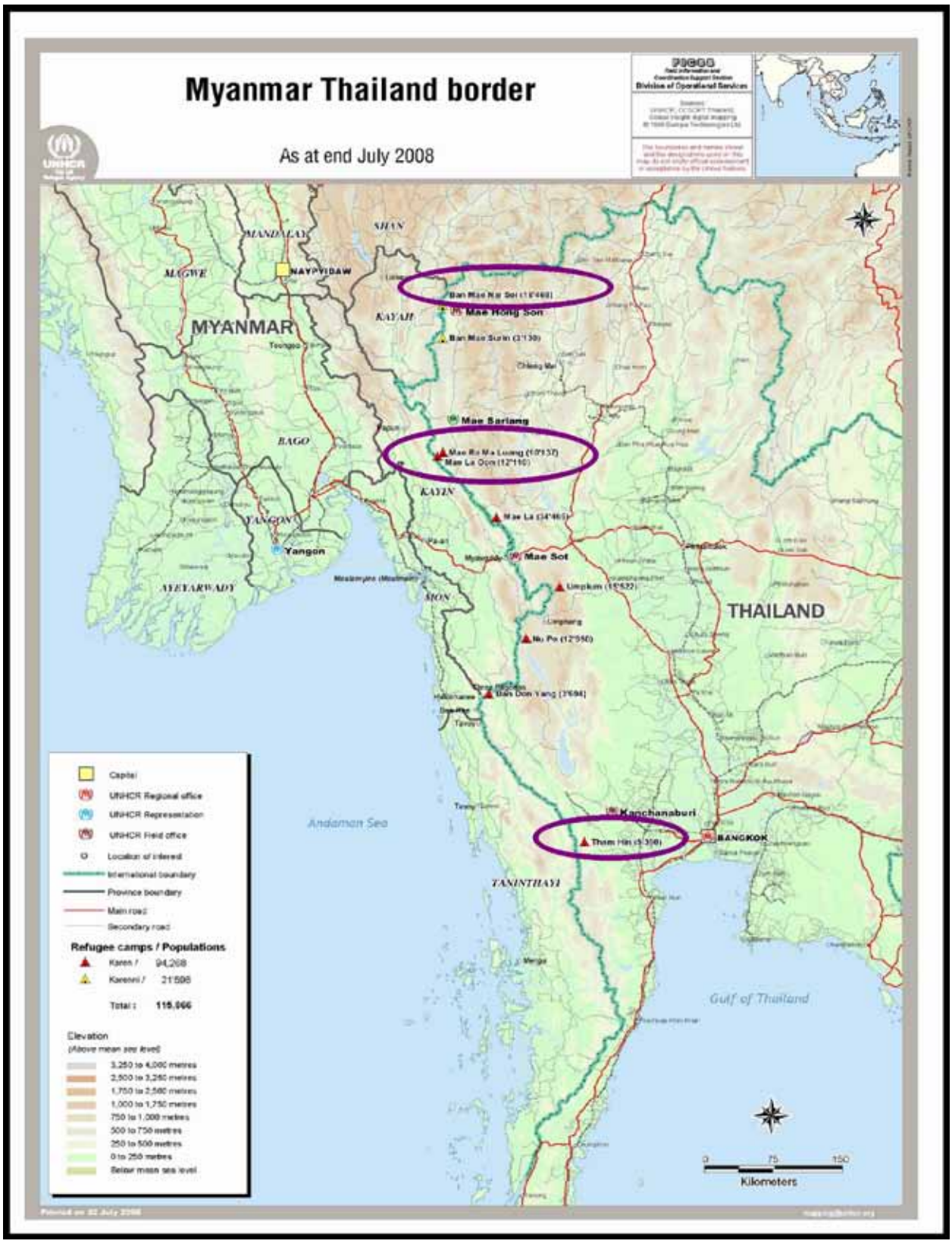
- *Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences* by FHI can be found: http://www.fhi.org/en/HIVAIDS/pub/guide/lowliteracyquide.htm

- Migration Away from HIV: Flip-book developed by FHI India. This can be adapted to suit mobile refugee males.

- Two detailed camp-specific BCC reports from Thailand (Mae La and BMNS) are also useful as they clearly identify specific characteristics of target groups as well as BCC barriers and enablers.

ANNEXES

ANNEX 1:
MAP, MYANMAR-THAI BORDER REFUGEE CAMPS



ANNEX 2: CONSENT FORM: FORMATIVE ASSESSMENT INTERVIEWS

My name is _____and I work with UNHCR. I would like to have a chat with you to understand a bit more about the health services in this camp, particularly related to HIV and sexual health. Although I work with UNHCR, and there will be some questions about people going outside of the camps, we have NO interest to identify anyone who leaves the camp, nor do we have any involvement with resettlement. The information you supply will be confidential. Based on the information you give us, we will be able to plan the best way of providing the community with HIV information and services.

Our discussion should last for about: 60 to 90 minutes (focus groups)
45-60 minutes (KII & IDI)

This is my colleague _____who is here to help us communicate better (interpreter).

Consent

I am now going to provide you with some information about your rights during this focus group discussion.

- You do not have to participate in the discussion if you do not want to.
- I cannot offer you anything for choosing to talk with me. Whether or not you choose to talk with me will not have any effect on the services you receive here.
- Anything you choose to share with me will be treated confidentially by myself and my colleagues, without identifying anyone.
- As we talk I will write down your responses but I will not use your name.
- You not have to answer every question.
- If at any point you decide you no longer want to participate in the discussion, you are able to leave.

Do you agree to answer some questions today?

[IF NO] I understand that you don't want to talk with me today. Thank you for your time.
[IF YES] Thank you for your willingness to talk with me. Do you have any questions before we get started?

Please remember, there is not right or wrong answer…I would like to hear your views, whatever they are! I will be helping to guide the discussion and make sure everybody has a chance to speak.

ANNEX 3:
SAMPLE LETTER OF REQUEST TO CAMP LEADERS

(Note: translate to suitable local language)

Dear ……..camp leaders/name if available,

Re: request HIV vulnerability assessment in (name) camp

During my recent visit to MHS we discussed the possibility of doing an assessment of HIV vulnerability amongst males in the (name) camp. The assessment will assist UNHCR to develop and implement a Behaviour Change Communication strategy to improve the HIV-related information and other services within camps, particularly targeting males. We anticipate that it will take a full five days to conduct the assessment in (camp name).

We hope to organize a number of focus groups and individual interviews during (dates).

It is proposed that,\ similar assessment will be undertaken in (number) other camps (specify area).

I ask your cooperation and support to carry out this assessment. Please note, the information we collect will not have any identifiable information of any individual or group and any information collected will be used for developing HIV-related information and other services within camps (specify area).

Thank you for your support,

Yours sincerely,

Name/designation/contact details/ Date

ANNEX 4: SAMPLE, ASSESSMENT SCHEDULE

Proposed schedule:
Behaviour Change Communication (BCC) Formative Assessment amongst men and boys in refugee camps, Thailand.

Overall goal: Improve HIV services to refugee men and boys.
Camp name and date/s

Kindly identify, recruit/organize following informants and male/female interpreters.				
Data collection	**Participants**	**Approx. time required**	**When**	**Other comments**
1. Informal meetings	1. informal discussion with the camp committee (group)	20 to 30 minutes	Day one	Preferably the first thing. Main purpose is to introduce the study and gain support.
	2. Informal meetings with one or two Religious and/or key opinion leader who are influential in the community (individual meetings)	20 to 30 minutes each	Day 1-3	Main purpose is to introduce the study and gain support.
2. Focus Group Discussions. 6- 8 members in each group.	1. Boys about to finish schooling **(16yrs-18 yrs)** 2. Boys outside of school system **(16yrs-18 yrs)** 3. Young males **(18yrs-24 yrs)** 4. Men **(25yrs-40yrs)** 5. Community Health workers **(male and females)**	90 minutes each	Ideally in the first two days	Primary data source as well as lead for possible IDI/KII. ***Ideal*** *if participants have first hand experience, living outside camps for longer periods.* ***Please arrange a suitable space for confidential group meetings***
3. Key Informant Interviews (KII)	Interview 6-8 persons who have very good knowledge about one or more males (men and boys) who leave camps for one month or more.	45- 60 minutes each	Ideally in **the first two days**	Primary data source as well as lead for possible IDI's /KII's. ***Please arrange space for confidential meeting.***
4. In-depth Interviews (IDI's)	1. Two-three HIV positive males (16-40yrs) 2. Two-three female partners of men who work/live outside camps (a month or more at a time) 3. Three- four men/boys who worked/lived outside camps for one month or more.	45- 60 minutes each	Ideally during Day 3/4	In-depth data. ***Please arrange space for confidential meeting.***

ANNEX 5:
CHECKLIST FOR DEVELOPING ASSESSMENT QUESTIONS[1]

Target population's characteristics

Knowledge:

- What is the level of awareness on HIV and AIDS?
- What is the level of awareness on existing products such as condoms?
- What is the level of awareness on existing services such as VCT?
- What is their familiarity with PLHIV?
- Do they know any PLHIV?

Attitudes and values:

- What is the perception of risk in this group?
- What are their perceptions of existing products, services, information?
- What do they think about PLHIV?
- What is their view of living in a community with PLHIV?
- What has been society's response to HIV and AIDS?
- What kinds of HIV and AIDS related stigma are there?
- What kinds of HIV and AIDS-related discrimination are there?
- What are the prevailing/positive/negative attitudes about HIV and AIDS?
- What standards for sexuality are considered normal?
- What values relative to HIV and AIDS should be considered when developing a BCC strategy?
- What are their concerns in relation to condom provision, sex education for unmarried people?
- What other barriers exist in terms of HIV service provision

Habits:

- What are their entertainment/ leisure activities?
- What media or technology do they use?
- Where can you find them individually or as a group?
- How long have they lived in the area?
- How often have they lived away from camp?
- For how long at a time?

Educational and social:

- What is their educational level?
- Are they married?
- Do they follow any religion?
- What is their socio-economic status?
- What sort of work do they do?
- What is their age-group
- Do they attend organised events, functions or associations?
- Who do they spend time/ travel with?
- Who do they discuss topics such as HIV/ sex with?
- What is their favorite event/festival/ceremony in the camp?
- What is the best time to reach them?

1 Adapted from Family Health International

What is their current behavior?

- What is the sexual behavior of this group?
- What is its risk behavior?
- Where does the risk behavior take place?
- How often?
- What events or conditions typically lead up to the behavior?
- What other behaviors are associated with the high-risk behavior?
- How are decisions made in risk situations?
- Why do they practice the current behavior?
- What are their condom use patterns (in and out of camp)
- What is their behavior relative to abstinence and fidelity?
- Who are their sexual partners? How do they meet them?
- What are their drug/alcohol practices?
- Any other risky practices such as tattooing?
- Where do they go for information on HIV/STI?
- Where do they go for care when sick?

Change to the desired behavior:

- What desired behaviour is feasible for this group?
- Why might they be motivated to change? (cues to action)
- What might facilitate change?
- Who are the positive influentials among them?
- What sort of message do they respond to?

Fears and aspirations:

- What are their fears, hopes, and plans for the future?
- What are their principal concerns?
- What are their priorities in life?
- How happy are they- work and camp?

Networks:

- What are the risk situations for HIV?
- Who are their sexual partners?
- How are sexual encounters held?
- How are sexual partnerships made?
- What influences decision-making during risk situations?
- How do peers influence decision-making?
- How do media influence decision-making?
- What else influences decision-making?
- Which individuals or groups comprise the social network of this population?
- Is there a specific person or group with great influence, authority or power?
- Who else influences their behavior?

ANNEX 5: (CONT.)
CHECKLIST FOR DEVELOPING ASSESSMENT QUESTIONS

Target population's characteristics

Key individuals, groups and opportunities for BCC:

- Who are the influential people in the community?
- Who are the advocates in the community?
- Who are the key opinion leaders in the community?
- Who are the gatekeepers in the community?
- What is the level of awareness of each group?
- What are the opinions of each group about HIV and AIDS?
- What are their involvement in HIV service provision, if any?
- What are their opinions of UNHCR and other IPs?
- What group or community associations can help with the BCC intervention? (women's group, men's group, youth group, PLHIV)
- Where are they located?
- What can be done to get their support?
- Any talented persons/group available to support any BCC interventions?
- Any PLHIV willing to support BCC intervention?
- If yes how can they support at what level?

Facilities:

- What facilities can help the BCC intervention (health services, schools, church, transport)?
- Where are they located?
- What leisure activities take place in the community?
- Where do they take place?
- How can they be accessed?
- What condom distribution facilities are available?
- Where facilities are available for meetings, IEC distribution and campaigns?

Other resources:

- What kind of HIV/sex education is available for youth and men?
- What kinds of existing BCC materials are available?
- Who provide these materials and how often?
- What is the appropriateness and quality of these materials to refugee males?
- Do they have easy access to condoms and needles: inside and outside camp?

Media and communication:

- What radio and television stations are there?
- What are the community listening patterns?
- Viewing patterns?
- What print media exist?
- What other communication technologies are there such as phone/mobile?
- What movie/video facilities are there?
- What alternative media are there?
- What theater/art groups performers are there
- What is their interest in and response to alternative media?
- What are the costs/rates/accessibility for each?
- What are their preferred ways to receive information on HIV/STI?
- Who owns what media?
- Describe media capabilities? Costs? Accessibility?
- Publishing? Printing? Video production, Advertising agencies?

ANNEX 6:
KEY INFORMANT INTERVIEW (KII) GUIDE 1:
Camp committee/ Popular Opinion Leaders other local leaders/men's/women's organizations.

Record: Age, educational level, marital status, practice faith/religion, profession/skills.

Part A (general questions) ***Note whether the interviewee is new or a participant from other interviews or Focus Groups. If not new, acknowledge/ skip relevant questions (part A) and continue.***

1. How long have you lived in this camp?
2. If you have a health concern where do you go for information and treatment? Who do you speak to?
3. Have you ever heard of HIV or AIDS? Can you tell me a bit about HIV/AIDS?
4. Are you aware of any HIV-related services that are available in the camps? Probe: HIV information, condom, VCT, PMTCT, HIV care, support and treatment?
5. If people wanted information about HIV where do they go?
6. I do not want to know anyone's names, but do you know of people who have HIV?
7. What does the community generally think or say about people living with HIV?
8. What do you think of persons that have HIV?

We are particularly interested in how we can provide information and other HIV services to people that move in and out of the camps, especially men and boys.

9. I don't want to know names but can you tell me a bit about the men/boys that leave the camps? (Prompt: How old are they? Are they married?)
10. When they go away from the camp, do they usually plan for some time before leaving?
    a. Do they discuss their travel plans with anyone?
    b. When they leave the camps where do they go?
    c. Why do they go?
    d. Do they travel with anyone?
    e. How do they get there?
    f. What sort of work do they do?
    g. How long they go for?

11. Do they maintain communication with home/camp? If yes, how? Prompt: access to Mobile phones.
12. When they come back to the camp how long do they stay for?

Part B (target specific questions)

13. Do you think men who travel away from home for long periods of time could be more at risk of getting HIV? If so, why do you think they may be more at risk?
14. What do you think can be done to reduce the spread of HIV, particularly amongst men and youth? Probe: providing more information and education about HIV? Providing access to HIV services such as HIV counseling and testing? Providing access to the means to prevent HIV transmission such as male and female condoms?
15. Do you know if men/boys have access to any HIV services mentioned above, whilst outside the camp?
16. Do you think it is difficult for people to obtain above services in this camp? If so why? Prompt: barriers (information/VCT/condoms) - shame/ fear/lack of information.
17. Do you know how we can improve the above services here? Prompt: how to overcome those barriers.
18. If you would like to improve HIV prevention in the camp, who do you think should be provided with information and services relating to HIV?
19. What do you think is the best way that information could be given out, particularly men and youth? Probe: what are the best ways to convey information e.g. written information, comic books, games, films, radio, street theatre, Mobile phones?
20. What are the best times to reach men/youth who are outside of the camps? Are there particular times of the day or the year when they are more likely to come back to the camps e.g. festivals or other community events?
21. What can you do in your very influential role here to reduce HIV transmission in the camp?
22. Do you have any other concerns about HIV education and information being provided in the camp?
23. Do you know anyone here (in the community) who you think would have knowledge about men/boys who leave the camps for work? (note those leads for KII or IDI).

That's all from me. Do you have any questions or comments before we finish?

Thank you very much for your valuable input and time.

ANNEX 7:
KEY INFORMANT INTERVIEW (KII) GUIDE 2:
Interview Guide: Religious Leaders

Informal introduction and open discussion

Welcome, personal introduction followed by introduction of the 'assessment' aimed at improving HIV/AIDS services within the camp.

1. Please tell me a bit about your role in this camp. Also prompt: how long have you lived or associated with this camp
2. Have you ever heard of HIV or AIDS? Can you tell me a bit about HIV/AIDS?
3. If people wanted information about HIV/STI where do they go?
4. I do not want to know anyone's names, but do you know of people who have HIV?
5. What do you think of persons that have HIV? And what does the community generally think or say about persons that have HIV?
6. Do you see any role for yourself/your religious group (name religious groups) in preventing and responding to in the camp? If so what would that role be?
7. Do you have any concerns about HIV education and information being provided in the camp?
8. In order to improve HIV prevention in the camp, who do you think should be provided with information and services relating to HIV?
9. Would you recommend anyone in this community whom I should talk to who you think would be able to support HIV services here? (note possible leads).

That's all from me. Do you have any questions or comments before we finish?

Thank you very much for your valuable input and time.

ANNEX 8:
FOCUS GROUP DISCUSSION (FDG) GUIDE 1:
FOCUS GROUP QUESTIONS (<18yrs: student and non student groups)

Record: Age, educational level, marital status, practice faith/religion, profession/skills

1. How long have you lived in this camp?
2. If you have a health concern where do you go for information and treatment? Who do you speak to?
3. Have you ever heard of HIV? Can you tell me what HIV is?
4. Have you ever heard of AIDS? Can you tell me what is AIDS? *Probe; how is AIDS different from HIV?*
5. Can you tell me how HIV is spread? How can HIV NOT spread?
6. Are you aware of any HIV-related services that are available in the camps? *Probe: HIV information, condom, VCT, PMTCT, HIV care, support and treatment?*
7. If people wanted information about HIV where do they go?
8. I do not want to know anyone's names, but do you know of people who have HIV?
9. What does the community generally think or say about people living with HIV?
10. What do you think of persons that have HIV?

We are particularly interested in how we can provide information and other HIV services to people that move in and out of the camps, especially men and boys.

11. I don't want to know names but can you tell me a bit about these men/boys that leave the camps? (Prompt: How old are they? Are they married?)
12. When they go away from the camp, do they usually plan for some time before leaving?
    - 12.1 Do they discuss their travel plans with anyone?
    - 12.2 When they leave the camps where do they go?
    - 12.3 Why do they go?
    - 12.4 Do they travel with anyone?
    - 12.5 How do they get there?
    - 12.6 What sort of work do they do?
    - 12.7 How long they go for?