



# Learning, Sharing to Action:

HIV/AIDS prevention among  
young people in South Asia

# Learning, Sharing to Action: HIV/AIDS prevention among young

## A publication of UNICEF ROSA

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# Foreword

Two decades of fighting the HIV/AIDS epidemic have shown that complacency is a deadly mistake, and dedicated actions against HIV/AIDS yield positive results. Countries such as Brazil, Cambodia, Thailand and Senegal have provided the world with enough evidence that it is indeed possible to reduce HIV infection rates. Success stories come from countries with both low and high HIV prevalence. We have also learned that young people and people living with AIDS are the most powerful, still untapped resources, for fighting the HIV/AIDS epidemic.

Examples of outstanding committed leadership, of effective community-based programme interventions and of school based programmes abound. Advocacy tools, training manuals and information material dealing with HIV/AIDS are already available in abundance. Global and regional networks have been formed and electronic forums established.

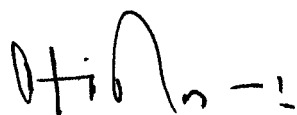
But too little is still known about the majority of programme interventions in South Asia, the strategies used and the lessons learned on what has worked and what has not. This document is an effort by UNICEF ROSA to partially redress this gap, and to promote south-south exchange of lessons learned in the region on programming for young people.

This Publication is a compilation of twenty six programme interventions, including eight in-depth case studies. It is designed to serve as a resource for policy makers, programmers, advocates, community organisations, UNICEF staff and partners.

None of the programme interventions described in this Working Paper is by any means perfect. On the contrary, they are 'work in progress', still struggling with unresolved challenges and shortcomings. Yet they reflect impressive track-records of innovation and achievement from which lessons can be drawn to inform and guide those involved in programming for young people.

This Working Paper draws on the research, analysis and experience shared by a number of individuals and organisations. Many have contributed to the compilation of this document. My thanks to all of them, in particular to the organisations which allowed UNICEF to document their work. Without their cooperation, this document would not have been possible.

I do hope that this Working Paper would contribute to our commitment and efforts to act now to protect South Asia's young people from HIV infection and to secure their future.



Sadig Rasheed  
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May, 2003

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#### CD Rom

Review of 18 Programme Interventions from the Region

List of Web-based Reference Sources on HIV/AIDS Prevention and Care among Young People

Report of South Asia Regional Forum for Young People on HIV/AIDS, Kathmandu, 15-18 December 2002

Proceedings of the South Asia High Level Conference: 'Accelerating the Momentum Against HIV/AIDS in South Asia' Kathmandu, 3-4 February 2003

Issues Papers:

Paper 1: Accelerating the Momentum in the Fight Against HIV/AIDS in South Asia: An Overview Paper

Paper 2: Lack of Education in South Asia: the Devastating Liability to Combating HIV/AIDS

Paper 3: HIV/AIDS related Discrimination and Stigma in South Asia: A Violation of Human Rights

Paper 4: Gender-based Violence, Sexual Abuse and Exploitation in South Asia increases Risks and Vulnerability to HIV/AIDS



## Section One

# Background and Rationale

## Background and Rationale

Young people<sup>1</sup> are at the centre of the global HIV/AIDS epidemic. It is no different in the countries of South Asia, where the HIV/AIDS epidemic disproportionately affects young people. Compared to other regions, however, the HIV prevalence in the countries of South Asia remains low. The window of opportunity, through which a major health, social and economic catastrophe can be averted, is still open. Rapid acceleration and expansion of HIV/AIDS prevention activities amongst, with and by young people in the countries of South Asia is the most powerful force against the epidemic.

Though increasing attention is being paid to HIV prevention among young people, the pace of implementation, however, is not keeping up with the spread of HIV infection. At the recent South Asia Regional Forum for Young People in Kathmandu, forty young people from the countries in the region developed country specific action plans, asked for immediate action through the outcome document they adopted: Young People's Call for Action 'Young South Asians Assert their Rights'<sup>2</sup>.

This Call for Action, in which young people demanded the fulfillment of their rights to protect themselves from HIV/AIDS was presented at the South Asia High Level Conference 'Accelerating the Momentum in the Fight Against HIV/AIDS' which took place in Kathmandu from 3 to 4 February, 2003. During this Conference, children and young people reminded Governments in South Asia of the commitments already made to prevent a major epidemic at international and

We, the participants, commit to:

- Speak out and break the silence and denial on HIV/AIDS and stop the stigma and discrimination. Leadership at all levels should use every opportunity, including working with the most vulnerable groups and young people, to openly discuss the issues surrounding the spread of HIV/AIDS. This should include issues of gender inequalities and human rights violations, especially the abuse and exploitation of women, and young girls and boys, which fuels the epidemic;
- Accelerate actions at the national level to meet the goals and targets set in the international, regional and national commitments, specifically actions to ensure that there is equitable access to prevention, care and support services, including voluntary counselling and testing, particularly for the vulnerable and young people in South Asia;
- Giving special emphasis to widen and facilitate educational opportunities in the pursuit to educate all as a key to combat HIV/AIDS, development and quality of life;
- Accelerate actions to address the main determinants of the rapid spread of the epidemic such as stigma and discrimination, gender inequalities, poverty, illiteracy, lack of awareness, inaccessibility to services and non-fulfilment of human rights;

Excerpt from Outcome Document of South Asia High Level Conference: 'Accelerating the Momentum Against HIV/AIDS in South Asia'. Kathmandu, Feb.2003

regional fora. They presented their concerns and requested to be equal partners in the accelerated fight against HIV/AIDS. The conference participants comprising of ministers, policy makers, religious leaders, young people further reaffirmed their commitments to meet these needs.<sup>3</sup>



In most countries of South Asia, national programmes are in place and a number of programme interventions for young people are on-going. Task forces and working groups on young people have been

At the United Nations General Assembly Special Session on HIV/AIDS in June 2001, Heads of State and Government committed themselves to meeting a number of key goals to diminish HIV prevalence among young people aged 15 to 24. These include:

- Reducing HIV prevalence among the young by 25 per cent in the most affected countries by 2005, and by 25 per cent worldwide by 2010.
- Ensuring that young people have the information, education, services and life skills to reduce their vulnerability to HIV, reaching 90 per cent by 2005 and 95 per cent by 2010.

Additional goals address gender discrimination and the problems of young people who are especially vulnerable. A complete list of the goals is available at [www.unaids.org](http://www.unaids.org), the website of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

formed in some countries by NGOs and UN agencies to share information, strengthen and upscale programming in this critical area. Some effective prevention work is being done, and a number of 'best practices' have been identified.

The need for sharing of experiences and lessons learned has been expressed at many regional and country fora. Some of the work being done in the region have been included in 'best practice' publications.<sup>4</sup> But, there are many more programme interventions about which we know too little. These can offer useful lessons on effective strategies and operational

issues related to the planning and development processes as well as on monitoring and evaluation.

In consultation with UNFPA Country Support Team for Central and South Asia, the UNDCP Regional Office for South Asia, WHO Regional office for South East Asia and working through UNICEF country offices, twenty six programme interventions for and by young people were identified. These illustrate a wide spectrum of programme components and approaches were identified. The selection of the interventions was made on the basis of jointly agreed criteria related to the four essential components of HIV/AIDS prevention and care, namely: information, skills, services and a supportive environment. The selection also takes into account the extent to which the programme interventions reflect internationally agreed good practice in the key areas of life skills based education and 'adolescent friendly' health services.<sup>5</sup>

The compilation process, which does not claim to be exhaustive, was constrained by the limited documentation available on the planning and development processes of the interventions. Few of the interventions had monitoring and evaluation data to provide sufficient evidence for conclusions to be reached on the effectiveness of approaches used and on results achieved. Despite these constraints, the majority of the interventions reviewed have been found to have lessons to offer which can inform and guide programming in the region. Opportunities have been identified for integration of HIV/AIDS prevention into on-going interventions which have adopted a holistic approach to young people's, in particular to girl's overall development and

empowerment. Reflections on what did not work may have value for others involved in planning and in the development of interventions.

This document focuses exclusively on analysis of HIV/AIDS prevention work being done in the countries of South Asia while drawing on experiences and lessons learned in other regions. It is designed for use by policy makers, programme planners and administrators, who are interested in or are already promote the sexual health and overall development of young people from:

- Ministries of Health, Education, Information, Youth Affairs, Social Welfare and related departments at district, state (or provincial) and national levels;
- Non-government organisations, community groups, faith-based organisations, institutions, activists and the mass media. All who are concerned about issues of social development, human rights, gender discrimination, young people, HIV/AIDS, and sexual and reproductive health.
- UN agencies, international NGOs, and funding agencies with an interest in providing financial or technical assistance to programmes, especially interventions aimed at HIV prevention among young people, in the South Asian region.

The document starts with an overview of the epidemic in South Asia and how it affects young people. It looks closely at the principles and global lessons learned which guide the strategic approach and programming for HIV/AIDS prevention amongst young people. The main body of the document comprises of a documentation and in-depth analysis of eight case studies – one from Bangladesh, three from India, three from Nepal,

and one from Pakistan. Attached to the document is a CD ROM containing a descriptive review of the remaining 13 programme interventions. Initiatives that have been covered in other 'best practice documents are not included. An annex comprising of programming guidance notes and principles entitled 'At Glance ...', as well as sources for further reference is attached.

## Young People and HIV/AIDS - The Facts

### The Context

Almost 1 million people in Asia and the Pacific acquired HIV in 2002, bringing the number of people now living with HIV to an estimated 7.2 million – a 10% increase since 2001. Current UNAIDS/WHO projections suggest that more than 40% of the estimated new infections between 2002 and 2010 will occur in Asia and the Pacific.<sup>6</sup>

The potential for a major epidemic in the region cannot be underestimated. Several socio-economic factors which make people vulnerable to a large scale epidemic, such as poverty, low levels of literacy, gender inequality, increased mobility, exist in all the countries of the region. Surveys have indicated that, unsafe sexual and drug use practices and sexual networking, which increase the risk of infection, are well established in the region. Sexual transmission is the main mode of HIV infection in all the countries of the region.

Certain areas in some countries are already experiencing rapid infection rates. In India an estimated 3.97 million people were living with HIV at the end of 2001 – globally the second largest number after South Africa. But India's national adult HIV prevalence rate of less than 1%,

for example, offers little indication of the serious situation facing the country. In countries such as Bangladesh, Nepal and Sri Lanka, there are rapidly developing local epidemics among vulnerable groups.

If left unchecked, concentrated epidemics affecting only a few individuals can rapidly develop into more generalised one as it happened in Indonesia and is increasingly happening in Nepal (Figs.1 & 2). In Thailand it took less than four years for the epidemic to shift from groups at risk to the general population.

### The Facts

Globally, there are increasing infection rates among younger people and in particular among young girls. UNAIDS reported at the end of 2002, six thousand new infections daily among young people. Available data from India, Nepal and Pakistan suggest that new infections are occurring increasingly in young people below the age of 29 (Figs. 3 & 4).<sup>7</sup> This has serious implications for countries in the Asian region where approximately 54% of the population is below the age of 25.

Young women in particular are vulnerable because of their lack of information, low social and economic status as well as the norms of femininity that make it important for girls to appear inexperienced in sexual matters. The average age of marriage in Nepal, Pakistan and in the northern states in India is 14 –18 years when the immature cervix and genital tract are more susceptible to sexually transmitted infections.

In India of the 25 million live births each year, 16 percent are those in adolescent girls between 15 and 19 years. In some states in India, up to 85% of women attending antenatal clinics are below 20 years of age, indicating something of where the future burden of the epidemic will lie<sup>8</sup>. Evidence from a study in India indicates that young women who are being infected are increasingly those within the context of a monogamous relationship.<sup>9</sup> All this puts young women at increased risk of infecting themselves and their babies.

Denial of adolescent sexuality and a reluctance to discuss sex and sexuality leads to inadequate provision of young people-centred information and services. These are

Fig.1: Indonesia:after years of silence

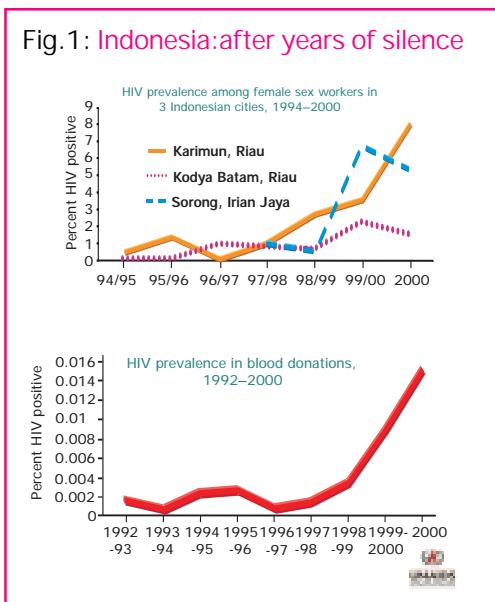
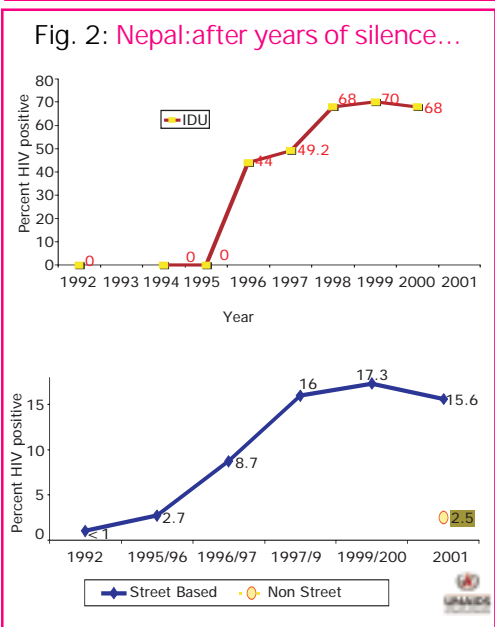


Fig. 2: Nepal:after years of silence...

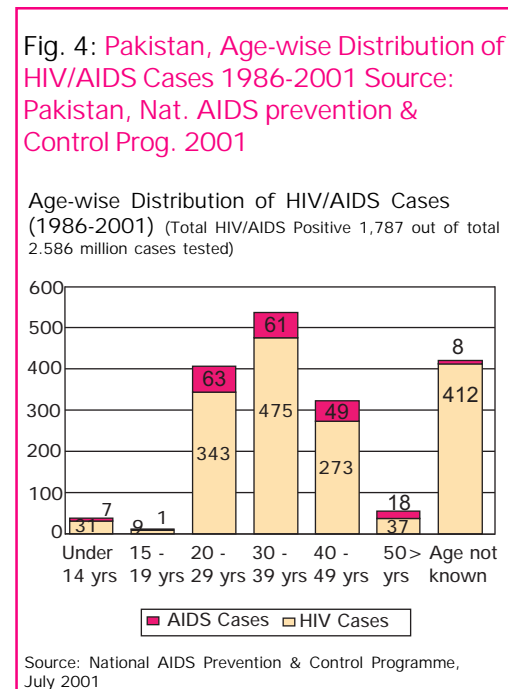
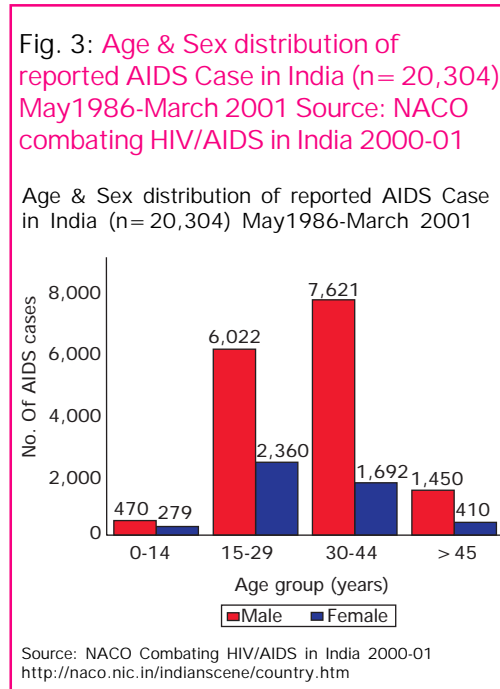


among some of the factors that make young people vulnerable. Available data suggest that the magnitude of adolescent sexual behaviour is significant. In rural Maharashtra, a 1998 study among married adolescents reported premarital sex among 48% of boys in the study population.<sup>10</sup> Another study among 450 students in 15 Mumbai schools found that at least 13% between ages 12 and 15 had sexual experiences of these over 75% had more than one partner.<sup>11</sup> The findings of a Family Health International study in Nepal in 1996 revealed that 43 % of sex workers were married when they were less than 15 years of age; 21 % had their first sexual intercourse before the age of 16 and 12 % before the age of 12. Condom use in such relationships remains the exception rather than the norm.

Risk to infection is also increase through young people in Nepal, India, Pakistan and Bangladesh turning more and more to drug use particularly to injecting drug use. Recent data from a rapid situation

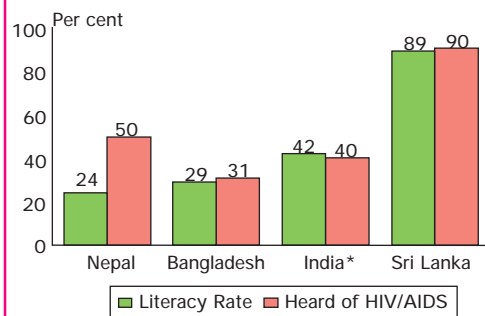
assessment in India on drug use shows that the age of onset of drug use in various cities ranged from 15 to 18 years.<sup>12</sup> Half of Nepal's 50,000 drug users, including non-injecting drug users, are in the age group of 16-25. HIV prevalence shot up among injecting drug users in Nepal from 2.2% in 1995 to 50% in 1998 and in Kathmandu to 68% by 2002<sup>13</sup>. Infection has spread to non-injecting sexual partners.

Awareness levels remain relatively low in most countries of the region and even where awareness levels are shown to be high as in India, misconceptions regarding transmission and prevention abound. Behavioural Sentinel Surveillance data, 2001 from India indicate that though overall 76% had heard of AIDS only 46.8 % in the entire country were aware of the two important methods of prevention.<sup>14</sup> In Bangladesh, 86 per cent of married girls between 15 and 19 years don't know how to protect themselves.<sup>15</sup>



**Fig. 5: Literacy and awareness of HIV/AIDS among ever-married**

women 15-49 years in selected countries of South Asia<sup>15</sup>



Note: \*Awareness data for India is for married women

In areas hard hit by the epidemic, AIDS is likely to become the leading cause of death among young adults. HIV in India is already one of the two largest and growing causes of death.<sup>16</sup> Children may become the household's only breadwinners if working-age adults are sick. Exacerbated by gender stereotyping, girls are likely to be kept at home to care for sick relatives, or to do housework. This is serious enough in countries where the gender gap is slight, but in South Asia it compounds existing inequalities in the uptake of schooling by girls. Though the precise numbers of individuals as yet affected within the region is unknown, and more research is needed, there can be no room for complacency in this respect.

### HIV/AIDS Prevention has Worked – The Evidence

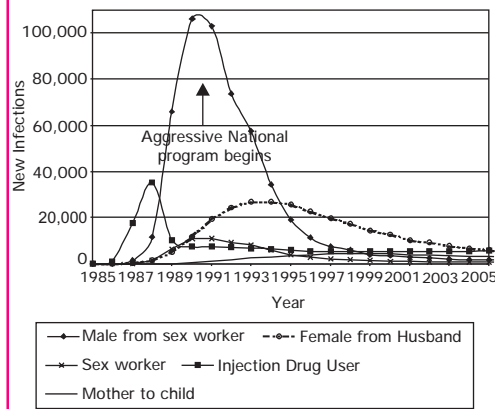
Considerable experience over the last twenty years with HIV/AIDS has shown that it is technically, politically and financially feasible to prevent new infections and to reduce the impact on those already affected. Commitment to immediate and expanded action by

government and civil society leadership is the key. Partnerships between government and civil society – people living with AIDS, community-based organisations, young people religious and academic institutions, the private sector have resulted in increased human and financial resources to increase the pace and upscale programmes to reach larger numbers in need.

There is evidence that when serious and sustained efforts are made to ensure that young people live in a supportive environment and have the knowledge, skills and services to protect themselves, HIV rates decline<sup>17</sup>:

- **In the state of Maharashtra in India**, HIV/AIDS responses appear to have resulted in higher levels of awareness and behavioural change among female sex workers, their clients and injecting drug users. 66%, 77% and 52% of whom, respectively, said they consistently use condoms—among the highest rates in India.<sup>18</sup> This may have helped prevent the generalised epidemic of the state from spinning out of control.
- **In Thailand**, the Government carried out a campaign promoting '100 per cent condom use' in brothels and embarked on an ambitious effort to change male attitudes towards women. Young men reduced their visits to sex workers by almost half between 1991 and 1995. Their condom use increased from 60 per cent to nearly 95 per cent. The net result was a drop in the percentage of young men infected with HIV from 8 per cent in 1992 to less than 3 per cent by 1997.

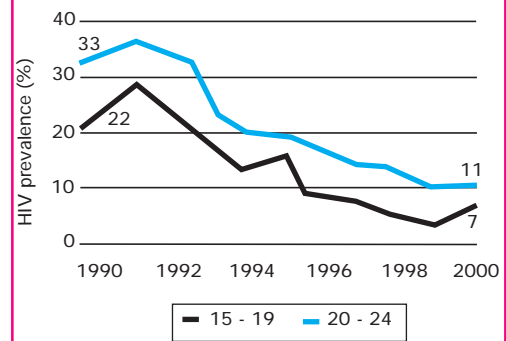
**Fig. 6: Thailand: HIV infection by route of transmission: 1985 to 2005**



Source: Chitwarakorn A. Presentation at S.Asia High Level Conference, Kathmandu, Nepal, 3-4 Feb.2003

**Fig. 7: National Commitment Counts**

Decreases in HIV prevalence among young pregnant women in Kampala, Uganda, 1990-2000



Source: National STD/AIDS Programme, Uganda, 2001.

- **In Kampala, Uganda,** HIV prevalence rates among pregnant girls aged 15 to 19 fell from 22 per cent in 1990 to 7 per cent in 2000, most likely because of delayed first intercourse, fewer partners and increased condom use. The President of Uganda has spoken openly about AIDS, and the mass media as well as the Government and community and religious organizations have active public education campaigns.
- **In Lusaka, Zambia,** HIV prevalence among adolescents aged 15 to 19 declined from 28 per cent in

1993 to 15 per cent in 1998. There is also evidence of increased condom use and fewer sexual partners, attributed to a vigorous programme providing life skills education and health services for young people.

- **In Brazil,** widespread information campaigns and prevention services have yielded positive results: in 1999 half the young men having sex for the first time used a condom, compared to fewer than 5 per cent in 1986, and condom sales rocketed from 70 million in 1993 to 320 million in 1999.

## Section Two

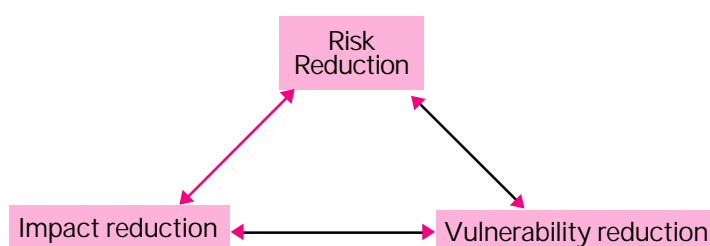
# HIV/AIDS Prevention for Young People – Programme Principles and Approaches



## HIV/AIDS Prevention among Young People – Programme Principles and Approaches

Risk to HIV infection is associated with specific behaviours. These are most commonly unprotected sexual intercourse and the use of infected, injecting equipment. There are also situations, where there is a risk of HIV infection such as a blood transfusion in a setting where blood safety precautions are not implemented or being forced to have sex. A HIV positive pregnant mother risks transmitting the virus to her baby either during pregnancy/birth or through breast feeding.

Vulnerability to HIV risk taking behaviour exists primarily when people are limited in their abilities to make and effect free and informed decisions. Vulnerability is influenced by political factors such as the lack of will to respond effectively to the epidemic; economic factors such as poverty; education sector factors such as lack of good quality schooling; contextual factors such as dominant gender roles and expectations, violence and conflict, family breakdown or lack of 'connectedness' to family, school or community; and environmental factors such as absent or inadequate health and social services. Singly, or in combination, the above factors render some groups more systematically vulnerable to HIV than others.<sup>19</sup>



An 'expanded response' to the epidemic is one that acts simultaneously on reducing risk, vulnerability and impact. To be effective, HIV prevention needs to focus on the inter-related dynamics of reducing social vulnerability to the epidemic and to provide the means for individual risk reduction. Tackling both vulnerability and risk is central to prevention success. If, in addition, the impact to the epidemic is lessened than vulnerability can be reduced and the risk of infection will fall.<sup>20</sup>

Programmes need to address both **what** places individuals at risk and **why** they are at risk. Education and information is vital for increasing risk reduction behaviours such as abstinence and the delay of first sex; promoting the use of condoms among those who are sexually active and reducing the number of sexual partners; reducing alcohol and substance use; and increasing understanding of the risks associated with injecting drugs.

But, knowledge by itself is not sufficient to enable young people to protect against HIV/AIDS. What is equally needed, is teaching and learning that helps individuals acquire the understanding, attitudes and skills to take greater responsibility for their own lives, resist negative pressures, minimize harmful behaviours and make healthy choices. Services must be made accessible to support them in carrying out their choices.

In the provision of information, consideration should be given to the great diversity in cultural groups, variations in level of poverty and striking urban and rural differences. Young people cannot be treated as a homogeneous group with a universally shared set of needs. Programmes must be tailored to the



differences between boys and girls, young people living in rural and urban areas, children in and out of school, young people married and unmarried. Policy makers and programmers need to recognise young people's immediate needs for shelter and food as well as their need to earn an income in safe and non-exploitative ways.

Based on these principles and building on experience to date and lessons learnt, the recommended four main programme components for HIV prevention among young people, which must be evidence-based and results-oriented, are:

- Information about HIV/AIDS and other sexually transmitted infections: how HIV is (and is not) transmitted, how it affects people, how young people can protect themselves from HIV infection or avoid transmitting it to others. A UNAIDS review of 53 programmes in 16 countries has shown that when young people are provided with accurate information on sexual and reproductive health, they are more likely to practice abstinence, delay onset of sexual activity and to practice safer sex (ie. consistent and correct condom use) when they do become sexually active.<sup>21</sup>
- Life skills to be able to use new knowledge about HIV/AIDS and sexual health. To make safer choices regarding HIV/AIDS and related issues, young people need skills in negotiation, problem solving, interpersonal relationships, critical thinking, decision-making, and communication. Such skills can build self-esteem and help young people resist pressure to take risks.

- A supportive social and policy environment, in which the rights of young people to information and services are protected. Advocacy with political leaders, government officials, mobilisation and partnerships with teachers, the mass media, community leaders, people living with AIDS, parents and other sections of society for political and social commitment to prioritise prevention and care for young people, for policies and legislation for provision of information, life-skills and services for young people. Advocacy is needed to fight stigma and discrimination and ending the wall of silence. Denial about HIV/AIDS persists, and stigma and discrimination are hampering effective prevention responses.
- Health services that are 'youth-friendly', i.e. services that are effective, efficient, equitable, comprehensive, appropriate, acceptable and accessible to young people.

#### Cross Cutting Basic Principles

A number of basic principles are recommended to guide HIV/AIDS prevention and care programming:

- The respect, protection and fulfillment of human rights constitute the foundation of the programming framework.<sup>22</sup> No strategy to reduce the spread of HIV/AIDS and to promote overall health and development can be effective unless the rights of children and young people are protected as outlined in the Convention of the Rights of Child.
- Addressing explicitly gender inequalities, which fuel the epidemic. Programmes must not

only recognise the unequal power balance between men and women but also that the gender specific needs of girls are different from those of boys. It is essential that these differential gender specific needs of both boys and girls must be addressed.<sup>23</sup>

- Ensuring participation of young people: Fulfilling the rights of children and young people to have a voice and to be directly involved helps to ensure that the best interest of children and young people are met. Involvement of young people, with real decision-making power, in all phases from design to evaluation contributes to programme relevance, sustainability of programme interventions and leads to ownership by young people. True participation is a partnership in which both young people and adults have agreed on their responsibilities.<sup>24</sup>

- People living with and affected by HIV/AIDS must be actively engaged and supported in their efforts to address the epidemic in communities. Young people living with AIDS are in a strategic position to make major contributions to the design and implementation of prevention and care efforts.<sup>25</sup>

### Major Lines of Action

Programming emphasis is dependent on the type of epidemic that prevails at country level. The epidemic in the countries in South Asia is dynamic, complex with different patterns and speed of infection resulting in different levels of epidemics even within countries. The table below outlines the key components of programmes for young people to be carried out in collaboration with young people, which have been identified within the context of the three types of epidemic.

### Key Programme Components in Setting of Different Epidemics <sup>26</sup>

Countries with Emerging/Low epidemics focus on risk reduction	Countries with Concentrated epidemics focus on risk and vulnerability reduction	Countries with Generalised epidemics focus on risk, vulnerability and impact reduction
a) Communication initiatives to provide relevant, accurate information to all young people on risk reduction	a) Communication initiatives to provide relevant, accurate information to all young people on risk and vulnerability reduction	a) Communication initiatives to provide relevant, accurate information to all young people on risk, vulnerability and impact reduction
b) Life skills based HIV education programmes for all young people in and out of schools	b) Life skills based HIV education programmes for all young people through in and out of school interventions	b) Providing life skills based education for all young people through in and out of school interventions
c) Advocacy to break the silence	c) Providing accessible, quality, and youth-friendly health services for all young people,	c) Providing accessible, quality, and youth-friendly health services for all young people
	d) Develop programmes to provide a-c above to especially vulnerable young people (e.g. Injecting Drug Users (IDU), Men Having Sex with Men (MSM), Commercial Sex Workers (CSW)	d) Develop programmes to provide a-c above to especially vulnerable young people (e.g. IDU, MSM, CSW)
	e) Advocacy to break the silence	e) Develop care and support services for young people living with and made vulnerable by HIV/AIDS
		f) Advocacy to break the silence

## Review of Programmes for Prevention of HIV/AIDS for Young People

This review of selected programmatic efforts in Bangladesh, India, Nepal and Pakistan is intended to illustrate the different approaches adopted, to share lessons learnt in what has worked and to gain an understanding of what does not work. The review has attempted to identify the challenges to be met to overcome constraints in terms of programme development and implementation processes. In community based programme interventions focussing on the overall development of young people, entry points and opportunities have been identified for integration of HIV/AIDS prevention.

Many of the programmes reviewed did not have strong research designs and only few were evidence based. The review and analysis were also constrained by the limited documentation of the development and implementation process. The review is therefore mainly based on visits to project sites, focus group discussions, review of project documents and evaluation reports where available. This, understandably cannot lead to valid conclusions that certain programme models are more effective than others and more importantly on programme impact.

The following is a summary of these findings and observations. The suggestions and recommendations are based on a combination of these findings and observations together with findings of assessments conducted by other agencies of strong research based sexual and reproductive health programmes for young people from South Asia and from other regions:<sup>27</sup>

1. **Innovative and sustained advocacy strategies** have been effectively used, by a number of projects. Humsafar Trust and the NGO Sevadham in India, the Family Planning Association of Nepal (FPAN)<sup>28</sup> successfully overcame opposition by communities, parents or governments to HIV/AIDS education for young people. Education to prevent HIV infection can be controversial, for educators as well as for the community. Political commitment at the highest level, and most certainly from within ministries of health and education, is vital for success. Sevadham in Pune India, made a major break through by sustained advocacy to transfer ownership of the Family Life Education Programme to the Ministry of Education. Nepal has developed a comprehensive National Adolescent Health and Development Strategy but its implementation unfortunately lags behind due lack of resources and technical expertise<sup>29</sup>.

In general, **advocacy efforts must be sustained and intensified** to persuade key political leaders to implement young people specific positive policies. Issues that need specific attention for adolescents are: access to condoms, harm reduction for injecting drug users, access to voluntary counselling and testing and to STI treatment; introduction of age appropriate life-skills-based education before adolescents become sexually active; teacher and health worker pre and in-service training; resource allocation and capacity building to upscale on-effective interventions.

Governments must make sexual violence unacceptable by **enacting and enforcing laws that protect both girls and boys, young women and men from all forms of sexual**

**violence and exploitation.** These national policies and legislation are necessary not only to protect young people from abuse but also to ensure access to information and young people friendly services. Impact projections, behavioural data, data on cost benefits of prevention versus care have been found to be effective tools to influence leaders to invest in young people's policies and programmes.

2. Review and research have shown the **value of school based interventions to provide young people with knowledge and information.** First, because the school system brings together students, teachers, parents, and the community; second, because preventing AIDS through education avoids the major AIDS-related costs of health care and additional education supply.<sup>30</sup> A number of countries in South Asia have implemented school based education and are in the process of upscaling them. Most notable are the efforts being made in the States of Maharashtra and Andhra Pradesh, India, to upscale the peer-based, school education initiative to reach state-wide coverage. The approach used has benefited from the experience of the Sevadham/UNICEF school-based Family Life Education Programme in Pune, India.<sup>31</sup>

But for school-based education to make a difference, **age appropriate HIV/AIDS information and life-skills based education should be introduced early.** It is critical to reach young people prior to onset of risk taking behaviour and before they leave school. For example in India sex education can only be introduced to children in schools after the age of 15. Which means, by the time any form of sex education/HIV preventive education is

given, about forty percent of all the boys and almost 60 per cent of girls would have dropped out of school. Of the total number of children in schools, an average of 53 percent in Bangladesh and 56 percent in Pakistan don't complete their primary schooling.<sup>32</sup> However, in addressing these issues related to school-based life skills based HIV/AIDS education, it is important to work within traditional cultural values and norms of society to facilitate community acceptance.

Experience in school based education has highlighted the importance of **teacher education,** sensitisation and skills building in sensitive issues. Interviews with students from programmes in India and Kenya reveal that even when HIV/AIDS education is integrated into the curriculum, selective teaching takes place. This is due partly to teacher's own inhibitions in dealing with sexual issues, perceived parental disapproval, religious barriers and to limited skills. The expansion of the Sevadham/UNICEF Family Life Education to integrate education on HIV/AIDS/STIs and TB into the curriculum at teacher training colleges for secondary school teachers is a step that is recommended for all teacher education colleges. Teacher Training should include interactive processes that treat adolescents as active learners and foster learning by doing. Teachers must be sensitised to treat both boys and girls equally, and be given the responsibility to ensure that school environment is safe for both sexes.

3. **Placing HIV/AIDS education in the context of the community** results in community and parental support for school-based programmes. In homes where families communicate openly about

sexuality, young people often can make safer choices on behaviour related to sex and drug use. The added benefit is the flow of information from schools to parents and to the community at large. This could be used as an entry point to reach the even larger population of young people not in schools and who might be even more vulnerable to risk behaviour such as young sex workers, drug users, men having sex with men. Schools should explore the possibility of becoming drop-in centres for out-of school young people which can result in establishing links between the formal and non-formal education.

For programme interventions in both formal and non-formal sectors, **the expansion of and accelerating the pace of this expansion requires priority attention.** This is of critical importance in the countries of South Asia with large populations of young people and adolescents - many of whom still remain unreached by interventions.

4. **Out of school and marginalised young people need to be reached through community based programme interventions.** NGOs have been taking the lead in implementing community based programme interventions. The NGO Swasthya works with young people in the urban slums of Delhi through participatory action research and focuses on community participation to promote sexual health. The Adolescent Girls Initiative (AGI) trains adolescent school dropout girls for the prevention of HIV/AIDS and promotion of the overall health and development of girls in the urban slums of Mumbai. The Alcohol and Drug Information Centre (ADIC) works with both school children and young people in the community to reduce drug and alcohol consumption through community out reach.<sup>33</sup>

Reviews emphasize that comprehensive programming addressing the underlying factors which contribute to risk taking behaviour of vulnerable young people may have more impact compared to fragmented problem-based approach. Continuity of interventions is key – interventions that do little bit here and there are not effective.

Further work needs to be done to draw on these experiences so as to be able to identify the best approaches based on the contextual situation of young people. Planning should include considerations for upscaling and for long term sustainability which will contribute to reaching the large numbers of young people in need of information and services.

5. For both in-school and out-of-school interventions, greater emphasis needs to be placed on enabling young people to make the right choices through **life skills development** particularly in critical thinking, decision making, conflict resolution, and communication skills<sup>34</sup>. These skills help boys and girls learn to relate to one another as equals, work in groups, resist peer pressure to take unnecessary risks. Different approaches such as the use of creative communication - theatre, song, storytelling - have been tried out in several countries to help young people gain such insights, engage them through talking over difficult issues followed by support to reflect on their options<sup>35</sup>.

The life skills training can be provided in different contexts. In Nepal, this is done through listeners clubs set up as part of the radio series ' Chatting with my best Friend'.<sup>36</sup> In Bangladesh, life skills training has been linked with

training to develop marketable skills and employment opportunities: 20,000 girls and young women have received non-traditional education, skills training and credit through the Bangladesh Centre for Mass Education and Science.<sup>37</sup>

6. The effectiveness of both school-based programmes, outreach interventions in non-formal settings and person to person community mobilisation and advocacy campaigns can be enhanced when **innovative mass media interventions** are implemented at the same time. These have the potential to reach large numbers of young people both in and out of school. Mass Media is effective to substantiate the knowledge and positive messages received through the school-based and non-formal projects. Well designed mass media interventions can counter popular misconceptions about adolescents, reveal discrimination, and abuse faced by young people and counter AIDS related discrimination and stigma.

Media campaigns that use famous actors, athletes or musicians provide role models for young people. By engaging People Living with AIDS to share their experiences on positive living, the media can contribute to convincing young people that they are all vulnerable to HIV infection and to counter AIDS related discrimination and stigma. Entertainment-Education media, based on needs assessment and audience research, using popular formats with emotional appeal can persuade and motivate young people to engage in healthy behaviours.<sup>38</sup> The radio programme 'Chatting with my best friend' and the TV series 'Catmandu' in Nepal not only use Entertainment-Education to disseminate messages but provide for feedback through listeners letters and have mobilised

large groups of young people through the establishment of listeners clubs.<sup>39</sup>

7. **A holistic, developmental approach** as the one adopted by Mahila Samakya in Bihar, India<sup>40</sup> that combines increasing the levels of literacy, building livelihood skills for young girls and women, provision of income generating opportunities and creating social support in the home, school, and community provides the ideal framework for integration of information and skills related to the prevention of HIV/AIDS/STIs. Adolescent Peer Organised Network (APON) in Bangladesh focuses on the underlying issues of gender discrimination, low literacy levels, poverty and violation of rights to empower girls while promoting their health and overall development and enabling them to protect themselves from exploitation.

These two programme interventions highlight the value of integrating HIV/AIDS into interventions which promote the overall health and development of young people. At the same time they offer important lessons in addressing gender as an integral component of any effective response to the HIV/AIDS epidemic. APON demonstrates the need to address the gender-specific needs of men and boys.<sup>41</sup>

8. In South Asian countries, HIV prevalence is low and the majority of young people are still uninfected. Here, **good quality education holds the potential not only to provide children and young people with hope for the future but also the skills and understanding to avoid infection and to fight HIV/AIDS related stigma and discrimination.**<sup>42</sup> In India those who cannot read are six times less likely to use a condom during casual sex than are their peers



who are educated beyond secondary school.<sup>43</sup>

In the countries in South Asia, many of which still have a long way to go to meet the goals of Education For All, priority should be given to **mainstream HIV prevention and care in education**: by engaging those working in education to prioritise HIV/AIDS; through convincing the education sector of the impact of AIDS; by demonstrating a human dimension through collection of life histories on how people's work and life have been affected by HIV/AIDS. Dovetailing expertise in HIV/AIDS and education through building networks between policy makers, practitioners and academics working in these often distinct areas of responsibility is currently being tried out in Mozambique, Malawi and the UK<sup>44</sup>.

9. **Making services available and accessible to young people** has remained a challenge. An even greater challenge appears to be to get young people to use them once they have been established. This has been the experience of FPAN and the Safdarjung Hospital Adolescent Healthcare Network (SHAHN) in Delhi, India.<sup>45</sup> Both projects reported under-utilisation of their facilities.

Well established large non-governmental programmes, however, have been able to draw young people to clinics through substantial outreach efforts. The Better Life Options Project in India, using an empowerment model with literacy, vocational training, family life education, has reported use of their health centres and increased knowledge of HIV/AIDS by the young people they serve. FPAN's positive experience providing 'safe space' through the youth informa-

tion centres for young people and discreetly making condoms available for young people could be combined with Voluntary Counselling linked to support for Testing.<sup>46</sup>

The provision of **supportive services including Voluntary Counselling and Testing (VCT)** will become even more acute as the epidemic progresses and as more infected young people start to fall ill. Nine out of ten people living with HIV/AIDS do not know they are infected. Studies have shown that young people have a strong interest in knowing their HIV status<sup>47</sup>. Young people who test HIV positive must receive referral for care and opportunities to talk to knowledgeable, sympathetic people who can help them understand what their HIV status means. Young pregnant women who test positive will need information and support to stay healthy and to reduce the risk of transmission to their babies.

This is clearly an area where more operational research is required. **Health Seeking Behaviour studies, including adult and community perceptions/attitudes conducted with involvement of young people**, will provide information towards services meeting the real needs of young people. Needs assessment of providers and their training is also critical to provide quality, friendly services. It is equally important to explore alternatives to clinics such as community outreach i.e taking services to young people rather than making them come to clinics; linkages and partnerships with social marketing programmes as well as with non-traditional providers such as pharmacies and the private sector

10. Almost all programmes reviewed have adopted some form of **participatory approach** - Swasthya

in India uses participatory action research, the Girl Child Shield Project in Pakistan empowers girl guides to be change agents in the community, likewise the Brothers Join Meena initiative in Pakistan mobilise boys to motivate parents to send girls to school.<sup>48</sup>

Peer education appears to be the approach most frequently adopted to involve young people. The **peer-based approach** has been observed to have positive results not only in school-based education programmes as in the Family Life Education Programme in Pune, India but also in non-formal settings as in APON 's efforts with adolescent girls in Bangladesh. It has been equally effective in Humsafar Trust's outreach to men having sex with men.<sup>49</sup>

Peer education can be effectively used as an entry point to discuss wider issues, which young people are generally reluctant to discuss with adults such as those related to sexuality and sexual behaviour, sexual abuse, violence and exploitation. To do this effectively, commitment and resources are required to support a steady flow of accurate information and to reinforce young people's capacity as peer educators. The reviews, also identified the need for more effort to be invested in ensuring true participation of peer educators in the development of the approach; to overcome selection bias and on the sustainability and cost effectiveness of the approach; the need for recognition of peer educators inputs since few receive any monetary incentives.

The Young Star Club (YSC) in Nepal has demonstrated how children and young people - if properly trained, encouraged and supported - can par-

ticipate meaningfully as protagonists in decisions and activities affecting their own lives and the development of their community.<sup>50</sup> YSC also demonstrates that placing promotion of sexual health and HIV/AIDS within the context of other young people relevant activities is more meaningful for young people.

**11. Integration of research and action:** A number of the programme interventions such as FPAN, Humsafar, 'Chatting with my Best Friend' conducted situation analysis, behavioural surveys and used the findings to design their interventions. **Operational research is the key to implementing evidenced based, results oriented programme interventions and should be part of planning for any programme** - research and action are interdependent and both quantitative and qualitative data are required to understand the real needs and situation of young people.

Areas needing attention are primarily those related to understanding behaviours: what influences shape positive behaviour, what leads to risk-taking behaviour. Situation assessment findings will enable planners to take into account dynamics and communication within families, gender power relations, alcohol and drug use, harmful traditional practices; condom use and access; community perceptions and attitudes to young people's sex and sexuality and risk taking behaviours and to HIV/AIDS/STIs. **The information collated should be disaggregated by age and sex.** One of the major drawbacks of on-going behavioural sentinel surveillance and sero-surveillance is that data is available for below 29 years of age but not disaggregated by age. Data hardly exist for those below 15 years of age.



Studies on health seeking behaviours would contribute to overcoming a certain number of barriers to use. Findings will also contribute to ensuring that services meet the differential needs of adolescents, and young people both married and unmarried; provide information on preferred locations and sources of services.

The benefits of **using participatory action research as well as young people centred approaches** are being increasingly recognised. The idea of young people as co-researchers is a vital one in the work of HIV/AIDS. Often the wrong questions are being posed – often by the wrong age group. Some of the more successful programmes on researching girls education have come from girls themselves. The ‘listen to girl child’ strategy in Zambia<sup>51</sup> was based on girls themselves researching the status of girls in their own community as co-researchers - through drama, interviews, observations. The incidence of mother to child transmission is increasing in the countries of the region, the involvement of young mothers will be critical to ensuring that services meet their needs.

Few of the programmes reviewed had a **Monitoring and Evaluation component**. The limited availability of evaluation and monitoring data, made it difficult to draw firm conclusions about programme approaches and their effectiveness. Monitoring and Evaluation, which should be an integral part of all programming, should consider both the strengths and weaknesses of the process and its outcomes, recognising and valuing success while always searching for better ways to do things the next time round.<sup>52</sup>

**Cost benefit analysis** is another area which requires attention in almost all the interventions reviewed. Cost benefit analysis comparing the effectiveness and costs of different combinations of interventions/ services in different contexts are particularly important in resource poor settings to guide decisions with respect to sustainability and scaling up. Decisions for payments for services of peer educators, for use of services can then be determined on the basis of the benefits to achieving the outputs. Results of cost benefit analysis will be useful for mobilisation of funds and to influence criteria used by funding agencies.

Funding agencies might consider revisiting their criteria and funding framework. HIV/AIDS prevention among young people demands cross sectoral action from a number of different partners. Most funding agencies limit the range of issues or types of projects for which their funds can be used. Cross sectoral programming for young people, through their participation, calls for long term solutions and investments and greater flexibility for local determination of funding priorities.

## 12. **Partnership building**

The programme interventions reviewed have demonstrated the value of partnerships as in Humsafar’s partnership with Sion hospital for provision of services, that of the NGO Sevadham and UNICEF, the Young Star Club with international NGOs. But for most implementers, partnerships are closely related only to funding.

**Strengthening key institutions around adolescents**, rather trying to reach young people directly has been found to be more effective and allow

for greater sustainability. The interventions ability to move forward, to ensure sustainability and upscaling would be considerably strengthened if the network of support and linkages is broadened to include net-

works of young people, schools, the different government sectors, NGOs, community leaders and religious organisations, technical institutions, the private sector and a coalition of funding sources.

### Ten-Step Strategy for the Way Forward

1. End the silence, stigma and shame
2. Provide young people with knowledge and information
3. Equip young people with life skills to put knowledge into practice
4. Provide youth-friendly health services
5. Promote voluntary and confidential HIV counselling and testing
6. Work with young people, promote their participation
7. Engage young people who are living with HIV/AIDS
8. Create safe and supportive environments
9. Reach out to young people most at risk
10. Strengthen partnerships, monitor progress

## Endnotes

- <sup>1</sup> Based on WHO definition: Young People: 10-24 years of age; Adolescents: 10-19 years of age
- <sup>2</sup> Annex 1: South Asia Regional Forum for Young People on HIV/AIDS, Kathmandu, 15-18 Dec.2002, outcome document: 'Young South Asians Assert Their Rights'
- South Asia High Level Conference: 'Accelerating the Momentum Against HIV/AIDS in South Asia', outcome document: 'The Kathmandu Call Against HIV/AIDS in South Asia: Accelerating Actions and Results'
- <sup>3</sup> Proceedings of South Asia High Level Conference in CD ROM
- <sup>4</sup> Family Health International/UNAIDS. (2001) Best Practices in HIV/AIDS Prevention Collection. UNAIDS (1999). Summary Book of Best Practices. Save the Children UK (2001) Young People and HIV/AIDS responding to the new Asian Crisis'. Population Council, Regional Office (1999) Adolescents in Transition: Programmes and Practices in India'. UNESCO/UNAIDS/UNICEF (1998) 'Catch 'em Young': a Best Practice Case Study on School-Based AIDS Preventive Education programmes in Maharashtra, India.
- <sup>5</sup> Annex 2: Summary Matrix of Programme Interventions included in this Document
- <sup>6</sup> Unless otherwise stated, all epidemiological are taken from UNAIDS, WHO (2002) AIDS Epidemic Update. December.
- <sup>7</sup> NACO (2001) Estimation of HIV/AIDS in India. <http://www.naco.nic.in/indianscene/esthiv.htm> and NACO (2000) Combating HIV/AIDS in India. <http://www.naco.nic.in/indianscene/country.htm>
- <sup>8</sup> NACO, UNICEF (2001) Feasibility Study of Administering short AZT Interventions among HIV infected Mothers to Prevent MTCT.
- <sup>9</sup> UNAIDS and Sociometric Corporation (2001) Gender Almanac. <http://www.unaids.org/gender/docs/Gender%20Package/GenderandAIDSAlmanac.pdf>
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- <sup>12</sup> Gary Reid & Genevieve Costigan (2002) 'Revisiting the Hidden Epidemic' A Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS. The Centre for Harm Reduction, the Burnet Institute, January.
- <sup>13</sup> Era/FHI, Study of HIV/AIDS among IDUs in Kathmandu, 2002
- <sup>14</sup> Source: Literacy: United Nations Children's Fund, The State of The World's Children 2003, UNICEF, New York, 2002. Heard of AIDS: Nepal: Ministry of Health, New Era, and ORC Macro. Nepal Demographic and Health Survey 2001. Nepal, 2002. Bangladesh: Mitra and Associates, National Institute of Population Research and Training, and ORC Macro. Bangladesh Demographic and Health Survey, 1999-2000. Bangladesh, 2001. India: International Institute for Population Sciences (IIPS) and ORC Macro. 2000. National Family Health Survey (NFHS-2), 1998-99: India. Mumbai: IIPS. Sri Lanka: Department of Census & Statistics, Demographic and Health Survey 2000, Sri Lanka, 2001.
- <sup>15</sup> Bangladesh Demographic and Health Survey 1999-2000. Dhaka. Bangladesh & Cleveland, Maryland, USA
- <sup>16</sup> National AIDS Control Organisation. MHFW. GOI. 2001
- <sup>17</sup> UNAIDS, WHO (2002) AIDS Epidemic Update. December.
- <sup>18</sup> Taken from: UNICEF, UNAIDS, WHO (2002) Young People and HIV/AIDS Opportunity in Crisis
- <sup>19</sup> Annex 3: Main Influences on Young People's Sexual and Reproductive Health, either as Protective or Risk Factors.
- <sup>20</sup> UNAIDS (2000) Framework for Global Leadership on HIV/AIDS. November.
- <sup>21</sup> UNAIDS (1997) Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: a Review Update.
- <sup>22</sup> United Nations Commission on Human Rights, Resolutions 1999/49, 2001/51, 2002/47; OHCHR/UNAIDS. International Guidelines on HIV/AIDS and Human Rights. New York and Geneva, UN. 1997
- <sup>23</sup> Annex 5: Alternative Approaches for Discussions on HIV/AIDS related Issues. CD ROM: UNICEF/UNAIDS (2003) 'Gender-based Violence, Sexual Abuse and Exploitation in South Asia increases Risk and Vulnerability to HIV/AIDS' Issues Paper 4, prepared for South Asia High Level Conference.
- <sup>24</sup> Annex 7: At a Glance: Gender and HIV/AIDS Rajani R. (2000) The Participation Rights of Adolescents: A Strategic Approach. Working Paper Series. UNICEF, New York, USA.
- <sup>25</sup> UNAIDS (1998) Greater Involvement of People Living with AIDS.
- <sup>26</sup> UNICEF (2002) Programme Working Note HIV Prevention Among Young People.
- <sup>27</sup> This review has drawn on findings and recommendations from :
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  - Focus on Young Adults (2001) Advancing Young Adults Reproductive Health; Actions for the Next Decade. End of Programme Report. Washington, DC/USA.
  - Actionaid (2002) 'The Sound of Silence' - Difficulties in Communicating on HIV/AIDS in Schools. Experiences from India and Kenya.
  - Save the Children (2001) Young people and HIV/AIDS. Responding to the new Asian Crisis.
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- <sup>28</sup> Case studies: 1, 3, 5 & 7
- <sup>29</sup> CD ROM: National Adolescent Health Strategy.
- <sup>30</sup> World Bank (2002) Education and HIV/AIDS: A Window of Hope. Washington, DC., World Bank. UNICEF/UNAIDS (2003) Lack of Education: the Devastating Liability to Combating HIV/AIDS. Issues Paper 2, prepared for South Asia High Level Conference. Kathmandu, Nepal.
- <sup>31</sup> Case study 1
- <sup>32</sup> South and West Asia Regional Technical Advisory Group and UNESCO (2000) Education for All in South Asia and West Asia: A Decade after Jomtien: An Assessment. Synthesis Report. Prepared by Jandhyala B G Tilak, National Institute of Educational Planning and Administration, New Delhi.
- <sup>33</sup> CD ROM : Programme Interventions
- <sup>34</sup> Annex 4: At a Glance Life Skills based Education and Young People
- <sup>35</sup> Annex 5: Alternative Approaches for Discussions on HIV/AIDS related Issues
- <sup>36</sup> Case study 2
- <sup>37</sup> CD ROM: CMES intervention review
- <sup>38</sup> Annex 6: At A Glance: Programme Communications and HIV/AIDS Prevention for Young People

- Johns Hopkins University (2002) Working Paper 6. Reaching Youth Worldwide. Center for Communication Program. 1995-2000.
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- <sup>39</sup> Case study 2
- <sup>40</sup> Case study 4
- <sup>41</sup> Annex 7: At a Glance: Gender and HIV/AIDS  
CD ROM: UNICEF/UNAIDS (2003) Gender-based Violence, Sexual Abuse and Exploitation in South Asia increases Risks and Vulnerability to HIV/AIDS. Issues Paper 4, prepared for South Asia High Level Conference. Kathmandu, Nepal.
- <sup>42</sup> UNICEF/UNAIDS (2003) Lack of Education in South Asia: The Devastating Liability to Combating HIV/AIDS. Issues Paper 2. South Asia High Level Conference. Kathmandu, Nepal
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- <sup>44</sup> Shepard B.L.(2001) 'Youth Programmes in the SADC Countries: Sexual and Reproductive Health and Rights' Technical Paper for the 1<sup>st</sup> Youth conference of the Southern Africa Development Community Region. June 13-16,2000. Mozambique. UNFPA/Pathfinder International
- <sup>45</sup> CD ROM: Intervention description
- <sup>46</sup> Annex 8: At a Glance: Young People Friendly Health Services Framework
- <sup>47</sup> UNICEF, UNAIDS, WHO (2002). Young People and HIV/AIDS Opportunity in Crisis.
- <sup>48</sup> Interventions description in CD ROM
- <sup>49</sup> Annex 9: At a Glance: Young People and Peer Education
- <sup>50</sup> Annex 10: At a Glance: Participation of Young People; Real Adolescent Participation checklist
- <sup>51</sup> Mwansa, Dickson (1996). Listening to the girl child. UNICEF Lusaka
- <sup>52</sup> Annex 11: Proposed Indicators for Young People among 10-24

# School-based Family Life Education and HIV/AIDS Prevention Sevadham/UNICEF India

Location: Pune, Maharashtra State, India

Target groups: Secondary school students, teachers and teacher trainees

Strategic approach: Family Life Education and HIV prevention through peer educators and teachers

Area of operation: 1,754 secondary and higher secondary schools in 14 municipalities, and 96 secondary teacher training colleges in Maharashtra State





# School-based Family Life Education and HIV/AIDS Prevention: The Power of Advocacy

## Background and rationale

When researchers asked women sex workers in the town of Sangli, in the Indian State of Maharashtra, which time of the year was the worst for business, they were shocked at the response. The women were unanimous that business was always worst in the month of March, when secondary school students were taking their final examinations. In fact their incomes fell by up to 50 percent at this time of year.<sup>1</sup>

This suggests that many boys aged between 15 and 17 were frequently paying for sex. The town of Sangli is by no means unique. It is likely that, in many other towns and cities in India, schoolboys are purchasing sex - usually without using a condom - from women and girls who are at high risk to HIV infection and other STIs and to transmitting them.

It is still widely believed in India that young people do not need information about sex, sexuality and human reproduction because they are not sexually active until after marriage. Traditionally, sex is not discussed

between parents and children. Young people are largely dependent on the fragmentary - and often inaccurate and misleading - information about sex which they glean from friends, newspapers, magazines, films, videos, television and radio.

The Sevadham Trust, an NGO based in the city of Pune, Maharashtra, India, in collaboration with UNICEF, works towards breaking this traditional mind-set. The Sevadham/UNICEF's Family Life and HIV/AIDS Education Programme was the first systematic attempt in India to involve secondary school students as peer educators together with teachers as the main players in school-based sex education and HIV prevention.

The start of the Family Life Education and HIV/AIDS Prevention Programme could hardly have been less auspicious. The process began in 1993, with a number of speaking engagements by Sevadham Trust in schools on a sex education and HIV/AIDS prevention project. This was met with objection from school administrators but with interest from the students. They took

up the initiative and informed the principal and other senior teachers that the session had been excellent. Moreover, they felt that either their teachers or their own parents should already have given them such information. They firmly believed students at other schools would also want to have it.

On the basis of this encouraging experience, Sevadham drew up a proposal for a pilot project, based on the strategy of peer education by trained student volunteers, supported by 'nodal' teachers, who would also receive special training. This strategy, which had not previously been tried in India, was a truly ground-breaking initiative.

Officials at the State Education Department did not directly approve the project, but indicated that they would not raise any objections. In 1994 the Trust, with technical and financial support from UNICEF Maharashtra, launched the Family Life Education and HIV/AIDS Prevention Programme in 30 secondary schools in Pune district. The programme has since expanded to reach 1,754 schools in 14 towns and cities throughout the State.

## Objectives

The Family Life Education and HIV/AIDS Prevention Programme began with the following objectives:

1. To impart updated knowledge on Family Life Education, including sexuality, STIs and AIDS to the teachers and students through training of selected nodal<sup>1</sup> teachers and peer educators.
2. To facilitate a healthy attitude amongst students towards sex and sexuality.

3. Through development of their skills, to protect students against HIV and AIDS.

In 1998, after four years experience, the objectives of the programme were re-defined as follows:

1. To fully inform adolescents about population education, HIV/AIDS transmission and means of prevention.
2. To enable the development of skills to act on knowledge and to communicate to others via extra-curricular activities.
3. To form appropriate and healthy attitudes and behaviour towards sexuality during adolescence.
4. To increase links among adults in the education system (especially teachers and parents) to provide a supportive environment.
5. To build a pool of resource people aware of issues on HIV/AIDS prevention for young people.
6. To transfer the responsibility of the programme to the Education Department, with Health providing a support system.

The most significant new objective was number 6. From the outset, the programme had been within the control of the Department of Health, where it had only limited influence on the education system and was unable to expand beyond Pune District. The Sevadham Trust realised that, for the programme to have a significant and lasting impact, the Department of Education also had to feel a sense of responsibility for its successful implementation.

<sup>1</sup> The term 'nodal' is often used for social planning purposes in India to denote an organisation, or a post within an organisation, from which information, skills and programme activities are promoted and disseminated.

## Programme components

Between 1994 and 2001 the programme consisted of three main components: peer education, nodal teacher support and advocacy. Since August 2002 the programme has included a fourth component: the training of secondary school teachers in 96 'Bachelor of Education' colleges.

### 1. Peer education

**Selection of peer educators:** Each school selects two students - a girl and a boy - from standards 9 and 11 when students do not have to sit for final examinations. Selection is done by the school principal based on criteria, such as self-motivation, popular with their peers, good communication skills, knowledge of the subject matter, as well as willingness to work occasionally outside normal school hours, such as on weekends and after school.

**Training:** The young peer educator training takes three days. On one of these days nodal teachers, who are also undergoing training, join the peer educators. The training manual and materials developed jointly with UNICEF and Public Health Department, Government of Maharashtra, cover HIV transmission, methods of HIV prevention, issues of HIV-related stigma and discrimination, moral values, relationship skills and basic facts about human anatomy and reproduction. The training, mainly carried out by nodal teachers and peer educators with several years of experience, uses participatory methods. Students themselves make presentations, comment on one another's performances, devise skits and role plays, and take part in discussion groups.

**Responsibilities of the peer educators:** The peer educators are ex-

pected to give two to four presentations on HIV/AIDS within a school classroom situation, using a set of wall charts produced by the programme. They also have an important role as informal HIV/AIDS educators amongst their peers outside the classroom, when young people individually seek their advice. In some schools, peer educators have also undertaken outreach education activities in neighbouring communities.



### 2. Nodal teacher support

School principals select two teachers (whenever possible – a male and a female,) to be trained as nodal teachers in their school. Nodal teachers attend a three-day training workshop, with one day spent together with trainee peer educators. Their training in HIV/AIDS is similar to that for student peer educators, but with greater emphasis on sexual and reproductive health issues. Training methods are informal and participatory. The trainers and resource persons are nodal teachers and peer educators with several years of experience, supported and co-ordinated by Sevadham staff. Schools that have been in the programme for several years have now five or six trained nodal teachers.

**Responsibilities:** Nodal teachers are responsible for encouraging, guiding and supervising the peer educators



in their school. They support the peer educators when, for example, they give formal presentations on HIV/AIDS in the classroom, and when they are preparing for special events such as rallies and marches on World AIDS Day. In addition, they conduct family life education sessions for students and organise extra-curricular activities such as workshops and sessions on HIV/AIDS for their colleagues, both teachers and administrative staff of the school, HIV/AIDS meetings for parents, inter-school competitions and HIV/AIDS training camps. Nodal teachers need to be willing to work, without pay, outside normal school hours.

Sexual health and HIV/AIDS are not core school curriculum subjects and students do not have to study them for the exams. However, teachers of science can incorporate sex education and HIV/AIDS into their teaching. In most schools, nodal teachers organise a question box, into which students put written questions related to sexual and reproductive health and HIV/AIDS. These are answered on a regular basis. Some teachers have also undertaken outreach work in nearby slum neighbourhoods: one teacher, for example, made a set of puppets and conducted over 100 shows about sex, HIV and STIs in local neighbourhoods.

### 3. Advocacy

When the Sevadham-UNICEF collaborative Programme was initiated, many parents, teachers and government officials objected strongly to sex education and HIV/AIDS prevention activities at school. In response, Sevadham embarked on a strategically organised advocacy campaign:

Through, quiet, behind-the-scenes networking and workshops,

Sevadham succeeded to get endorsement for the school-based strategy of sex education and HIV/AIDS prevention from influential teachers' organisations, in particular from the Association of Secondary School Teachers and the Association of Principals of Secondary Schools. Others who were won over were the teachers at the Bharat Scouts and Guides Association. The School AIDS committees on which parents, teachers and students are represented played an important role in dispelling misconceptions, defuse tensions. They contributed to developing a sense of local ownership of the programme. The role of the school principal, as chairperson of this committee is crucial.

Sensitisation workshops with the community helped to introduce the concept of school-based sex education and HIV/AIDS prevention in communities where the programme was just starting up. Dissemination workshops at the end of each year of the project, are critical to involve all stakeholders and make suggestions. This also fosters school, community and government ownership of the programme and can lead to innovative ideas for improving the programme. The concept of nodal schools - large schools that can take responsibility for training and supporting peer educators and teachers at five or six smaller schools - first emerged at a dissemination workshop. It has since proved to be very successful in several places.

The programme worked hard to win political support, especially from the Department of Education. Initially its advocacy efforts were concentrated on middle level government officials. With time, it became clear that approaching

policy and decision-makers at the highest level of the State Government would be more effective. This approach was particularly successful when the government officials were invited to speak at sensitisation and dissemination workshops. There was a double benefit to the programme: participants tend to take school-based sex education and HIV/AIDS prevention more seriously, and the government's sense of commitment to the programme also increases.

Through a combination of workshops and one-to-one advocacy, Sevadham promoted the value and benefit of sex education. When the programme began in 1994, many teachers were reluctant to become involved because they believed that AIDS did not constitute a major health issue for India, so schools should not become involved in sex education or HIV prevention. Interviewed by an evaluation team in 1998, teachers in five municipalities said that, in the early years of the programme, teachers who opted to be trained as nodal teachers were often mocked and ridiculed by their colleagues.<sup>3</sup> However, their attitudes changed when they became aware of the nature and magnitude of the problem of HIV/AIDS and other STIs in India.

#### 4. Pre-service training of teachers

In March 2002 the programme expanded to introduce Family Life Education, information on HIV/AIDS/STIs and TB into the curriculum at teacher training colleges for secondary school teachers attached to universities.

The plan was to train staff, students and administrators at 98 of the 144

Bachelor of Education Colleges affiliated to six out of the nine Universities in Maharashtra State. The target for the first year was to train 12,000 students, 1,210 teachers and 1,210 administrative staff from 98 Bachelor of Education Colleges in 24 districts. Advocacy workshops were conducted for key decision-makers from all the universities and colleges involved, as well as for officials of the Department of Education. The activities have been completed in the B'Ed colleges of two Universities.

"At the beginning parents were constantly saying that you should not tell these bad things to their children. Then their attitudes changed, as they fear of HIV/AIDS spread, and parents felt unable to communicate with their children about sex. They found it easier to let a teacher handle such things." Dhaware Dagdu, nodal teacher

## Funding

As the programme has expanded in recent years, so has its funding. Between 2001/2002 and 2002/2003, for example, its budget rose from Rs 2 million (US\$40,000) to Rs 4.7 million (US\$94,000). After initial funding from UNICEF, the programme's main source of funding has been the National AIDS Control Agency (NACO), via the Maharashtra State AIDS Control Society. The average cost per person educated in 2002/2003 is estimated to be Rs 9.

The budget for the programme to train secondary school teachers at 96 BEd Colleges in Maharashtra State in 2002/03 is Rs 2.4 million (US\$48,700). The average cost per participant is estimated to be at Rs 12.

## Achievements and lessons learned

When the Sevadham Trust and UNICEF started its Family Health Education and HIV/AIDS Prevention Programme in 1993, there was no guarantee that it would survive or be successful. In the past decade, however, the programme has defied its critics by not only surviving but expanding to 1,764 secondary schools in 14 districts of Maharashtra State. The Sevadham/UNICEF Family Life Education and HIV/AIDS Prevention programme has resulted in:

### Increased knowledge and skills among the targeted students

In 1999 an external evaluation<sup>4</sup> was carried out in secondary schools in five municipalities where the programme had worked since the previous year. The evaluators identified encouraging signs of success in terms of students' improved knowledge, attitudes and decision-making ability with regard to sexual behaviour and HIV prevention. Two-thirds of students interviewed were found to have a 'high' level of knowledge of family life, sexuality and HIV/AIDS, and another 20 percent had a 'fair' level of knowledge. In addition, 88 percent of respondents were found to have a 'high' level of decision-making ability with regard to sexual behaviour and HIV prevention.

A number of strategies have been responsible for this result. The Programme's approach of using **peer educators** has paid off in reaching young people with information and skills. Given the responsibility as peer educators in HIV/AIDS, girls and boys in their mid-teens have proven to be both competent and conscientious. They have gained the trust of their fellow students and the information given by them on sexual and other behavioural issues are seen

"Young people are very curious about sex, but they are not serious in their relationships," says 17 year-old Pallavi Mane, who is a first-year student at a senior high school in Pune. "Young people," she adds, "should be given detailed information about sex during adolescence so they don't go down the wrong path. Parents should also discuss sex and sexuality openly with their children. At the moment there is no way for them to do that."

Pallavi was trained as a peer educator at a junior high school in Pune, and she has fond memories of that time:

"I found it most difficult doing my sessions if the teacher was present. Her presence would put pressure on the students, and on us peer educators also. If the teacher isn't present the peer educator can communicate very nicely with the students."

"Everything I've learned about sex has been through school. My parents supported me in my work as a peer educator, but I have never discussed sex with them. I had a problem in standard 9 because, although I was a trained peer educator, I was still not aware of exactly what was involved in the sexual act. We were given incomplete information. I think we should have been told exactly what the sex act is."

Palavi Mane, peer educator

to be more credible than those given by teachers. In some schools, student peer educators proved to be less inhibited and more adept at discussing matters related to HIV/AIDS and sexual behaviour than the nodal teachers. More than one teacher has had to admit: "Sorry, but today I've learned from my student".<sup>5</sup> "The peer educator system changes the whole cultural environment," says Sevadham co-founder, Dr S. V. Gore. "It's the initiation of a process, not the end of it."

**Investment in comprehensive and on-going capacity building** of both the peer educators and the nodal teachers has assured quality. This was done through a strategy comprising of initial training with regular follow-ups and on going support to provide guidance and assure quality. Sevadham has found it useful to have trainers who have personal experience of the programme as nodal teachers and peer educators. High quality, factually accurate and reasonably comprehensive support materials in the appropriate languages in sufficient quantities has been of enormous benefit to both the peer educators and the teachers. These materials should be updated to include additional technical information.

Sevadham also realised early in its programme the **importance of keeping school principals informed and involved** in all stages of programming. Inviting them to participate in sensitisation workshops, as well as giving them the responsibility of selecting nodal teachers and peer educators for training, has been useful to ensure their interest in their performance of the programme

#### **Reached state wide coverage**

Both Sevadham and UNICEF had from the outset planned for the programme to move swiftly from a pilot project to state wide coverage. Between 1994 and 1998 the programme worked only in Pune District, where it reached 895 secondary schools and trained 3,464 peer educators and 2,377 nodal teachers. By end 1998 the programme had reached a total of about 700,000 secondary school students. In the second phase, since 1998, the programme has expanded and reached 1,754 schools in 14 municipalities of Maharashtra State. By

2003 the programme aimed to make information about sexual health and HIV/AIDS available to 350,000 secondary school students, as well as 80,000 parents, 40,000 teachers and 14,000 other school staff. Considering the size of the programme, the number of staff involved is very small - only 40 in 14 municipalities in the State of Maharashtra.

#### **Department of Education ownership of the programme**

One of the programme's objectives - the transfer of responsibility for the programme from the Department of Health to the Department of Education - was achieved in 1998. Since the programme is school-based, it is important that it be anchored within the Department of Education, with responsibility for its implementation, monitoring and evaluation. Many parents and teachers who previously were sceptical or even hostile to the programme have become enthusiastic supporters, and some have become active participants in activities.

In the medium-to-long term, ownership of the programme by the Department of Education must also involve financial responsibility and the incorporation of sex education and HIV/AIDS into the training of secondary school teachers.

Although the Department of Education had no funds to support the programme, this was still a breakthrough because it meant that the Department would issue instructions to school principals to ensure that sex education and HIV/AIDS prevention activities would be implemented in their schools.

The sustained advocacy at all levels in particular top level advocacy is responsible for this milestone achievement. In order to gain strong

political support for potentially controversial programmes, advocacy must be targeted at the highest possible level of government decision-makers. Advocacy is not a one-off exercise but an activity that must be planned, monitored and budgeted for. Government officials are frequently changing and new incumbents need to be informed about the programme and invited to participate in its activities. New children come to school each year, and their parents may have the same prejudices against sex education and HIV prevention as those in previous years. Teachers at schools where sex and HIV/AIDS are still taboo subjects may feel reluctant to become involved in the programme. Advocacy therefore should be a continuous process, with regular reviews of the strategies and channels used.

Advocacy efforts are not only needed at all levels of government. Sevadham worked also through non-governmental channels, such as teachers' organisations, NGOs and youth movements, to garner support from all available quarters. Through creative and persistent forms of advocacy, Sevadham has established the legitimacy of teaching adolescents about sexual health and HIV/AIDS within secondary schools in the State of Maharashtra.

**Inclusion of HIV/AIDS information and training into teacher training colleges** is in itself an achievement. The programme implementers recognised the immediate need for training of all teachers on HIV/AIDS and the need to insert it into all pre- and in-service training. Teachers often shy away from discussing HIV and sex or do selective teaching where HIV/AIDS information is given without any reference to sexuality. They either are not confident about their abilities to do so

and/or do often not have sufficient knowledge and skills to do. Participatory training methodologies can be used to help teachers in developing the skills necessary and to act as role models for their young students.

## Challenges for the way forward

The lessons learned from the Sevadham/UNICEF Family Life Education and HIV Prevention programme are being used to improve the implementation process of similar initiatives in Andhra Pradesh, India. At the same time certain constraints remain to be overcome and a number of challenges need to be met as it looks to the future, in particular:

**Policy restrictions:** The decree by the Minister of Health of the Government of India that school programmes should not provide students with information about condoms has posed a major challenge to the programme. It obliged Sevadham to remove information about condoms in some of the teaching materials. Nodal teachers are trained and encouraged to respond fully to questions from students about condoms, but condom demonstrations in class are not allowed.

Sevadham would also need to take up the challenge of advocating for the introduction of age appropriate school-based HIV/AIDS education including life-skills based education earlier so that most young people can be reached prior to onset of risk taking behaviour. In India, HIV/AIDS education can only be introduced to children after the age 15 in schools. Which means that by the time any form of sex education/HIV preventive education is given, half of all the boys and almost 60 per



cent of girls would have dropped out of school. There is now conclusive evidence that providing sexuality education in the schools does not promote earlier sexual initiation. On the contrary, in some cases it has helped to delay it.<sup>ii</sup>

**Operational research** could provide evidence of local teenage sexuality and risk taking behaviour as well as attitudes and perceptions of parents and community leaders. The findings will be useful to advocate for a policy change. Networking and coalition-building, mobilisation of communities and parents to support these advocacy efforts could bring about the desired change in policy restrictions.

**Strengthening links between communities and schools:** Sevadham has through advocacy overcome parental and community opposition. But no school exists in a vacuum and especially in the case of promotion HIV/AIDS and Family Life Education. Closer community links and community involvement will make a difference in not only prevention efforts but also to reduce AIDS related stigma and discrimination. These links could be created through parent-teacher associations, school-home liaison or through community-based organisations, mobilisation of community and religious leaders. Advantage should be taken of pre-existing systems of knowledge transfer – mothers, extended family members.

These school-community links would also facilitate the extension of HIV/AIDS prevention and Family Life Education in the classroom to the community to reach those significant percentage of children not in school. More than half the children in India never enrol in

secondary schools and a considerable number of them such as street and working children live in circumstances which make them vulnerable to both HIV/STI and drug use.

**Ensure comprehensive information related to real lives of young people:**

The Family Life programme has sometimes avoided giving peer educators full, explicit information about human sexual behaviour, due to fear of offending parents and teachers. Experience from other countries has shown that comprehensive information and education for young women and men together with skills-building and access to services is critical to bring about positive behaviour change.

Syllabi would also need to be broader than just information on HIV/AIDS transmission and prevention. What is needed is teaching and learning that helps individuals acquire the understanding, attitudes and skills to take greater responsibility for their own lives, resist negative pressures, minimise harmful behaviours and make healthy life choices<sup>iii</sup>.

To help students personalise the issues, the Family Life and HIV/AIDS education would need to include discussion on young people's sexuality drawing on local statistics of prevalence, case studies, voices of young people to make it more pertinent and to match the reality of their lives. Family Life Education should also be within a broader context which allows scope to challenge ingrained gender and power relations by giving space to boys and girls to discuss gender issues and to examine the power dynamics involved in intimate relations and in wider human relationships.

<sup>i</sup> UNAIDS (1997) Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People, a Review Update. Geneva.

<sup>ii</sup> Annex 4 : 'At a Glance: Life Skills Based Education and Young People'

Different approaches have been tried out in several countries to help young people gain such insights, engage them through talking over difficult issues followed by support to reflect on their options<sup>iv</sup>.

It is important that teachers too go through this process of self-reflection and be enabled to overcome their own prejudices and inhibitions through the same approaches. More attention needs to be paid to teachers training to ensure skills building in interactive process and alternative, creative ways to train young people in life skilled based education. Ministries of education will need to provide more conducive environments for discussion of sensitive issues and to promote open dialogue between adults and young people.

The findings of the evaluation showed that the Programme has successfully increased levels of knowledge. Information alone does not automatically lead to behaviour change as indicated by surveillance data in many countries where despite increased levels of knowledge, rates of HIV infection have continued to rise. The challenge for Sevadham is to create 'safe spaces' for young people to discuss among themselves sensitive issues but also to establish links/partnerships with services such as counselling, STI treatment and to access condoms.<sup>v</sup>

**Ensuring true participation of young people:** The peer educators provide information to their peers and lead discussions on HIV/AIDS related issues. For the genuine participation of young people they should be involved in all phases of the development of the information

material as well as in planning their use. Young people themselves can be trained as counsellors. Sevadham should consider strengthening the skills of peer educators to take on leadership roles in mapping out and setting the agenda, taking the lead to establish school-community links, to network and advocate for supportive policies<sup>vi</sup>.

**Staff turnover:** Staff are employed for only six months of the year on the school programme. For the other six months, they have to seek alternative employment until the start of the next school year. While the programme was confined to Pune district, Sevadham was able to offer staff alternative employment on other projects. With staff now dispersed in different parts of the State, this is no longer possible. Many staff are therefore leaving Sevadham at the end of their contracts, and much valuable time is lost every year in recruitment and training.

**Monitoring and evaluation for quality control:** With the rapid expansion of the programme since 2000, it has become increasingly difficult for Sevadham to ensure the quality of the peer educators and nodal teacher training. An organisational assessment may provide an opportunity to identify current staffing needs. Further, an evaluation of the existing training and support materials and methodologies used will also be useful to assure the quality of the programme.

Evaluations by independent agencies concluded that the secondary school programme carried out by the Sevadham Trust<sup>6</sup> was effective in increasing knowledge, awareness and

<sup>iv</sup> Annex 5 : Alternative Approaches for Discussions on HIV/AIDS related Issues

<sup>v</sup> Annex 8: 'At a Glance: Young People Friendly Health Services Framework'

<sup>vi</sup> Annex 10: 'At a Glance: Participation of Young People'

decision-making abilities of young people. However, the programme's impact on the sexual behaviour of young people has not yet been carried out and would be very valuable<sup>vii</sup>.

**Sustainability:** The Department of Education of Maharashtra State, has taken over administrative responsibility for the programme. However, it is severely cash-strapped and unlikely to make a significant financial contribution to the programme for the foreseeable future.

Financial support from UNICEF is likely to be phased out in the near future, leaving the programme dependent on support from the National AIDS Control Organisation (NACO). NACO has indicated that it is likely to continue financial support until 2010. However, a long term sustainability strategy, such as income-generating activities or diversifying donors might be an important next step.

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<sup>1</sup> The research was carried out by the Directorate of Health Services, Maharashtra State, and was reported on All India Radio (personal communication, Dr S.M. Bhadkamkar, Sevadham Trust).

<sup>3</sup> Professor P.K. Gowande, Report of Evaluation of Family Life, Sex and AIDS Education Project for School Students (IX & XI) from five Corporations of Maharashtra, 1999.

<sup>4</sup> Ibid.

<sup>5</sup> Personal communication, Dr S.M. Bhadkamkar.

<sup>6</sup> Catch 'Em Young. Best Practice Case Study on School Based AIDS Preventive Education Programmes in Maharashtra, India, UNESCO, New Delhi 1998.

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<sup>vii</sup> Evidence that changes in sexual behaviour can be measured comes, for example, from Uganda, where a recent study in Soroti District found that the proportion of sexually active 13-15 year-olds declined from 43 percent to 11 percent after a two-year school-based HIV prevention programme carried out by AMREF. See: "Increased sexual abstinence among in-school adolescents as a result of school health education in Soroti District, Uganda", by Dean A. Shue, Bernadette B. Babishangire, Samuel Omiat and Henry Bagarukayo in Health Education Research, Oxford University Press, Vol. 14, No. 3, 1999, pages 411-419.



# "Chatting With My Best Friend" UNICEF, Nepal

Location: Kathmandu, Nepal

Target groups: Adolescents (12-19 years old)

Strategic approach: Life-skills based education through 'entertainment education' (radio and television), supported by print materials

Area of operation: National with an estimated number of over 3 million adolescents and young people as listeners



# Tuning in to Life Skills "Chatting With My Best Friend" in Nepal

## Background and rationale

It is Tuesday afternoon - 16 young men and women are sitting on the floor of a sparsely furnished room in Pulchowk, an urban area of the Kathmandu Valley, Nepal. This is the weekly meeting to plan the following Saturday's edition of 'Chatting With My Best Friend' (Saathi Sanga Manka Kura in Nepali), a radio programme which has quickly established itself as a huge success with adolescents throughout the country.

One of the programme's presenters reads out a letter from a 15 year-old girl who is in despair after being rejected by her boyfriend. The group discusses the letter and agrees that it should be featured in the next episode of the programme.

'Chatting with my best friend' is the first - and so far the only - national radio programme in Nepal, which discusses personal issues, affecting young people in a frank and honest manner. It is the most widely listened to radio programme for adolescents in the country. The programme is presented in an entertaining way, through lively

discussions between the presenters and short, hard-hitting dramas, interspersed with popular music and songs. Feedback from listeners has been extremely positive. Over 700 letters are received from listeners each month, and more than 500 listeners' clubs were formed in the year 2002.

The programme - which includes the radio programme, printed materials and a television drama - is at the centre of UNICEF's support to the national response to the growing HIV/AIDS epidemic in Nepal. With its huge outreach, it served as an initiator and reinforcing factor for the accelerated prioritisation of more targeted life-skills based education being developed in schools and out-of-school settings through the Department of Education.

Nepal had, by the year 2000, entered the stage of a "concentrated epidemic". At that time, about 36,000 people were living with HIV/AIDS. By the end of 2001, this figure increased to 58,000 people living with HIV/AIDS with a quarter below age 25. Among injecting drug users, HIV prevalence

shot up from 1% in 1993 to nearly 50% in 1999, and a 2002 study revealed a scathing rate of 68% among male injecting drug users in Kathmandu.

## Objectives

The Communication Initiative focuses on adolescents, whose particular needs and problems are generally overlooked. The Nepali word for 'adolescent', *kissor kissori*, denotes an age group, with no connotations of special characteristics. The hierarchical traditions of Nepalese society deprive many young people of the information, skills and opportunities they need to make informed and responsible decisions about matters affecting their health and wellbeing.

The aim of 'Chatting with my best friend' is to increase young peoples' knowledge of issues affecting their lives and to help them deal with the difficult issues they face in their daily lives through life skills based education. The specific objective is to prevent HIV infection and injecting drug use through increased knowledge of HIV/AIDS and drug use related issues.

## Programme components

### Preparatory process

The first step in the preparatory process was a survey<sup>1</sup> carried out by UNICEF in 1999 to assess the programmatic response to the HIV/AIDS epidemic in Nepal and to identify gaps and needs. The survey identified the urgent need for a communication strategy targeted specifically at adolescents, who were vulnerable to HIV infection through unsafe sexual and injecting drug use behaviour.<sup>i</sup>

Based on the findings of this initial survey, which indicated lack of data on adolescents' and young people's behaviour and knowledge levels, UNICEF launched a national "Survey of Teenagers" to determine the target audience's attitude, needs, fears, and preferred media outreach format. This was done through a survey of Knowledge, Attitudes, Practice and Skills (KAPS) of 1,400 young people aged between 12 and 18 in seven districts representing all the country's geographical areas and development zones.<sup>2</sup>

The findings of the survey indicated that adolescents' main concerns centred around unemployment, education, family problems, health, money, as well as love, sex and marriage. 92 percent of adolescents interviewed had heard about HIV/AIDS. Some of the adolescents interviewed were already sexually active and some reported unprotected multi-partner sex and unsafe drug use practices: 22 percent of boys had already had sex, half of them with two or more partners. 22 percent of sexually active boys had, at least once, a sexually transmitted infection. Among 9 percent of sexually active girls, 14 percent had become pregnant and 13 percent had contracted an STI. While 74 percent of girls claimed that their partners had used a condom during sexual intercourse, only 65 percent of boys said they had done so.

Although few teenagers consumed alcohol regularly, 13 percent had used drugs and 5.4 percent were injecting drug users. Peer pressure was the main factor in drug use. 77 percent of respondents said they had started taking drugs at the suggestion of friends.

<sup>i</sup> Annex 6: 'At a Glance: Programme Communications and HIV/AIDS Prevention for Young People'

It was clear from the KAPS survey that risk behaviours of adolescents had their origins in deeper problems, such as emotional pain, conflicts with parents, anxieties about the future, peer pressure to take risks, and curiosity about sex in a conservative culture that inhibits open discussion about sexual issues. Their education, family upbringing and other background influences were not preparing them adequately to cope with the conflicting pressures and expectations which were placing their health and well-being at risk. The survey also demonstrated the urgent need for a life-skills based education to address the larger issue of positive self-development among adolescents.

Most adolescents interviewed said they were interested in learning more about sexual health and HIV/AIDS. The most popular media for information on health issues were radio and television, followed by books, magazines and newspapers. Radio was by far the most widely utilised mass medium: 86 percent of respondents said they listened regularly to the radio, which is cheaper and more easily accessible than other mass media in the country's mountainous terrain.

The 'Chatting with my best friend' programme has three main components: the radio programme, letters from listener and listeners' clubs. These are accompanied by a television drama programme and printed materials.

### 1. The radio programme 'Chatting With My Best Friend'

Ten young broadcast media professionals - all aged between 19 and 26 - underwent a six month-long training course in the design and production of 'entertainment-



education' programmes aimed at young people, with a particular focus on life skills for the prevention of HIV/AIDS, other STIs and injecting drug use.

The trainees consisted of producers, presenters and technicians. Training sessions were based on the UNICEF Nepal life skills handbook and on the results of the KAPS survey of adolescents. As part of their training, members of the group also accompanied research teams into the field and carried out individual interviews and focus group discussions.

A provisional list of 52 topics to be covered was drawn up, and ten episodes were pre-tested among a randomly selected group of 500 adolescents. The pre-test found that the format and contents of the programme were popular, and the first episode of 'Chatting with my best friend' went on the air in April 2001. Radio Nepal broadcasts the one hour-long 'Chatting' programme in the national language, Nepali, every Saturday afternoon. It is then repeated by eight FM stations in different parts of the country during the evenings of the following week. It is estimated that over 3 million<sup>3</sup> adolescents and young people - and an unknown number of adults - tune in to 'Chatting' regularly.



Aptly described as 'entertainment-education', the programme uses an entertainment format for educational messages. It persuades young people to engage in healthy behaviours, by addressing a range of relevant issues, including love, sex, marriage, pregnancy, drug abuse, problems with parents, HIV and other STIs.

The format and contents of the programme are designed to appeal to young people, especially to adolescents. The presenters are all in their early to mid-twenties. The programme establishes a friendly relationship between presenters and listeners - like close friends talking to one another. The format of the programme consists of chats between the two co-hosts - a young woman and a young man - combined with short dramas, music and songs. It is able to engage different groups of young people, including those who are married, unmarried, in and out of school, rural and urban as well as young people who are sexually active and those who are not.

Listening to listeners: When 'Chatting' was first broadcast it drew upon the findings of the KAPS survey for topics to be covered in the chat and in the drama. After a few weeks, however, listeners' letters provided more than enough material for the programme on topics such as boy-girl relationships, sex, HIV/AIDS and other STIs, handling emotions, communicating with parents, and alcohol and drug use. In each episode of the programme, four or five letters are read out and the co-hosts discuss possible ways of responding to the problems described in them. They also challenge listeners to ask themselves what decisions they would make if they found themselves in similar situations.

In the first two years after 'Chatting' went on the air, the programme received almost 15,000 letters from listeners all over the country. In 2002 the average number of letters per month exceeded 700. In April 2002, a year after the programme first went on air, a local NGO, Oxygen Research and Development Forum, was contracted to respond to listeners' letters. Every listener who writes to the programme receives an individual response. Every effort is made to ensure that the presenters' responses to the letters are non-judgmental, factually accurate, and that they incorporate life skills messages, such as the importance of setting personal goals, and how to think both critically and creatively in difficult situations.

The most popular subjects touched on in letters have to do with love and relationship issues, which are directly related to sexual behaviour. Listeners are also sent one or more booklets and photo novellas relevant to the particular life skills referred to in the letter. These are designed as self-learning tools to help young people understand themselves and

"I have been in love with a low-caste girl for the past 14 months. We love each other very much and want to live our lives together. But society does not permit us to get married, as we are of different castes. I cannot live without her, but I cannot make my mother cry either. My mother has brought me up on her own, since my father died when I was five. What shall I do now?"



to use specific life skills (e.g. managing emotions and stress, critical thinking, showing empathy) to deal with potentially difficult situations.

## 2. Listeners' clubs

Ten months after 'Chatting' first went on the air, listeners were encouraged to form clubs so they could listen to the programme together, discuss the issues raised and perhaps undertake some activities together. This was based on focus group discussions with adolescents, parents and community leaders in five districts in different parts of the country.<sup>4</sup>

The initial survey findings showed that existing youth clubs were not helping adolescents to deal effectively with their personal problems. Almost all the boys and girls interviewed felt there was a need to establish 'Chatting' listeners' groups. Since the programme talked about 'embarrassing issues' many young people said they would be more comfortable listening to it in the company of their friends, rather than at home, where their parents and grandparents were likely to hear it. For young people from poor families listeners' clubs would provide an opportunity to be freed from working in the fields or domestic chores on Saturday afternoons. Girls welcomed the idea of a club because they thought this would help to convince their parents that they would be safe by attending a semi-official activity, especially if held in a village meeting place.

The call from the programme for listeners' clubs to be formed met with an immediate and positive response. Within eight months over 500 listeners' clubs had been formed in 61 of the country's 75

districts - a remarkable response. Some clubs were youth groups that were already in existence and simply added listening to 'Chatting' to their activities. Others were formed as groups dedicated to listening to the programme.

Most clubs consist of 8-20 adolescents, of both sexes, who meet on Saturday afternoons to listen to the programme together. Some clubs are still quite informal but others are highly organised. Many clubs have collected funds to cover their running costs, for example, for stationery and postage, or for buying a radio. Some clubs have gone even further, and embarked on activities to help adolescents protect their sexual health, stop using drugs and alcohol, and avoid HIV and other STIs. In Palpa district, for example, a listener's club formed a partnership with the local health centre, and organised a three-day workshop to educate adolescents about sexual and reproductive health. To fund this initiative the members collected donations (cash, food, blankets - anything people could spare). The same group also obtained funds from the District Development Committee to start their own newsletter. Clubs in other districts have also reported collaboration with health centres for condom distribution and in some places the village development committee has provided the club with a meeting place.

## 3. Television drama 'Catmandu'

'Catmandu' drew its initial inspiration from the thousands of letters received from listeners to the 'Chatting with my best friend' radio programme. Targeted mainly at young people living in urban areas, especially in Kathmandu, the 'Catmandu' plots depict young people dealing with emotional



conflicts, facing tough choices and going through situations which demand empathy, creative and critical thinking, problem-solving abilities and other life skills.

At 7 p.m. every Saturday evening, Nepal TV broadcasts a half-hour programme which regularly attracts an estimated 50 percent of the station's viewers. 'Catmandu', the first television programme acted and directed by young people for young people in Nepal, takes the form of a drama on personal issues affecting young people.

'Catmandu' has attracted many young viewers and receives a lot of letters from viewers, which the young producers weave into scripts for new episodes in the series. Many viewers write to the station asking for a stronger social role for young people, including activities to help people with information on HIV and AIDS and the formation of a Web Site to give young people a voice.

'Catmandu' has only two full-time staff - a director and a script writer. The actors are all young amateurs, some of whom are still at secondary school. Yet the programme reaches a wide age group. One teenage girl wrote: "I like this programme coz once in every week for 30 minutes our TV set turns into a mirror, reflecting the society and its people. It's me and my feelings. I find my parents there, solutions to my problems and most of all, it makes our family come together within a boundary of understanding."

#### 4. Printed support materials

The UNICEF manual, Life Skills: A Facilitator's Guide for Teenagers, has been adapted into eight booklets and published in Nepali. Each booklet covers one topic and consists of exercises to help

adolescents understand themselves better and learn how to tackle daily situations through a combination of skills. In addition, UNICEF has produced a set of colourful photo novellas on similar themes. Featuring the cast of the popular 'Catmandu' television series, the photo novellas were designed as an easy-to-read, self-learning tool for adolescents, and are particularly suitable for use in rural areas with high illiteracy rates.

#### 5. Monitoring and evaluation

Programme monitoring is done through focus group discussions. In December 2001, a focus group survey carried out in five districts showed that 70 percent of young people were regular listeners to the programme.<sup>5</sup> A teenage boy reported that he had done a survey of 30 people of all ages in a small town in Bhojpur district, and found that 70 percent listened to the programme. He wrote: "They were students, educated people, housewives and adolescents. I have their names and signatures but since I can't put everything in this short letter I've copied out short quotes from them."

The quality of the programme is monitored through analysis and discussion of listeners' letters. Many of these demonstrate that young people have understood the concept of life skills and are trying to apply specific skills in their daily lives, especially in their relationships with their friends and parents.<sup>6</sup> Some young people, however, have written to the programme to report that they have tried to apply certain life skills, but without success.

The programme is addressing these limitations by responding to every letter received from listeners, thus establishing a one-to-one, two-way communication process, and also by

sending listeners booklets and photo novellas relevant to the issues that concern them. The establishment of listeners' clubs - each of which receives a full set of life skills books, photo novellas and leaflets - is also intended as a means of enabling young people to provide one another with mutual encouragement and support so they can more effectively integrate life skills into their lives.

The extent to which 'Chatting with my best friend' is helping adolescents to deal with the personal and social problems affecting their lives, and their sexual health, has yet to be evaluated. The survey carried out in 2000, however, provides the baseline data for such an assessment to be made. Plans are underway for an evaluation of the impact of the programme to be carried out by the end of 2003.

## Funding

"Chatting with My Best Friend" has proved to be a relatively low cost initiative. The cost of production of 52 weekly episodes "Chatting With My Best Friend" and broadcast on the national AM network and eight commercial FM radio stations is under US \$75,000 (less than US \$1500 per episode or 2.5 cents per listener per episode). With the additional components of TV, print material and the life skills-based education in and out of school, the annual budget for 2002 was over US \$250,000.

UNICEF has provided all funding for the project so far, apart from some in-kind contributions from Radio and TV Nepal. Within the UNICEF funding component, some support has come via UNAIDS through the UN Theme Group on HIV/AIDS in Nepal.

## Achievements and lessons learned

1. The programme provides accurate and comprehensive information on sex, HIV/AIDS and sexually transmitted infections and pregnancy. This is much needed information which is not otherwise easily available to young people. It has built up, within a span of two years, a large and appreciative

Prativa always wears dark sunglasses. Ever since the age of five, when she suffered from a serious illness, she has been partially sighted. Now aged 15, she and two other partially sighted girls stay with a family in Kathmandu, where they attend secondary school.

Every Saturday afternoon, just before 3.30, Prativa and her friends switch on the radio to listen to their favourite programme, "Chatting with my best friend". They know that most of their school friends will also be tuning in to the same programme, either in small groups or individually.

"When we come to school, we talk about the programme - the letters that were read out, the advice and the suggestions from the presenters. We discuss whether they would work, whether they are practical. It helps us to learn about different aspects of life and how to face up to problems."

Prativa feels able to discuss topics which previously she would have avoided:

"Now I can discuss things like sex and inter-caste marriages. Anything I know about these things is from 'Chatting'. When other young people talk about their problems I ask them if they listen to 'Chatting'. If they don't, I suggest that they should."

"Young people should be encouraged to discuss things like sex and HIV/AIDS openly. We need to know more about these subjects. If we have proper knowledge it will help us to avoid STIs and HIV/AIDS."

Prativa Tamang

audience, estimated to be more than 3 million adolescent boys and girls in 61 of Nepal's 75 districts. The focus group discussions carried out in December 2001 estimated that 70 percent of adolescents tune into the programme on a regular basis. Increased demand for the programme is substantiated by the fact that, even after its initial broadcast on Saturday afternoon, it is re-broadcast on eight FM stations in different parts of the country. The positive tone and the number of letters received by the programme indicates that it is widely appreciated by young people.

2. **Both the radio and the television programme contribute to breaking the silence and denial** often associated with HIV/AIDS, sexual abuse and incest by directly addressing them openly. Other sensitive issues such as unequal treatment of girls within the family, and taboos surrounding inter-caste marriage are also openly discussed during the programmes.

The topics covered by 'Chatting' and the language used are breaking new ground for Radio Nepal - the only national radio network in the country - which in the past has avoided sensitive issues such as sexual behaviour, and has not used words describing sexual organs and bodily functions. Scripts are carefully checked by the Censor Board of Radio Nepal before being cleared for broadcast, so the scriptwriters have to tread a fine line.

There have, however, been remarkably few moments of tension. As Rajendra Sharma of Radio Nepal explains: "We are not censoring content. It's not what we say but how we say it. The content should not be overtly vulgar, but otherwise we have no objection to sober

analysis, even of issues like masturbation or homosexuality."

At the same time, the programme promotes listeners' clubs, where young people can meet to share the ideas aired in the programme with one another, and to discuss their relevance to their own lives. The clubs also enter into direct correspondence with the producers of the programme, giving feedback on particular episodes and reporting on their activities. Some of these letters are then read out on air. There are exciting possibilities for many other forms of interactive communication which have yet to be explored, for example, through pre-arranged phone calls from schools, and listeners' clubs.

3. **The programme has mobilised young people and created an extensive network of listeners' clubs.** The programme's relevance and appeal have spawned a network of over 500 listeners' clubs in 61 districts. The clubs are entirely self-initiated, each made up of ten to twenty boys and girls between ages of 15 – 24. Their "reward" is a set of life skills booklets and photo-novellas, including information on HIV/AIDS, reproductive health, and the risk of drug use. Many club members are now actively promoting knowledge of safe sex, risks related to early pregnancy and drug use among peers. They also take collective action to resolve problems for their community, such as mobilizing health workers to give a talk on HIV/AIDS. The clubs constitute an important link in behavioural intervention – interpersonal discussions and peer influence – to bring about positive behavioural changes

4. **A thorough understanding of the audience is key to success of mass media programmes:** The success of

the programme is the result of two years of research, planning and training carried out by the UNICEF Nepal country office. The experience of 'Chatting' illustrates the benefits of programming based on research to understand the interests, needs, knowledge, attitudes, behaviour and life skills of the target audience, followed by ongoing monitoring and audience research to assess the impact and effectiveness of the programme. The initial survey and documentation of HIV/AIDS activities taking place in Nepal in 1999 helped planners identify the need for a communication strategy and programme aimed at adolescents.

The subsequent survey in 2000, of the interests, realities and needs of adolescents brought two major benefits. The Focus Group Study undertaken in 2001 helped to monitor the implementation process. The findings suggest that the programme was reaching an average of 70 percent of its target audience of adolescents, who were enthusiastic about its contents and presentation. The study also brought out the need for listener clubs and guided the project staff to take the necessary steps.

**5. Openness builds trust:** The frankness and honesty with which the programme has addressed sensitive, but critical, issues such as incest, masturbation, menstruation and pre-marital sex has appealed to adolescents and contributed to its success. One of the main reasons for the popularity of the programme is the fact that the producers and presenters are themselves young. They understand the culture of adolescents and the problems they face in their daily lives, and feel empathy with them. Young listeners can easily relate to

the presenters, whom they regard as friends they can trust and with whom they can freely discuss intimate personal problems, without fear of being condemned as immoral, immature or ignorant.

**6. Capacity building of staff is critical:** The programme has benefited significantly from the thorough training of all members of the production team in life skills based education. Though the producers were already fully trained professionals with several years of experience, they undertook a full-time, six month-long training course on the production of programmes on issues related to adolescents and life skills.

**7. Listen to your listeners and respond to them:** The popularity and quality of the programme have been greatly enhanced by the producers and presenters having access to hundreds of letters every month from regular listeners. Drawing on the comments, suggestions and queries of their listeners, the programme makers have been able to come up each week with episodes that deal with topics of burning interest and importance to their target audience. A mechanism has been developed, in partnership with an NGO, to respond to each and every letter individually. This interactive process of communication and learning, which is backed-up by mail-outs of printed materials on life skills, enhances the capacity of the programme to influence the attitudes and behaviour of young people.

## Challenges for the way forward

- 'Chatting' with its wide reach and popularity among young people has **successfully opened up discussions on sensitive issues.**

The programme could build on its popularity and the experience made by taking on crucial social issues such as access to education for all, sexual abuse, harm reduction for drug users; call for increased accessibility to condoms. It could open up public debate on HIV/AIDS related stigma and discrimination by offering a platform for people living with AIDS to openly discuss these issues while maintaining their confidentiality.

- **Listeners' clubs an established avenue for linkages with the community.** Leading members of 'Chatting' listeners' clubs will also be trained to strengthen the role of listeners' clubs as a national network of young people for social change. The training will be extended to children's clubs and community organisations in the 15 districts of the country where UNICEF provides support. The challenge is to strengthen the capacity of the peer leaders in listeners clubs to facilitate and guide discussions around sexual and reproductive health issues and HIV prevention.

Some listeners' clubs have begun organising their own activities, such as training in sexual health and HIV/AIDS prevention, in collaboration with local health centres and village development committees. Given more training in participatory skills, the members of the listeners clubs could engage communities and give them a voice in planning and decision-making with a real stake in their long term development, which should include HIV/AIDS prevention and care. Promoting the true and meaningful

participation of young members of the listeners clubs and that of the community would require a level of understanding of participatory principles and methods.<sup>ii</sup>

The possibilities for linkages need to be explored, for example with the Family Planning Association of Nepal (FPAN). FPAN trains peer educators in sexual and reproductive health in different parts of the country. The Green Clubs and Young Star Club also offer established forums for working with listeners clubs. Another option would be for government agencies and NGOs to set up counselling services for young people with linkages to the large and growing network of listeners' clubs

- **Reaching out to communities and parents:** The frankness and honesty with which the programme has addressed sensitive issues still arouse suspicion and hostility with many adults, which need to be addressed. Separate radio programmes broadcast at times convenient for older people and community mobilization of parents and key adults on adolescent needs and rights could be a solution.
- **Monitoring and evaluation:** The interactive nature of the 'Chatting' programme provides feedback, enabling the programmers to respond quickly and sensitively to the expressed needs and problems of young people. The next step should be an impact evaluation to ascertain the impact of the programme not only on knowledge levels but also on skills and on behaviour. The impact evaluation will provide

<sup>i</sup> Annex 10: 'At a Glance: Participation of Young People'

lessons on processes that have worked for building life skills through mass media supported by listeners clubs as well as data which might point to the need for an additional inter-personal component to strengthen the mass media component of life skills.<sup>iii</sup>

- **Sustainability:** From the outset, the programme has been supported operationally and financially by UNICEF. However, with such a positive impact to date, and bearing in mind the capacity already built amongst a core group of young writers, producers and broadcasters, there is a tremendous opportunity for them to assume full ownership and management of the radio and television components of the initiative. This would further strengthen the integration of these elements within the implementation of the National Strategic Plan on HIV/AIDS which has young people as a primary target for awareness, life skills development and access

to services, and open up opportunities for additional financial support via national funding mechanisms (including the Global Fund to Fight AIDS, TB and Malaria).

In addition, the fact that so many young people are listening and watching the programme opens up opportunities for advertising partnerships with selected companies or products; and also for radio stations (at the very least, the eight commercial FM stations) to be either buying broadcast rights or at least broadcasting free of charge, rather than charging for broadcast of a product that is attracting huge listenership.

Finally, the potential for increased listenership and impact, along with sustainability and national ownership will be strongly reinforced by the development of a comprehensive public relations and marketing campaign, including the development of a 'brand' for the initiative.

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<sup>1</sup> Who's doing what on HIV/AIDS in Nepal, UNICEF, Nepal Country Office, Kathmandu 2000.

<sup>2</sup> A Survey of Teenagers in Nepal for Life Skills Development and HIV/AIDS Prevention, UNICEF, Nepal Country Office, Kathmandu 2001.

<sup>3</sup> Extrapolation based on A Focus Group Study on Teenagers' Forums and Listeners' Groups (see below) and National Population Census 2001.

<sup>4</sup> A Focus Group Study on Teenagers' Forums and Listeners' Groups for 'Chatting with my best friend', UNICEF, Nepal Country Office, Kathmandu 2001.

<sup>5</sup> Ibid

<sup>6</sup> Cai Cai, UNICEF-Nepal, personal communication.

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<sup>iii</sup> Annex 4: 'At a Glance: Life Skills Based Education and Young People'



# Adolescent Peer Organised Network BRAC, Bangladesh

Case study 3: Non-formal Education and  
Skills Development for Adolescent Girls

Location: Dhaka, Bangladesh  
Target groups: Adolescent girls  
Strategic approach: Empowerment of adolescent girls through peer education  
Area of operation: 58 regions of Bangladesh



# Girl Power in Bangladesh: BRAC's Adolescent Peer Organised Network

## Background and rationale

When Eti came to the Reading Centre in her village one afternoon, her friends noticed immediately that she was upset. Asked what was troubling her, the 13 year-old explained that her parents had arranged for her to be married soon, but she was totally against the idea - she wanted to continue her schooling, which would be impossible if she were married. Her friends decided to persuade Eti's parents to drop their plans for Eti's marriage.

"We met Eti's parents," her friend Mili later recalled, "and we explained to them that she was not yet fully grown up, and if a girl under 18 is married she runs a greater risk of death due to pregnancy. We also explained that it is a punishable offence to marry off a young girl without her consent. And if they, as educated parents, didn't understand these matters, who else would?"

To Eti's relief, her parents were not offended by this bold action by her friends, but listened carefully to what they had to say. Eti's parents

changed their plans for her marriage and informed her that she could continue at the Reading Centre after school.

Only a couple of years ago, it would have been almost impossible to imagine such an event happening in Eti's village, in Rajshahi region, Bangladesh. Teenage girls lacked not only the knowledge, but also the self-confidence and the negotiating skills needed to protect one of their friends from an under-age marriage. Such arrangements were traditionally decided by parents - the girls themselves had no say in the matter. A quiet but profound transformation is now taking place in the knowledge, attitudes, social skills and self-confidence of a large group of adolescent girls, not only in Eti's village but also in over 6,000 other villages in Bangladesh.

The driving force behind this transformation is the Adolescent Peer Organised Network (APON), a project designed and implemented by one of Bangladesh's leading NGOs, the Bangladesh Rural Advancement Committee (BRAC). APON addresses the particular prob-

lems and needs of adolescent girls. They are often unaware about matters relating to sexuality and reproductive health due to the conservative nature of traditional Bangladeshi society, which prevents them from acquiring this information.

The APON project grew out of a large BRAC programme aimed at providing basic education to underprivileged children, especially girls, who have not previously attended primary school. Known as 'Basic Education for older Children' (BEOC), this initiative established basic schools for 11 to 14 year-old adolescents, which were to close after operating for four years. The school buildings then became the basis for Reading Centres (kishori pataghar), open to former BEOC pupils and other young people, particularly girls, who wanted to maintain their literary skills by reading books, magazines and newspapers about topics of practical interest and value. The APON project, which started in 1998-99 in 25 regions, is now in 58 regions with 6,500 Reading Centres and aims to reach about 200,000 adolescents, mainly girls.

## Objectives

The objectives of the APON project are to:

- Empower adolescent girls and develop their confidence and leadership skills.
- Develop adolescent girls' life-skills to become responsible members of their families, the communities and their country.
- Change traditional rural perceptions of the capabilities and value of girls.

- Provide adolescent girls with a network of peer support.
- Encourage adolescent girls to continue their education.

## Programme components

APON's strategic approach is to empower adolescent girls through education and skills development, provision of employment opportunities and through increased awareness of sexual and reproductive health as well as gender issues.

### 1. Education and skills development through Peer Education

Development of support material through participatory process: Through focus group discussions, BRAC learned that young women wanted to learn about reproductive health, contraception, sex education and sexually transmitted infections. They also wanted information on sensitive social issues such as inheritance law, oral divorce, dowry, women's legal rights, nutrition, children's health, physical harassment, acid attacks, and how to deal "diplomatically" with mothers-in-law. Based on this information, BRAC set up the Reading Centres in 1999 where girls could acquire knowledge and life skills that would enable them to make informed choices and to develop their leadership potential.

A set of 20 booklets on 40 different social, economic and environmental issues were developed for use in the Reading Centres. The booklets, developed with full involvement of the adolescent girls in all phases, aim to impart social skills to help girls and young women to cope with gender inequality issues. They also provide information about

whom to contact and what actions to take in the event of sexual abuse, symptoms of particular diseases, and how to obtain legal aid. Their preferences are reflected in the topics and format of the materials, and in the terms and the level of language used.

The BRAC programmers knew that making the 20 booklets available at the Reading Centres alone would not be effective. For the messages to be discussed, remembered and acted upon, an interactive learning process with facilitators/teachers was needed. Initially BRAC field staff was not convinced that teenage girls could be trained to lead the teaching and learning processes. They planned to use adult teachers to run the sessions in the Reading Centres.

BRAC carried out a study to compare the knowledge and teaching skills of adult teachers with those of secondary school students trained in peer education.<sup>1</sup> The results of this study showed that the trained students remembered the contents of the booklets significantly better than the adult teachers, although the teachers had the edge where methodology was concerned. Importantly,

adolescents retained knowledge much better when taught by the students than by the adult teachers. In light of these findings, BRAC redesigned the APON project so that adolescent girls - not adult teachers - would be trained as peer educators to carry out the learning exercises in the Reading Centres.

**Peer education**

The over 5,000 young (average age 17), unmarried young women peer educators are the frontline workers of the APON project. They are based at Reading Centres established and supported by BRAC. In September 2002, over 6,000 Reading Centres with a total membership of 221,326 in 58 districts had either completed or were still running the APON course.

APON members are encouraged to share their new knowledge with their peers and others in the village. They are also encouraged to record their activities. Twice a month, they meet to compare experiences, make suggestions and reinforce one another's knowledge and communication skills. They also plan and carry out collective actions, such as working together to prevent early marriages and oral divorces.

Trainee peer educators, students from Class 8 between the ages of 14 and 18, are chosen from among the participants in the Reading Centres. Special preference is given to girls who have attended a BRAC basic education school, or who are divorced, belong to an underprivileged minority, or are from a particularly poor family. The peer educator training, for the specifically selected trainees, is a five-day, participatory workshop, facilitated by adolescent and adult trainers at a BRAC Team Office, focusing on course information and leadership skills.

**APON STRUCTURE AT FIELD LEVEL**

BRAC Education Programme Office  
 Reading Centre Supervisors  
 (each responsible for about 20 Reading Centres)

Adolescent Monitors  
 (each visits about 8 Reading Centres per month)

Adolescent Supervisors  
 (each visits 7 or 8 Reading Centres per month)

Peer Educators  
 (two per Reading Centre)  
 APON participants  
 (about 25 adolescent girls per class)



Every adolescent leader supervises seven or eight Reading Centres, including her own, and also doubles up as a peer educator at her own Reading Centre. One-day refresher training workshops for peer educators are held once a month. The most able adolescent leaders are trained to become supervisors and monitors. By the end of 2001, the APON project trained 5,200 peer educators, 444 adolescent leaders, as well as 850 adolescent supervisors and monitors. Female Adolescent Monitors are employed by BRAC to visit eight Reading Centres per month in their regions. They review attendance, record the activities being carried out, take note of problems encountered and discuss these with the peer educators.

## 2. Advocacy to overcome parental resistance

Initially many parents voiced their opposition to the idea that their daughters would be exposed to information about sensitive issues such as sexual and reproductive health and women's legal rights. To overcome this opposition, BRAC staff went door-to-door, explained to mothers, fathers, grandmothers, mothers-in-law and other relatives how the classes would help rather than harm the girls. Monthly parents' meetings were also instituted to answer questions and allay fears. Once parents realised that the project did not support risky sexual behaviours and promiscuity, and that their daughters would also learn useful income-generating skills, they started to support the project.

## 3. Empowerment through livelihood programmes

BRAC's programmers recognised that to be really empowered, girls needed access to employment opportunities, livelihood training

and micro-credit. The APON project itself provides many girls with part-time employment. By July 2002, for example, 5,374 girls were paid a small sum for working as peer educators; another 344 were working as adolescent leaders and 856 as adolescent supervisors. Their performance has been almost uniformly excellent, and the fact that they are regularly bringing money into their families has boosted their self-esteem and status within their families.

In addition, BRAC has trained a total of 411 girls in photography, computer data entry, journalism and in agricultural areas such as dairy, poultry keeping and nursery management. They are given with loans to start their own businesses, for example, as photographers. A local television network, ETV, trained girls from the APON project as journalists and reporters, and several episodes produced or researched by the girls from APON have been broadcasted on a local television programme.

APON for Boys is an initiative to improve the quality of life of BRAC male graduate adolescents who are currently studying in high schools. The program aims to raise the boys' awareness of issues relevant to them and to build their skills to make the right choices. The curriculum, designed for the APON boys, has an emphasis on male puberty and reproductive health but also deals with issues such as acid throwing, abuse, dowry and other culturally relevant issues. Issues related to family planning, sexual abuse, HIV/AIDS and drug use will be added to the curriculum.

## Funding

The APON project is part of BRAC's Adolescent Development

Programme, through which roughly 5,000 Reading Centres are being funded by a consortium of donors consisting of UNICEF, the Royal Netherlands Embassy, NOVIB (Oxfam Netherlands), the European Commission, the Aga Khan Foundation, CIDA and DFID; an additional 2,000 are funded separately by UNICEF through the Kishori Abhijan Project, which grew out of the APON project

## Achievements and lessons learned

**1. Increased knowledge and strengthened life-skills:** About 200,000 adolescent girls attended APON training courses between May 2000 and September 2002. Though no formal impact evaluation has been carried out, the adolescent girls have during focus groups discussions and interviews indicated that they have increased their social skills and self-confidence and know more about sex and sexuality, health in general and sexual health in particular, women's rights and other important but sensitive issues. Girls trained by APON have been able to use their knowledge and social skills successfully to influence important decisions affecting not only themselves but other members of their extended families.

An adolescent leader in Natore region explained: "We discuss the things we have learned with our peers in the community, and somehow the information spreads to the next village, where there is no Reading Centre. Married adolescents from that village come to me to learn about family planning methods, sexual infections and so on. When I help them I feel useful and productive."

Girls who have taken on leadership roles in APON have also developed

critical thinking skills. While adolescent girls generally spend a lot of time thinking about their impending marriage, girls involved in APON tend to have a much broader perspective. A peer educator from Natore region described how she is trying to change the fatalistic approach which most girls have towards early marriage: "I have taken on the responsibility to create awareness among girls. If I get married at this stage, who will listen to me? The members of the Reading Centre regard me as their role model." Girls trained by APON are also able to address very sensitive issues, such as sexual abuse of girls by men from within the extended family.

Working for APON has given many young women a degree of mobility which previously was unthinkable. Using bicycles provided by the project, they are able to travel well beyond the confines of their own local communities. This has not always been easy, as one adolescent supervisor explained: "When I started riding a bicycle around, our villagers made various negative comments about me. But I respected them as much as possible and continued my job. Now they say that if their daughters had studied in a BRAC school they could have had the same opportunities as I've had."

Girls involved in APON are becoming more ambitious. A peer educator in Gazipur region described her aspirations: "I want to work equally with men and reduce discrimination in society. With my earnings I will be able to re-enrol in school"

**2. Changes in family and societal attitudes:** An important outcome is how the attitudes of the girls' own families and their communities have changed towards them. This is



especially the case for girls who have directly or indirectly gained employment through the project. In the past, their parents and other members of their extended families would have regarded them as a burden that should be hidden from sight in the family home. Now, however, because they are bringing money, information and social skills into the home, they are valued by their parents as competent, knowledgeable individuals who are capable of adding to the family's resources. Morshed Begum, a Reading Centre Supervisor in Sherpur region explained:

"My earnings, though not very much, helped my sister and myself to pay our exam fees. They also paid for the cost of my mother's medical treatment. Also, I am now able to talk freely about all my problems with my father. I don't give money directly to him but he considers me as an earning member of our family. Nowadays he involves me in all our family level decisions. I've also noticed a big difference in the community, where people now respect me a lot and listen to what I have to say, because I am the only female High School graduate and I also have a job."

As girls become valued income-earners for their families, the pressure on them to marry early decreases. At the same time, they find themselves consulted by their parents on family matters and even on issues concerning agriculture or animal husbandry. Their increased status within the family has enabled many girls to delay marriage and complete their secondary school education, while further developing their knowledge and skills.

Nevertheless, many girls still face pressure from their parents to marry young, even if this means ending

their schooling. The project has devised a Delayed Marriage Scheme to enable girls to complete their secondary school education before being married. Through this scheme, the project pays Tk 700 to girls for their Senior School Certificate examination providing they do not get married before the age of 18. By September 2002 a total of 89 girls had received this payment and none had broken their promise not to marry before 18 years of age.

### 3. Empowerment through capacity building and opportunities for income generation:

Monitoring has shown that 319 of the girls trained and assisted by the project have been successful, for example, in starting a photo, sewing or poultry business, or getting a data entry job in an office. Nearly 100 of the girls trained, however, have so far been unable to find employment. This is partly because many are still attending school and are seeking part-time work, for which there is only limited demand from employers. Another reason is the fact that many employers are looking for girls with formal qualifications (e.g. High School Certificate) rather than practical skills. The project is now following a policy of first identifying particular employment gaps and then training girls to fill these.



4. **Community support:** Parents and community leaders are often distrustful of initiatives to educate young people - especially girls - about sexual and reproductive health. Their opposition can paralyse a programme. But their support is critical in creating supportive environments for girls and boys, to reduce young people's vulnerability and risk to HIV infection as well as unwanted and early pregnancies. The APON project has dealt successfully with this problem by informing parents and community leaders about the programme before it started. Monthly meetings were held to foster friendly and open working relationships and to maintain community support for the peer educators. The major lesson learned is the need for on-going advocacy with parents and community leaders to gain and maintain parental and community support.

5. **Young people valued as peer educators:** The project demonstrates the importance and effectiveness of peer education<sup>1</sup>. The young girls clearly preferred learning about sexual and reproductive health issues, including those related to HIV/AIDS, from their peers. The project implementers have learned through use of the peer education approach that:

- **Payment of peer educators ensures loyalty:** The project has paid a modest honorarium to all peer educators and other part-time staff to recognize and reward their efforts. This has also promoted loyalty and continuity amongst staff. The APON project has also learned that paying an honorarium has been vital to win parental support for the project as well as to raise the status of girls within their own family.

Importantly, it helped the girls to continue schooling and to delay marriage.

- **Peer educators require regular support and supervision** to maintain the quality of the programme and to avoid incorrect information being taught. Support should start by introducing the Peer Educators to the other participants and emphasising that they have been trained to run the APON course at the Reading Centre. If this is not done, the peer educators might not be sufficiently respected by their peers or by community leaders and parents.
- **Adolescents and peer educators should be involved in decision-making:** The project has benefited greatly from involving adolescent girls in decision-making about all aspects of the project, especially curriculum development, training needs, teaching materials, organisational arrangements, and liaison with parents and community leaders. Initially this was done through focus group discussions. As the project unfolded, it has been done through routine monitoring by project staff and additional focus group discussions with girls at the Reading Centres.

## Challenges for the way forward

- **Reducing peer educator and staff turnover:** Peer educators as well as other staff continued to leave the project, due to migration to other areas after marriage. These losses are being reduced by the Delayed Marriage Scheme, which enables girls to stay at school until they have completed their

<sup>1</sup> Annex 9: 'At a Glance: Young People and Peer Education'

Senior School Certificate examination. However, any programme which works with young people as peer educators should seek to address these needs and realities to avoid high turnover.

- **How to reach married adolescent girls:** In rural areas of Bangladesh most adolescent girls are married before the age of 19 and, on an average, their spouses are several years older. The health and well being of married adolescent girls are at greatest risk through sexual activity but they often have little or no access to the knowledge and life skills available to unmarried girls through the APON project. They also have fewer opportunities for social interaction and exchange of information with their peers. BRAC has therefore started a pilot APON project for married adolescents and their husbands. Both spouses are asked to attend the sessions, which deal with issues such as reproductive health, relations with in-laws, domestic violence and communicating skills. However, it remains a challenge to involve husbands, as they generally come expecting training in income-generating skills and stop attending when they realise that this is not the case. Project staff conduct outreach visits to persuade them to return. More effective ways need to be developed to integrate and maintain the involvement of adolescent girls' husbands in the project.
- **Strategies to involve boys:** Boys involvement and support is critical for girls' development to succeed, particularly in conserva-

tive rural societies. BRAC Programmes which aim to reduce girls' vulnerability and risk to HIV infection should involve young men in a way which is culturally appropriate and addresses male fears and needs. BRAC has made a commendable start by piloting an APON course for adolescent boys in six regions. This uses the same organisational structure as APON for girls, and is carried out mainly by boys who have been trained by the project as peer educators. The process has to be accelerated and BRAC needs to ensure that equal effort is put in to reach both married and unmarried men and boys.<sup>ii</sup>

- **Access to friendly services:** So far the APON project has not established linkages or a referral system to health and social services. However, for projects working to improve young girl's and boy's sexual and reproductive health, access to services is critical. The project would benefit from exploring possibilities of linkages with government/private health services to enable young girls and boys access for treatment of sexually transmitted infections, for voluntary testing and counselling and for condoms.<sup>iii</sup>

A study on health seeking behaviours would provide the necessary information on barriers and ensure that services meet the differential needs of adolescents, young people both married and unmarried. The findings will also enable the project to deal with issues which will influence sexual and overall health and

<sup>i</sup> Annex 7: 'At a Glance: Gender and HIV/AIDS'

<sup>ii</sup> Annex 8: 'At a Glance: Young People Friendly Health Services Framework'

development such as dynamics and communication within families, power relations and violence among males between sexes, alcohol and drug use, harmful traditional practices. Such a study should include community perceptions and attitudes to young people's sex and sexuality and risk taking behaviours and to HIV/AIDS/STIs.

- **Taking further efforts to empower girls through livelihood training:** APON's strategic approach of providing livelihood training and income earning opportunities has changed the lives of some of the girls. But to better translate livelihood interventions into income generating opportunities for the girls requires a thorough evaluation of and interaction with market needs, contacts and networks. APON has already initiated this to a limited extent. But to better market the training, skills and products, it might be worthwhile to conduct a market assessment. This would require technically qualified staff and effective tool kits that go beyond gender-biased traditional skills and incorporate knowledge of market assessment and opportunities.
- **Sustainability:** Funding for the APON project is limited to five years,<sup>iv</sup> but efforts to empower adolescent girls will have to continue for much longer. The sustainability strategy being followed by APON is to involve the community at every step of the project, and to train adolescents to take over the management of the activities when project funding stops. Local adolescents are already responsible for the day-to-day manage-

ment of the Reading Centres and the APON training activities. It is expected that Reading Centre management committees, chaired by local community leaders, will take over the responsibility for managing and financing APON activities. This strategy has not yet been tested in practice.

## The future

The Adolescent Peer Organised Network in Bangladesh has demonstrated that, even in a conservative rural society, it is possible to empower adolescent girls with the attitudes, knowledge and skills they need to take greater control of their lives. Moreover, adolescent girls themselves, provided they are properly trained and supported, can become main change agents in the process of empowerment, which can also help to protect them from the threat of HIV/AIDS and other STIs.

It is envisaged that the APON project will continue for another five years, starting in January 2003, but that the concept and organisation of the Reading Centres will undergo substantial changes. Originally, the Reading Centre used the buildings left behind by BRAC's Basic Education for older Children project, which routinely closed after operating for four years. The Reading Centres themselves, however, closed down after another three years, leaving the APON project without a home, despite protests from local communities. In view of the demand from communities for APON training, BRAC proposes the following changes in the Reading Centre concept:

- Adolescent Development Centres (ADCs) should be housed in their own rented premises so they can be open for a longer period and

<sup>iv</sup> UNICEF funding is for a three-year time period.

be used whenever needed for training purposes.

- ADCs should be opened wherever surveys indicate that there is a demand among adolescent girls.
- ADCs should run for as long as the community wishes instead of automatically closing down after three years, providing the community can agree on a plan for financial sustainability. This
- could include, for example, recovering the operating costs of the centre through small user fees.
- The curriculum and teaching materials need to be reviewed and consideration given to including issues such as equity and gender, social harmony, civic consciousness and religious tolerance.

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<sup>1</sup> Nashidan Ahmed and Anwara Begun (2000). Level of Knowledge, Attitudes and Skills of Adolescent Leaders and Peer Educators: an Evaluation, BRAC, Dhaka, Bangladesh





# The Mahila Samakhya Programme in Bihar India

Location: Patna, Bihar State, India

Target groups: Adolescent girls and adult women, especially from scheduled castes and tribes, and other disadvantaged communities in rural areas of Bihar State

Strategic approach: Education and empowerment of women and girls

Area of operation: 2,063 villages in eight districts of Bihar State



# Women's and Girl's Education and Empowerment: The Mahila Samakhya Programme in Bihar

## Background and rationale

"Four years ago, if a policeman walked through the village, we would be afraid. We would go indoors," says Shanti, a women's group leader in a village in the Indian State of Bihar. "But today, when a policeman comes here, we go out and ask him, 'What's the news? How are you? Why have you come here? Can we help you?'"

A teenage girl in another village says: "As a young girl I was told by my mother that I should not dream the impossible, like going to school. Yet today the gods have surprised me with the chance to hold a book, and to read and write. Now I dare to dream the impossible."

Mukha, a women's leader, says: "In the past when village meetings were held we were never informed. But now, whenever there are meetings we are given prior information. Even in the meetings of the village education council our opinions are respected."

These statements illustrate just a few of the changes that have been brought about in eight districts in the Indian State of Bihar through the Mahila Samakhya<sup>i</sup> programme, which began in 1992 as part of the Bihar Education Project.

The programme was introduced to address the especially disadvantaged situation in which women and girls find themselves in Bihar, especially in rural areas, where over 80 percent of the population lives. Women and girls in rural Bihar are subject to oppression and discrimination both within society and in their own homes. They are discouraged from taking part in decision-making processes within the community and their own family. Their labour is grossly undervalued and women are paid less than men for the same work.<sup>1</sup>

Education is traditionally considered a 'luxury which women can do without'. According to the 1991 Census, female literacy in Bihar was only 23 percent, compared with 52

<sup>i</sup> Mahila means 'woman' and samakhya means 'interaction between equals'. The term Mahila Samakhya can be translated as 'education for women's equality'.

percent for men - the lowest in India.<sup>2</sup> Women's literacy rates amongst scheduled castes and scheduled tribes were even lower - 9.3 percent and 6.77 percent respectively.<sup>3</sup> Girl children are worse off than their brothers. They are given less to eat whenever food is scarce, and are more likely to be taken out of school if money is scarce or if their labour is needed at home. At the time of the 1991 Census, some 80 percent of girls between the ages of 10 and 14 in Bihar State were not attending school.<sup>4</sup>

The health needs and problems of women and girls in rural Bihar are also grossly neglected. Lack of information and services in areas such as nutrition, immunisation, sexual and reproductive health have taken a heavy toll on women's health and general well-being. These factors also make women and girls more vulnerable to HIV infection.

Mahila Samakhya is based on the recognition that, for women deprived of the basic necessities of life and denied their rightful place in the family and society, education is not a perceived primary need. "Will holding a slate fill my stomach and clothe my children?" is a common question asked by poor women about literacy.<sup>5</sup>

As a first step, therefore, the Mahila Samakhya programme in Bihar helped poor women to identify the main problems faced in their daily lives - lack of drinking water, low wages, domestic violence - and to dare to dream of a future where they could make their own decisions and enjoy a life of dignity, freedom and respect. This was no easy task in a society where, since birth, women have been brought up to believe that they have no minds of their own, and that the sole pur-

pose of their lives is to bear and rear children, keep their menfolk happy, and to accept without question all the suffering that life holds in store for them.

As the women gained new information and knowledge, however, their self-confidence increased. They also began to realise that their inability to read and write - or even sign their names - was a severe handicap when they had to deal with local government offices, banks, land owners, the Post Office, schools and contractors. Even keeping records of their own women groups' activities and setting up a savings account was impossible without literacy and numeracy skills.

Through the Mahila Samakhya process and activities, women became aware of their urgent need for relevant, life-oriented literacy, numeracy, information and knowledge. Moreover, they wanted to ensure that their daughters would also have access to the same knowledge and skills. In this way, the process of women's empowerment created a strong demand from women and girls for education appropriate to their needs. Moreover, as they gained greater access to education through Mahila Samakhya activities, they used their new knowledge and skills to become more empowered and to improve the lives of their families and communities. Education and empowerment thus became mutually reinforcing strategies.

## Objectives

Women's empowerment - both at the individual and the collective level - is the ultimate aim of Mahila Samakhya. The programme defines women's empowerment as "the process of change, where the



women take control of their lives, become self-confident, develop a positive self-image, have a greater accessibility to resources and challenge existing power structures.”<sup>6</sup>

The Mahila Samakhya process aims to enable women to speak their minds, articulate their needs, and join hands with other women to identify their collective strength, participate with confidence in community activities, and share community responsibilities. The specific objectives of the programme can be summarised as follows:

- Enhance women’s self-image and self-confidence, enabling them to recognise their contributions to society and the economy.
- Create environments where women demand knowledge and information, empowering them to play a positive role in their own development and in the development of the society.
- Create an effective vocal demand for educational facilities in the villages, where the project operates.
- Create opportunities for education of women and adolescent girls by providing necessary support structures and an informal learning environment that respects their needs, given the multiple demands upon their time.
- Increase women’s and girls’ participation in both formal and non-formal education so that education can serve the objectives of women’s equality.
- Revitalise the existing educational structure and build mechanisms

to ensure that women monitor their own education and that of their children.

- Establish decentralised and participatory management with decision-making power developed at district and village levels.

## Programme components

The programme follows a set of ten ‘Non-negotiable Principles’ to guide every stage of the processes of planning and implementation of activities. These guidelines were developed through a process of workshops, seminars and meetings with women’s groups, social activists and staff of the Government of India’s Ministry of Human Resource Development.

The Mahila Samakhya programme consists of five main components:

### 1. The Mahila Samooh - a ‘space’ for nurture and action

The main component of the programme is the Mahila Samooh, or women’s group, which is a nurturing space where women, including married and widowed ones, can meet to reflect, ask questions and analyse their problems. As women share their experiences and articulate their problems and needs, any negative self-image gives way to a more positive one. After a few months the women of the Samooh designate one of their members with leadership qualities and a willingness to work for the benefit of all as the local Sakhi, or leader of the group. After intensive training by the programme, the Sakhi, who is an unpaid volunteer, helps her fellow members to strengthen the Mahila Samooh and to carry out its activities.

Once the Mahila Samooh is well established, the members begin to seek collective solutions to their problems, mobilising support from the community and calling on government structures at Block and District level for assistance when necessary. The issues taken up by Mahila Samoohs are many and varied, but they include among others those related to girls' education; drinking water and primary health care; violence and sexual harassment.

The Mahila Samoohs consist mainly of women from scheduled castes and tribes, and other disadvantaged communities, who face severe problems of poverty, debts and periodic unemployment. The programme introduced a savings and credit scheme, by giving each Mahila Samooh Rs 200 per month over a period of three years, which they put into a savings and credit fund. This fund is increased with contributions from individual members. Members of the groups use loans from this fund for medical costs and house repairs, and income generating activities such as goat rearing, poultry, rice milling, selling fertilisers, growing and selling vegetables, and setting up small businesses such as running a canteen or a bicycle repair shop. Some members have been trained in bookkeeping and help to manage all the accounts.

## 2. Jagjagi Kendra - 'awakening the world'

The word jagjagi was coined by combining two Hindi words: jag from jagat ('world') and jagi ('awakening'). The concept of jagjagi is based on the conviction that, if society is to be awakened to the fullness of life, women - who are currently deprived and silenced in so many ways - must be awakened through empowering

### The Ten Non-Negotiable Principles

- Initially, when the women are consolidating themselves, their time and space are not hurried or short-circuited.
- Women participants in a village determine the form, nature, content and timing of all the activities in their village.
- The role of project functionaries, officials and other agencies, is facilitative and not directive.
- Planning, decision-making and evaluation processes at all levels are accountable to the collective of village women.
- Education is understood as a process which enables women to ask questions, conceptualise, act, reflect on their actions and raise new questions. Education is not to be confused with mere literacy.
- Acceptance that, as an environment for learning is created, what women decide to learn first may not be reading or writing. Women's priorities for learning must always be respected.
- Acceptance that, given time, support and catalysts for such reflection, women are of their own volition seeking knowledge with which to gain greater control over their lives.
- The educational process and methodology must be based on respect for women's existing knowledge, experience and skill.
- Every intervention and interaction occurring in the project must be a microcosm of the larger process of change. The environment for learning, the respect and equality, the time and space, the room for individual uniqueness and variation must be experienced in every component of the project.
- A participatory selection process is followed to ensure that project functionaries at all levels are committed to working among poor women and that they are free of caste or community prejudices.

Source: Bihar Education Project, Mahila Samakhya-Bihar: A Journey in Women Empowerment

education. Jagjagi is therefore a term for this empowering form of education, which enables women to take control of their lives, opening themselves up to many opportunities and possibilities for their holistic development.

The Jagjagi Kendra is a day school for young girls (9-15 years) and women who have either not completed or never attended primary school. Lessons on basic literacy and numeracy are held five days a week for four hours a day. Special worksheets and a Jagjagi manual have been developed which are gender-sensitive and relevant to local conditions and problems. The manual covers issues such as health,

legal aid, the environment and women's issues. Girls and women in the Jagjagi Kendras, mainly from disadvantaged and marginalised communities, are also helped to gain greater control over their lives, both individually and collectively. Many girls of primary school age have managed to transfer from the Jagjagi Kendra to a mainstream primary school.

The instructor at the Jagjagi Kendra, known as the Saheli (friend), is generally a woman from the local village. The Mahila Samoohs are responsible for selecting their Saheli, paying her honorarium and monitoring the activities of the Kendra.



### 3. Bal Jagjagi Kendras - early childhood centres

In villages where there are no government-supported integrated child development centres, the programme has established early childhood development centres for three to six year old children. These are also managed by the Mahila Samooh, which pays the honorarium of the Bal Mitra (teacher). These centres, which provide gender-sensitive care and education for girls and boys, have successfully motivated many parents to ensure that their children attend primary school.

### 4. The Kishori Manch - a forum for girls

This is a club, which meets once a week. It aims to provide both in-school and out-of-school girls with

a place to meet and discuss issues affecting their identity and well-being, such as reproductive health and personal hygiene. The members have opportunities for special training, orientation, interaction and sharing experiences with other groups.

### 5. The Mahila Shikshan Kendra (MSK) - full-time education and training

MSKs are residential education centres where semi-literate women and adolescent girls can complete their education up to secondary level, and where illiterate women can acquire basic education and life skills. The main purpose of the MSKs is to develop a pool of trained, highly motivated rural women to assume leadership roles in their communities.

Six MSKs, started in 1994/95, offer an eight-month residential course coupled with a three-month skills development programme. Experiential, participatory, interactive teaching and learning methods are used, with specially prepared books and teaching aids. The training provided by the MSKs is designed to empower women as facilitators. The holistic nature of the MSK courses emphasises the need for a positive self-image and confidence building, and skills for the analysis of personal and social situations. Special attention is paid to practical work experience in the village, both during the training period and during follow-up.

### Programme management and support

The programme is implemented by staff who are responsible for strategic planning, training, community support work and on-going monitoring of activities at village level.



It employs a total of 1,640 staff: 15 programme personnel, 15 support staff, 25 trainers, 185 Sahyoginis (cluster animators) and 1,400 Sahelis (Jagjagi Kendra instructors).

The Sahyogini, or community animator, is crucial to the success of the programme. She initiates contact with the villages, brings together a group of women to form the nucleus of the Mahila Samooh, and assists in local training programmes, village surveys and workshops. She is also involved in the management of the Jagjagi Kendras and other programme activities within the community. The Sahyogini must have some formal education, be literate and numerate. She is expected to live within the cluster of ten villages, which she coordinates. She must also be free from any caste or communal prejudices, and have a strong desire to work amongst low-income rural women and girls.

The Saheli, who runs the Jagjagi Kendra, is generally a young woman who has completed primary or junior secondary school, and has been trained by the programme to teach literacy and numeracy, as well as other subjects of relevance to the daily lives of rural women and girls. The Saheli must be also non-judgmental and highly motivated. She is paid an honorarium by the Mahila Samooh, to whom she is responsible.

The District Core Teams are responsible for planning and implementing the Mahila Samakhya programme, in collaboration with the Mahila Samoohs, the Sahyoginis and the State-level office of the programme. Implementation of the programme starts with the District Core Team selecting a single Block in a District for organised action, and then extending coverage to all

villages in the Block. The same process is then repeated in another block, until the whole District is covered. Each team consists of two or three capable women with the necessary educational qualifications and a commitment to women's causes. They are selected and trained to work as key animators of the Sahyoginis and other implementers of the programme at community level.

The District Training Team meets the continued demand from the Mahila Samoohs for various types of training at Block and village level. The team stays in close touch with activities at community level and constantly revises and updates its training methods to ensure that they are both innovative and relevant.

District Resource Centres and State Resource Centres provide the venue for meetings, training programmes, seminars, workshops and related activities. They are equipped with libraries, musical instruments and audiovisual equipment, and have hostel facilities for visitors.

The State Core Team consists of three people who are responsible for the overall planning, implementation and monitoring of the Mahila Samakhya programme at all levels. This team carefully nurtures the participatory nature of the programme, and also ensures coordination with government departments and other activities of the Bihar/Jharkhand Education Project.

## Monitoring

The Mahila Samakhya programme is monitored at all levels, which enables everyone involved in planning and implementation to be analytical and self-critical. The emphasis in monitoring is not so much on quantitative achievements

as on the processes of implementation. The monitoring is done at the village and district levels through sharing of experiences, networking, monthly/bimonthly meetings. At State level, review sessions of the District Core Teams are held every three months. The sharing of experiences and views, combined with decision-making as a group, helps to foster the team spirit which is an important aspect of the programme. Inter-cluster and inter-district monitoring and evaluation is carried out from time to time by District Core Teams and representatives of the Bihar Education Project.

## Funding

Between 1992 and 1997 the Mahila Samakhya programme was funded by the Government of Bihar, the Government of India and UNICEF. Since 1998 it has been funded by the World Bank, along with the State and national governments. UNICEF is still a partner providing technical support. In 2002/03 the programme had an annual budget of Rs 35.5 million (US\$750,000).

## Achievements and lessons learned

1. **Provided opportunities to women and girls to learn to read and write:** Just over a decade ago, when the Mahila Samakhya programme began, there were many villages in the State of Bihar where it was difficult to find even a single literate woman. In 2001, at least in the eight districts<sup>ii</sup> of Bihar State where the programme has been operating, the number of literate and numerate women and girls has significantly increased. In Bihar as a whole, female literacy rose from 23 percent

Amrita Kerketta, from a very poor family is 22 years old. As a child, she was sent off to graze the cattle but the only thanks she ever received was a scolding from her parents. She was married at the age of 10 or 11 to a man who was twice her age but the marriage did not last long - she was back at her parents' home after only three days.

She had never been to school before her marriage but had attended the Jagjagi Kendra for two months and wanted to continue her schooling. The Mahila Samooh selected her to attend the MSK to catch up on the education she had missed. Everyone in her family supported her wish to get an education, with the exception of her brother, who thought she should just look after the family. Later, however, her brother would visit her regularly at the MSK and felt proud of the progress she was making there.

After completing the MSK course Amrita went to Ranchi for training as a Jagjagi Kendra instructor, and she now teaches 30 children. She is now respected by the village community. Even her husband, who previously had abandoned her, wanted her back but she declined his offer. Amrita, who previously used to take the cattle out for grazing, now rides around on a bicycle. Men sometimes taunt her for being so daring, but she ignores them.

Source: Anita Dighe, Mahila Shikshan Kendras of Bihar

in 1991 to 33.57 percent in 2001.<sup>7</sup> In some districts where the Mahila Samakhya programme has been operating for several years, however, there are villages that can boast of 100 percent enrolment in primary school and over 80 percent female literacy.<sup>8</sup> By October 2002, a total of 886 Jagjagi Kendras, with a total enrolment of 14,680 girls and 5651 adult women, had been formed in eight districts of Bihar

<sup>ii</sup> Four districts where the Mahila Samakhya programme operates have been handed over from Bihar to Jharkhand State, which was established in 2001.

State. In addition, a total of 8,810 teenage girls who attended the Jagjagi Kendras have been able to continue their education in formal schools

Girls have also demonstrated that, armed with literacy and knowledge, they can influence their parents on issues concerning their own future. For example, many girls who have attended the Jagjagi Kendras have refused to be married when they found out that they were below the legal marriage age, and their parents have accepted their decision.

The adolescent girls and women will stand to benefit even more if the programme could cater for the differential learning capacities of girls and women. Adolescent girls are more likely to learn faster than adult women. The Sahelis therefore find it difficult to teach girls and women in the same group, which slows down the pace at which the group as a whole can make progress. The Jagjagi Kendras work seemed to have worked best when girls and women learn in separate groups.

**2. Enabling collective action through group mobilisation:** Almost all the Mahila Samoohs are cohesive and active groups. By October 2002, a total of 2,079 Mahila Samoohs, with 52,168 members, had been formed in eight of the 37 districts in Bihar State. The Samooh is an important weekly meeting place for women, even if they have nothing urgent to discuss, where they know they can express themselves freely. For many young women and girls, the Jagjagi Kendras - where they can meet, talk, and share their feelings and experiences - perform a similar function.

The construction of the Mahila Kutirs (women's huts) is a good

example of collective involvement, decision-making and control. Women needed a space of their own, which they could control, and fought to obtain land and construct the building. In some villages, individual members of the Samooh persuaded their families to donate land for the building. In others, women had to fight hard to take possession of land allotted to them by local government authorities. When funds from the programme were not sufficient to complete the building, several Samoohs used their own savings to do so.

Members of the Samoohs have learned about laws that affect them, and have taken steps to improve their condition and status in society. They know about government programmes and services intended for their benefit, and go to the Block and District offices by themselves to get work done. For example, many groups have managed to have hand-pumps installed in their villages; others have taken action to reform the Public Distribution System of essential commodities, which is often affected by corruption. Women trained by the programme are more conscious of their own health needs and those of their families, and insist that the auxiliary nurse/midwife visits their villages on a regular basis.

**3. The programme has contributed to building positive self-image and unprecedented self-confidence:** Through education and group activities, thousands of women and girls involved in the programme have discovered a 'power within', enabling them to develop a new, positive self-image and unprecedented self-confidence. This has given them the courage to take action on issues such as wife beating, rape, alcohol consumption by men, under-age marriages, and

the casting-off and even murder of wives by their husbands.

The 'power within' has also led to other important changes in the lives of many women. These include, for example, being able to travel outside their homes and villages, being able to express their opinions to people in positions of power within the family (father, husband, other men) and the community (Block Development Officer, police, village leaders) and managing better to cope with conflict situations within their families.

4. **Enabled increased access to economic resources and assets:** By June 2001, a total of 1,141 Mahila Samoohs had established saving and credit funds, with capital amounting to Rs 11.9 million. Thousands of women had taken out individual loans, but some were also for collective purposes. For example, in 1994 a group of six women in Rohtas District took up a loan to set up a canteen on the District Institute for Education and Training campus. The individual and collective income-generating schemes started with support from group savings funds have given many women the confidence to take a stand for their rights and those of their children.

**Successful self governance:** The Mahila Samoohs have been able to manage not only their own affairs but also those of the Jagjagi Kendras and the Bal Jagjagi Kendras. They are responsible for obtaining a venue, informing the community about the activity, hiring and paying the instructors, supervising the work of the instructors, purchasing stationery, maintaining accounts and carrying out ongoing monitoring of activities. A particularly close working relationship has developed

between the Sahelis, the girls attending the Kendras and the Mahila Samooh, and this will enhance the sustainability of the Kendras after external support for the programme is phased out.

5. **Initiated the promotion of young people's participation:** The Kishori Manch organisation brings together school-going girls and girls attending Jagjagi Kendras on a weekly basis, so they can identify and articulate their shared needs and problems, and work together for solutions. In most villages, however, the purpose of the Kishori Manch is still not clear. The Mahila Samakhya programme would need to identify a clear role for an organisation of adolescent girls, to train leaders in the necessary skills and to provide ongoing support and encouragement. The Kishori Manch could be used as platform to promote genuine participation of young people by providing training in leadership and in participatory skills.

6. **Training in income-generating skills is an important part of the MSK curriculum:** It is an area in which girls are interested and a motivating factor for parents to send their daughters to the MSK. However, the skills that are currently being taught - such as embroidery, painting, bindi making, stitching, and making decorations - require raw materials which are not easily accessible to the girls, as well as marketing skills which they do not yet possess. Moreover, these skills, which are those traditionally associated with women, tend to reinforce gender stereotypes. There is an urgent need to identify through a market assessment, income-generating opportunities. Training should then focus on providing skills, which go beyond gender-biased traditional skills to meet the needs of the market. This will be both

economically more viable and will also change the traditional image of what counts as 'women's work'

7. **Sustainability:** Part of the Mahila Samakhya process is the phasing-out of the programme and its replacement by federations of strong women's groups managing their own affairs at district and state level. It took three years of sensitisation and discussions, however, before women in these districts were ready to embrace the idea of managing their affairs through a federation under their own control, without depending on support from Mahila Samakhya. By the end of 2001 Mahila Samoohs had initiated the process of forming a network of district and state-wide federations in the four districts. One of the districts drew up a check-list of 13 points to assess whether a group was ready to join the federation.

The formation of federations was in the initial plans. However, the process leading to self-governance is a long and complex one requiring time. Though the programme in Bihar State began in 1992, ten years later the process of developing a federal structure was still on-going.

8. **Trained women's leaders:** **The six Mahila Shikshan Kendras (MSKs) have made a** major contribution to the success of the programme by training young women who are now playing leading roles in their communities. By January 2001, a total of 2,153 women had graduated from the MSKs. Nearly all of these women were from scheduled castes (801), scheduled tribes (671), remote communities (494) and minority communities (121). Many of these women have joined the Mahila

Samakhya programme as Sahyoginis. Others are teaching at Jagjagi Kendras or Bal Jagjagi Kendras, and many others are leaders of women's groups. Over 500 have started an income-generating activity after completing the MSK course.

9. **Political involvement:** Through the Mahila Samakhya programme, many women have gained the courage to become politically active. In Muzaffarpur District, for example, 141 women from Mahila Samakhya groups stood for Panchayat elections in 2001. Of these, 54 won, six were elected to the Panchayat Samiti and one was elected as Mukhiya (village head).

## Challenges for the way forward

**Sexual and reproductive health (SRH) and HIV/AIDS:** Although HIV/AIDS data for Bihar are still limited, HIV prevalence in nearby States such as Maharashtra and Andhra Pradesh already exceeds one percent and is still rising. Other sexually transmitted infections (STIs) are also widespread and on the increase. Growing numbers of sexually active young men are migrating to urban areas in these States and other parts of the country, where they are likely to be exposed to HIV and other STIs, and on their return home may infect their wives or other sexual partners.

Women are biologically more susceptible to HIV infection than men. They are also socially and economically disadvantaged, and exposed to gender injustices such as wife-beating, rape and under-age marriage to older men. These factors increase their chances of being infected with HIV, even when they themselves are monogamous.<sup>iii</sup>

<sup>iii</sup> Annex 7: 'At a Glance: Gender and HIV/AIDS'



The Mahila Samakhya programme has already demonstrated how, through education, training and economic empowerment, women can gain enormously in self-confidence, develop their own organisations and achieve greater control over the factors affecting their lives. But the programme has even greater potential. Through its organisational structure and staff and volunteers, Mahila Samakhya can also provide a framework for empowering women and girls with the information and skills they need to protect themselves against the risk of being infected with HIV. This would be entirely in keeping with Mahila Samakhya's holistic and comprehensive approach towards improving the education, status and health of women and girls.

The women's and girls' groups established by the programme already include some education and training in sexual and reproductive health, and related human rights and gender issues. Young women also need training in life skills, such as self-awareness, critical thinking, coping with emotions, interpersonal communication and problem-solving. These skills are particularly important in making decisions about sexual behaviour. The programme faces the challenge of introducing these types of skills into the activities of the Jagjagi Kendras or the Kishori Manch groups.<sup>iv</sup>

Facilitating access to friendly, quality health services is equally

important. Empowered with new knowledge about HIV/AIDS, women are more likely to utilise services such as voluntary counselling and HIV testing, condoms and treatment for STIs - or to lobby for such services where they are not yet available. The project should explore possibilities of linkages with government/private health services to enable young girls and women access for treatment of sexually transmitted infections, for voluntary testing and counselling and for condoms.<sup>v</sup> A study on health seeking behaviours would provide the necessary information on barriers and to ensure that services meet the differential needs of adolescents, young people both married and unmarried. Such a study should include community perceptions and attitudes to young people's sex and sexuality and risk taking behaviours and to HIV/AIDS/STIs.

Addressing the sexual health and HIV/AIDS prevention needs of girls and women will require recognition of both areas and women, girls and boys as critical players to ensure effective HIV/AIDS prevention. To meet the challenge of HIV/AIDS prevention, the programme should seek to work with NGOs who are already involved in the work encouraging boys and men to adopt positive behaviours and placing on them the onus of responsibility to protect their partners, families and themselves.

<sup>iv</sup> Annex 4: 'At a Glance: Life Skills Based Education and Young People'

<sup>v</sup> Annex 8: 'At a Glance: Young People Friendly Health Services Framework'



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# Working with Young People On Sexual & Reproductive Health Family Planning Association, Nepal

Location: Kathmandu, Nepal

Target groups: Young people aged 13-24

Strategic approach: Increasing young people's knowledge of sexual and reproductive health (SRH) and utilisation of SRH services

Area of operation: Originally 72 villages in five districts



# Working with Young People On Sexual & Reproductive Health

## Background and rationale

Slightly built and small for his age, 17 year-old Vinod Khadka is the leader of a boys' peer educator group in Nasika village, in the hills about an hour's drive northeast of Kathmandu. There are also two girls' groups in the village. All three groups meet separately in the local Youth Information Centre (YIC). The boys in Vinod's group are all 16 or 17 year-olds attending secondary school in the nearby town of Kavre.

Vinod was selected for training as a peer educator through a process of debate organised by the local Family Planning Association of Nepal (FPAN) office for High School students. He enjoyed the five-day training course:

"I learned a lot, but what struck me most was the knowledge I got about all the physical and emotional changes that happen to young people during adolescence. After the course I did more reading at the YIC so I could prepare myself to give talks to groups of youth, and also in public. At first I was shy and nervous talking about such things,

especially with girls, but I got used to it. Now I give a talk to the girls' group every month. Before, I didn't know about any of these things. Now that I do, I want to pass on my knowledge to others."

The Youth Information Centre (YIC) in Nasika is one of 15 set up by FPAN as part of its project 'Working with Young People on Sexual and Reproductive Health', which was implemented in five districts from April 1999 until December 2002. The first of its kind in Nepal, this innovative project blazed a trail which has since been followed by all of FPAN's programmes to promote the sexual and reproductive health (SRH) of young people.

FPAN defines the term 'sexual and reproductive health' (SRH) as "freedom from gender discrimination and violence; healthy sexual and family relationships; the ability to enjoy sexual relationships without fear of infection, unwanted pregnancy or coercion; the ability to regulate fertility without risk of unpleasant or dangerous side-effects; the ability to go safely through pregnancy and childbirth; and the ability to bear and raise healthy children".<sup>1</sup>

There is no doubt about the need of young people in Nepal for more SRH education and services. Most young people in Nepal lack the knowledge, the life skills, the social support and the necessary services needed to make informed, responsible and healthy choices about their sexual and reproductive health. Socio-cultural and religious traditions are major factors in the high prevalence of pregnancies amongst adolescent girls. Nearly half of 15-19 year-old girls are married, but only 12 percent practice contraception. One in every four girls between the ages of 15 and 19 is either pregnant or has already had a child, and is likely to have experienced problems during her first delivery.<sup>2</sup>

The mean age of first sexual intercourse is 16.4 years for males and 16 for females.<sup>3</sup> Despite the likelihood of sexual encounters during adolescence, many young men and women are unaware of the consequences of their sexual behaviour or its impact on their partners. They also lack access to 'youth-friendly' SRH services such as counselling and treatment for sexually transmitted infections as well as for condoms. As a result, adolescent girls in Nepal are at risk of unwanted pregnancy and unsafe abortion, and are equally vulnerable to STIs including HIV. Young men - many of whom migrate to India and other countries in search of work - are increasingly likely to be in situations which put them at risk to HIV infections and other STIs. The migrant labourers in many countries form the bridge population bringing these infections to their sexual partners on their return.

Based on this background, the target group for the project are male and female adolescents and young people aged 13-24, both married and unmarried. The project was implemented in 72 villages in five of Nepal's 75 districts, with a total population of 950,000. The project started in April 1999, was originally planned to run until June 2002 but was extended to December 2002.

## Goal and objectives

The goal of FPAN project 'Working with Young People on SRH' was "to empower young people in selected districts of Nepal to adopt safe sexual and reproductive health behaviour and practices". The project adopted a two-pronged strategy to increase:

- young people's knowledge of sexual and reproductive health (SRH), and
- young people's utilisation of SRH services.

The objectives of the project, in terms of benefits for young people, were:

- Increased participation of young people in the design of SRH strategic plans and activities.
- Enhanced availability of appropriate SRH information and services for young people.
- Enhanced awareness of SRH among young people.
- Enhanced linkages and co-ordination with community leaders, parents, CBOs, line agencies etc for creating a favourable support system to improve SRH of young people

## Programme components

An assessment of adolescent sexual and reproductive health needs was carried out prior to implementation of the project in 1999.<sup>4</sup> This was followed by a baseline survey and focus group discussions with adolescents and young people in five districts in 2000.<sup>5,6</sup> These studies provided the project with the baseline data required for planning, implementation and evaluation. The programme was implemented through four main components.

### 1. Advocacy and community mobilisation

When FPAN designed the project Working with Young People, in 1998/99, it was breaking new ground. At the time, no other organisation in Nepal had attempted to provide sexual and reproductive health information and services designed with and for young people. The Ministry of Health had developed a National Reproductive Health Strategy, which included adolescent reproductive health as a component, but the implementation of this component of the Adolescent Strategy had not yet begun.

The FPAN project, from the outset, focused on the 'sexual' as well as the 'reproductive' health of young people. This was based on study reports, which showed that young people - unmarried as well as married - engage in sexual activities for different reasons, including fertility expectations as well as for pleasure. The project was designed to give young people the lead role. They were trained as peer educators to organise SRH educational activities within their own communities and schools.

To win official and public support for the project, advocacy activities were carried out on two levels: with policy makers, mainly before the implementation of the project; and at the community level, particularly during the first year of the project but also in subsequent years.

**Policy makers:** The first task faced by FPAN was to convince policy makers at national level that the new project was in accordance with government policies. Seminars were organised with high-level officials from the National Planning Commission, the Ministry of Health and the Ministry of Finance. FPAN officials argued successfully that the project was consistent with the new National Reproductive Health Strategy and would supplement the government's efforts to implement the adolescent reproductive health component of the strategy. Subsequent seminars and other meetings were held to keep national level policy makers informed about the direction of the project. For example, the results of the baseline study and the implication of the needs assessment carried out in 1999 were discussed with government policy makers.

**Community level:** Many people in the communities were initially opposed to the idea of unmarried adolescents learning about sexual and reproductive health, and perhaps even having access to contraceptive services. Parents felt especially protective about their daughters who, they believed, would lose their 'purity' by being exposed to SRH information and services. Girls, for their part, felt very hesitant about the prospect of discussing issues such as menstruation, pregnancy and contraception in public, especially if boys were present.



The project therefore undertook a huge advocacy effort with parents, community leaders, community-based organisations (CBOs) and local government authorities. Young organisers and counsellors, both females and males from the project organised meetings with groups of parents and community leaders to explain the purpose of the project and how the activities could be organised. These meetings helped to allay many fears and misconceptions about the project. The FPAN youth organisers also held meetings with village level young people and women's groups, which helped to create mutual understanding and good working relationships. In 2001, for example, a total of 2,359 people attended such meetings.

At district level, bi-monthly meetings were held with Rural Health Coordinating Committees, which coordinate the activities of government health services, CBOs and NGOs. These helped to identify opportunities for collaboration, avoid overlapping activities and deal with potential problems. FPAN's own networks also helped to create goodwill for the project at community level. For example, 216 Reproductive Health Female Volunteers previously trained by FPAN were given an additional three days of training, after which they played a key role in persuading parents of adolescents to allow their children to participate in the project.

Through these advocacy efforts, resistance to the project at community level declined rapidly and was replaced by strong support.<sup>7</sup> Families and communities were particularly supportive of the Youth Information Centres (YIC), 15 of which were established by the

project. When external funding for the project stopped as planned in December 2002, all but one of the communities where a YIC had been started by the project had made plans to continue its activities, using their own resources.<sup>1</sup>

## 2. Information, Education and Communication (IEC)

Production and distribution of materials: The project has produced and distributed a wide range of IEC materials in the national language, Nepali. The topics covered include issues related to growing up and adolescence; sexuality, reproductive rights and family planning; abortion; menstruation and menarche; wet dreams and masturbation; pregnancy, marriage and infertility; STIs and HIV/AIDS.

One of the most attractive materials produced by the project is a question-and-answer game on SRH issues, played with cards, a ball and a target on a piece of soft cloth. The project also developed and printed a SRH wall chart and flip chart, as well as several training manuals and guidelines for school teachers, peer educators, youth organisers and laboratory assistants. The project also used various 'small media', such as roadside billboards and wall paintings, to communicate SRH messages.

All these materials were introduced to their respective target audiences at training workshops and other meetings, and distributed via YICs, family planning clinics, FPAN branch offices and schools, a mobile film screening. Street theatre was used to reach a wider audience at community level. In 2001 an estimated 20,801 people watched street theatre performances by peer groups from the YICs.

<sup>1</sup> The YIC in Achham District was closed down because of the activities of Maoist rebels.

### Information through Peer Educators

There were a total of 216 peer educator groups with three peer educator groups in each of the 72 villages where the project operated with a total membership of about 2,000. The great majority of the participants are unmarried and under 20 year olds. For many girls, being in a peer educator group provided an opportunity to do something useful and interesting during the 'empty' time in their lives between leaving school and getting married.

Each peer educator group has eight to twelve members. Group leaders are trained by FPAN over a five-day period in adolescent sexual health and physical development, pregnancy, contraception, HIV/AIDS and other STIs. Issues such as child abuse, rape, early marriage, and gender discrimination within the family and wider society were also included. Group leaders also received training in communication and organisational skills.

When the first peer educator groups were started in 1999, many parents objected to FPAN's original concept of mixed groups of boys and girls. FPAN, then encouraged young people aged between 14 and 19 to form same-sex groups, but promoted the idea of mixed groups for 20 to 24 year-olds. The single-sex groups, however, proved to be more successful than the mixed groups, and no mixed groups were formed after 2000. By the end of 2001 there were 99 all-female groups, 89 all-male groups and 28 mixed groups.



The peer educator groups each meet at least once a month for a talk and discussion, usually with a speaker from FPAN, who leads the discussion in an informal, participatory way. Individual peer educators are expected to talk with friends and family members about adolescent SRH issues, including HIV/AIDS. It is difficult to estimate how many young people have been reached in this way, but an external evaluation carried out in August 2002 put the figure at between 8,000 and 12,000 - equivalent to 4 percent of the 13-24 year-old population in the project districts.<sup>8</sup> In addition, the groups perform street theatre in local communities and skits in schools, covering not only SRH topics but also human rights issues such as discrimination against girls within the family and society.

### Teacher training

The project has helped to strengthen the teaching of SRH in secondary schools, which was introduced in the late 1990s but for which teachers were generally unprepared and lacked teaching materials. In 2000/2001 the project trained 672 teachers from 148 schools in SRH issues, and also provided teachers with supplies of IEC materials. This has been one of the most important activities carried out by the project, reaching almost every secondary school in the five project districts. The teachers trained have since taught 10,000 students each year in SRH issues, using the knowledge and materials obtained from the project.

### 3. Youth Information Centres

The operational base of the peer groups is the Youth Information Centre (YIC) of which there are a total of 15. This is a one-room building where young people can meet safely, amongst themselves,

for recreation and social activities but also to learn about SRH and other health and development issues. The YICs are open for 8-12 hours a day, six days a week, and are run by a Youth Organiser assisted by Peer Group Leaders and Reproductive Health Female Volunteers.

The YICs also have a small library of books, newspapers and magazines. In response to the wish of parents that the YICs should not focus exclusively on SRH issues, these materials cover a wide range of topics, including health, nutrition, the environment, sanitation, development, agriculture and current affairs. Each centre also has a video player and a stock of tapes on health, environmental and development issues. In 2001 the 15 YICs in the project carried out a total of 591 video showings on SRH and other health and development issues to nearly 9,000 young people.

Some YICs also have a question box, where young people can put anonymous letters about personal issues which they are too shy to discuss with a health worker, a teacher or a parent. FPAN staff regularly collect the letters from the question box and take them to the local branch office, where the counsellor, staff nurse and youth organisers prepare individual replies. These are then posted on the notice board in the YIC, along with the original unsigned letter. This seems to be an effective way of responding to the information needs of particular individuals, and at the same time educating a larger group of young people.

One particularly innovative aspect of the YICs is their role as a distribution point for condoms. Usually a box of condoms is attached to a wall near the entrance

to the building, at a height convenient for adolescents but too high for young children to reach. Visitors to the centre can help themselves to condoms free of charge, without registering their names, which ensures that young women as well as young men have equal access to them. In practice, however, young women - even those who are married - still feel inhibited about taking condoms from the box at the door of the YIC.

Apart from their educational activities, the YICs also perform an important function as a place where young people can meet socially and play games such as badminton and volleyball. This is particularly important for girls, who otherwise have few, if any, recreational facilities of their own.

#### 4. Provision of Sexual and Reproductive Health Services

The project provided SRH services through clinics at five FPAN district branch offices, 72 outreach clinics attached to village development committees and 15 YICs. A total of 28 staff (10 counsellors, five laboratory assistants, five staff nurses and eight Auxiliary Nurse Midwives) was employed to provide the following services:

Counselling: Two counsellors - one male and one female - were employed at each of the five FPAN district branch offices so young people could be counselled by someone of their own sex if they wished. The counsellors, all in their twenties, were mostly from non-health backgrounds but received special training from FPAN to prepare them for their role. Although based at the FPAN branch office at district headquarters, counsellors frequently travelled to YICs and outreach family planning clinics to provide services. Each

counsellor, however, carried out only one individual counselling session per day on average.<sup>9</sup> Most of their time was spent on health education at YICs, advocacy at community and local government levels, training teachers in SRH, and writing reports for FPAN branch offices.

**Contraceptive services:** The main method of contraception provided by the project to young people was the condom, which was available free of charge from FPAN branch office clinics, project outreach clinics and YICs. A small number of unmarried adolescents received the contraceptive pill at FPAN and outreach clinics, but on a more or less secretive basis.<sup>10</sup> Many young people preferred to collect condoms from a box at the YIC, where there was no need to disclose their personal details. In 2001 the project distributed a total of 47,966 condoms to young people.

**Laboratory testing facilities:** The project had five laboratories - one in each district - to carry out blood, urine, stool, semen and sputum tests to assist in the diagnosis of SRH-related conditions, including pregnancy, in young people. The numbers involved, however, were small.

We never talk with our parents about anything to do with sex.

“Young people around here do practice unsafe sex. There are teenage pregnancies before marriage. Whenever that happens the girls’ parents either arrange for the girl to have an abortion, which is against the law, or they force the boy to marry the girl.

Vinod Khadka, peer educator

## Funding

The project was part of the Reproductive Health Initiative (RHI) in Asia, supported by the European Union and UNFPA, which was designed to accelerate implementation of the Programme of Action of the International Conference on Population and Development in 1994. Projects in the RHI are funded by the European Union and coordinated by UNFPA. The ‘executing agency’ was the Netherlands-based NGO, the World Population Foundation, which provided technical support to the project. The implementing agency, the Family Planning Association of Nepal (FPAN), is the Nepalese member organisation of the International Planned Parenthood Federation, which provided indirect support to the project via FPAN.

The total cost of the project for the period April 1999 - December 2002 was US\$749,000. The unit cost of the project per beneficiary has not been calculated.

## Achievements and lessons learned

An external evaluation<sup>12</sup> of the project carried out in May 2002 assessed its achievements based on the outputs it set out to meet. The following is a summary of the findings of this evaluation and the lessons learned in strategic approaches adopted towards meeting the outputs of the project:

**1. Increased participation of young people in the design of SRH strategic plans and activities:** Through formation of the peer educators groups the project increased the direct participation of young people. Members of the peer groups had ample opportunity to express their concerns at monthly

meetings and through focus group discussions. Although they have had no direct input into project decision-making at district or national level, youth organisers and counsellors from the project have fed the views of peer educators into the decision-making processes of the project. The decision to increase the frequency of peer group meetings - from quarterly to monthly - was made in response to a request from peer educators.

Increased participation of peer educators led project implementers to recognise the differential needs of young people. The project assumed that all young people had SRH problems and needs, but found itself catering mainly to the needs of unmarried, educated adolescents between the ages of 15 and 19 because they were attracted especially to the peer educator groups and the YIC. These young people, however, were generally not yet sexually active and had little need to visit the outreach clinics, which were greatly under-utilised. Similarly the IEC materials, though attractive and technically accurate, were not meeting the needs of married and unmarried young people. The project design did not take into account the fact that married and unmarried young people, that young people in their early twenties, in their mid-teens are likely to have different SRH interests, experiences, needs and problems. Programmes need to be designed to take into account these differences.

**2. Enhanced availability of appropriate SRH information for young people:** All YICs are well stocked with SRH materials produced by the project. The project aimed to reach ten percent of adolescents and young people in the project area with SRH information via peer

group members, video shows, theatre and schools. The total reached through all these channels of communication, however, probably exceeds 20 percent, mainly because all existing means of communication were fully exploited simultaneously – bill boards, small media, street theatre<sup>13</sup>; the showing of videos in the Youth Information Centres.

YICs provided 'safe spaces', where young people can meet, amongst themselves, for group counselling, education about sexual and reproductive health, recreation and the discreet distribution of condoms. This is the kind of 'safe' environment which is conducive for provision of SRH services to unmarried young people. The conventional family planning clinics are not perceived as discreet and sensitive to their particular needs and problems

The project achieved wide coverage by forming partnerships, especially with all the secondary schools in the five project districts. In these districts school teachers were supposed to teach SRH but were poorly prepared and equipped to do so. FPAN worked with the schools thereby reaching all the children in schools. Other valuable allies were the Reproductive Health Female Volunteers already trained by FPAN in the past, as well as women's groups and local government officials.

**3. Enhanced availability of appropriate SRH services for young people:** Free condom distribution at YICs, with no questions asked, has been generally accepted - not only by young people but also by local communities. Other SRH services are still greatly under-utilised. The lesson learned in condom distribution was that discretion in condom



distribution facilitates its use. Placing free supplies of condoms in the YICs, where they can be picked up anonymously, is a more effective means of distributing them to unmarried young people than via FPAN clinics and outreach centres.

#### 4. Increased awareness on SRH among young people:

The evaluation found that, in view of the scope, breadth and depth of information available through the project, "it is very likely that those who have been involved in the project do have correct knowledge and sound opinions" about SRH issues affecting young people. This was confirmed in interviews with peer educators from the project and with secondary school students taught by teachers trained by the project.<sup>14</sup> Amongst all these issues, however, the one which predominated in the minds of most young people was HIV/AIDS prevention. The evaluator concluded that at least 75 percent of young people involved in the project knew at least four means of protection against HIV.<sup>15</sup>

Young people involved in the project were able to speak easily, without embarrassment, about issues such as menstruation, sexual behaviour, sexual abuse, HIV prevention, age at marriage and preferred number of children. The project began by encouraging the formation of mixed groups of boys and girls, but this was not acceptable to parents, and many girls also were not comfortable with this form of organisation. When the project switched to same-sex groups, especially for adolescents between 15 and 19, it attracted much greater participation by both boys and girls. It is important to recognise the local cultures and what will be accepted by the both young people and adults when designing and implementing projects.

#### 5. Sustainability through mobilisation of community-based support:

The success of the project depended largely on forging strong links with community leaders, parents, CBOs, schools and local government officials. This component of the project has been enormously successful: positive and active links have been established with all these groups. In contrast with the situation at the start of the project, virtually no parents expressed any objections any more to the teaching of SRH issues in the school classroom after teachers were trained in 1999/2000. The project aimed to reach 75 percent of secondary schools but almost 100 percent coverage was achieved. Nine of the 13 active YICs were taken over by the Village Development Committees at the end of the project in December 2002. This was an impressive expression of community support for the continuation of the project and a major contribution to its sustainability. In most cases the local community formed a registered society, with a membership of nine to eleven people. Most have also raised Rs 25,000-50,000 from membership fees, individual donations and contributions for the village development committees. This degree of community support for the project clearly demonstrates that local communities regard it as serving a useful purpose. FPAN will continue, via its local branch offices, to provide technical support to the YICs and peer groups at village level.

#### Challenges for the way forward

The first ever project to make SRH information and services available to young people in Nepal can contribute further to moving the agenda of SRH including HIV/AIDS



prevention. This will require the refinement and expansion of strategies that have worked and a re-think about those that have not been as effective.

- **Further strengthening the capabilities of young people to protect themselves:** FPAN has increased awareness on SRH among young people and increased availability of appropriate SRH services for young people. There is a growing recognition and evidence that promotion of sexual and reproductive health for young people works best when life skills-based education (LSBE) is provided in addition to sexual health information and services. As young people grow from their earliest years through childhood, adolescence, and into young adulthood, developing psycho-social and interpersonal skills can protect them from health threats, build competencies to adopt positive behaviours, and foster healthy relationships. From a programming point of view, LSBE for sexual and reproductive health promotion and in particular for HIV/AIDS prevention is effective because it focuses specifically on HIV/AIDS and the related health and social issues affecting young people within their own context and needs. It is geared towards behaviour development and change using interactive teaching and learning methods to internalize knowledge, attitudes and skills that make education enjoyable, relevant and useful. The process lays stress on the gender dynamics to make it gender-fair throughout.<sup>ii</sup>
- **Ensuring true participation of young people in all phases of project implementation:** FPAN

used peer educators to provide information and through the establishment of YICs created 'safe space' for young people to meet among themselves. For the genuine participation of young people they should be involved in all phases of the development of the information material as well as in planning their use.<sup>iii</sup> Young people themselves can be trained as counsellors. The Youth Information Centres already established and popular with young people could be further exploited as space for young people's participation and for the institutionalisation of participation. YIC could be strengthened as safe space for services - bringing services to young people instead of them having to go to the services will go a long way to their use

- **Integration of research and action for design, planning, monitoring and evaluation:** The needs assessment in 1999 conducted identified the many constraints which unmarried young people face in accessing SRH services<sup>16</sup>. Monitoring of the SRH services confirmed their low utilisation by young people. Project staff attribute this to the inhibition felt by unmarried young people about attending family planning clinics which are also used by married people who might be their neighbours and relatives.

A study on health seeking behaviours would contribute to overcoming a certain number of barriers and to ensure that services meet the differential needs of adolescents, and young people both married and unmarried. The findings will also enable the

<sup>i</sup> Annex 4: 'At a Glance: Life Skills Based Education and Young People'

<sup>ii</sup> Annex 10: 'At a Glance: Participation of Young People'

project to deal with issues which will influence sexual and overall health and development such as dynamics and communication within families, power relations and violence among males between sexes, alcohol and drug use, harmful traditional practices. Such a study should include community perceptions and attitudes to young people's sex and sexuality and risk taking behaviours and to HIV/AIDS/STIs.

The benefits of using participatory action research as well as young people centred approaches are being increasingly recognised. To what extent might young people themselves be appropriate researchers to not only suggest questions and approaches but also to interviewing their peers to understand the differing response of males and females to health and use of services? What gender factors need to be taken into consideration when planning responses? The incidence of mother to child transmission is becoming an increasing issue in the countries of the region, the involvement of young mothers will add a critical dimension.

Health seeking behaviour study should provide information on preferred locations and sources of services. Projects should explore alternative ways to bring services to young people. The findings of the operational research would, in general, contribute to more evidence and results based agenda setting. For example the findings can also be used to build on and adapt traditional customs that promote health. A Zambian project positioned its health facility staff to

be regarded as "grandparents," the group traditionally tasked with discussing sex and reproduction with youth.<sup>iv</sup> The findings of operational research in addition to available epidemiological data will be invaluable information to convince policy makers and public health providers that young people have a right to information and services.

- **Reaching all those in need of information and services:** The project appears to have reached mainly adolescents who are relatively well educated.<sup>17</sup> It has already been noted that the project has been particularly successful in reaching young people in schools. The main users of the Youth Information Centres are girls and boys aged 14-19 who are either still studying at secondary school or who have recently left school. There appear to be several reasons for this bias towards educated adolescents. First, many young people, especially girls, with little education are already married and are busy in full-time employment or occupied with family responsibilities. This is particularly the case with those in the 20-24 year-old age group. Second, many young men - and some young women - in their early twenties work for long periods of time in India or other in the Gulf States. Third, many young people with little education probably feel intimidated by the prospect of joining a group of educated young people who read well and are able to make full use of all the printed materials at the YIC.

A particular challenge will be to reach those poorly placed to

<sup>iv</sup> Chirwa, A. 1998. "Community Mobilisation in Support of SEATS Lusaka Urban Youth Friendly Services." (Unpublished document prepared for John Snow Inc./SEATS Zambia). As cited in: Bonnie Shepard: 'Youth Programmes in the SADC Countries: Sexual and Reproductive Health and Rights. Technical paper for 1<sup>st</sup> Youth Conference of the Southern Africa Development Community Region. June 13-16, 2000. Maputo, Mozambique

access the SRH information and services such as those working full-time or have heavy domestic responsibilities. Currently married adolescent girls and young women who, due to traditional values, lack of mobility and domestic demands on their time, have little or no access to SRH information and services. A particularly crucial group to reach are young male and female migrant workers, who spend long periods of time abroad. Many of these migrant workers are vulnerable and at risk to HIV/STIs, which they then transmit to their sexual partners when they return home.

Several innovative ways have been used to transform service to make it more friendly. For example the Banja La Mtsogolo (BLM) Malawi<sup>v</sup> encouraged young people to come through outreach activities, training community-based workers who were selected by community and their peers, and the training of everyone from guards to clinicians. But in addition: opened the backdoor of the clinic to encourage young people to 'hang out' and played music for them, painted the clinic to make it visually more appealing, and most important made peer educators available to make referrals for other services and to accompany shy, hesitant young clients to the clinic. Alternative ways to make services more accessible should also be explored such as public-private sector partnerships. For example, exploring how pharmacies could be better equipped with information and skills to serve young people.<sup>vi</sup>

- **A supportive environment through policy development and implementation:** One of the major challenges facing not only this project but others attempting to provide services is the lack of a policy climate which will ensure access to all young people friendly services which will best meet their needs. A policy that specifically aims to meet all the health and overall development needs of young people will also contribute to creating a supportive environment to enable young people to protect themselves from HIV/AIDS, other sexually transmitted diseases and drug use. Policies affecting the health and development of young people should not be centrally set by officials but should be done through the involvement of young people if it is to address the real needs of young people. Nepal is one of the few countries in the region which already has an adolescent strategy and policy (included attached CD ROM). Efforts need to be taken for a review of this policy by young people and to advocate for its immediate implementation.
- **Sustainability:** By the end of 2002, most<sup>vii</sup> of the YICs established by the project have been handed over either to the local Village Development Committee or in a few cases the local branch of the FPAN. A number of constraints, however, will need to be overcome to ensure its continued effectiveness in meeting the needs of the community. For example, the loss of staff - such as counsellors, nurses, youth organisers and village workers - will limit the

<sup>v</sup> As cited in: Bonnie Shepard: 'Youth Programmes in the SADC Countries: Sexual and Reproductive Health and Rights. Technical paper for 1st Youth Conference of the Southern Africa Development Community Region. June 13-16, 2000. Maputo, Mozambique

<sup>vi</sup> Annex 5: 'At a Glance: Young People Friendly Health Services Framework'

<sup>vii</sup> The two YICs in Achham district had to be closed down due to the activities of Maoist insurgents in the area.

scope of the work that can be done at community level. During the hand over of the project, it would have been important to have established a sustainable mechanism to provide technical assistance and capacity building to ensure that the project meets the continuing as well as the changing needs of young people. This could be done through establishing effective partnerships and linkages with community groups and technical professionals working in the same area.

A major challenge is to keep the 216 young people trained as peer group leaders, who have been the backbone of the project at community level, but have so far not received monetary incentives. The needs assessment had proposed that the project should give peer educators some small tokens of recognition. The newly formed NGOs which will manage most of the YICs - the

organisational base for the peer educators' activities - will have to deal with the question of how to provide peer educators with adequate recognition, within the strict financial limits of a community-owned and managed project.

One important step would be for the project to do a cost benefit analysis. The decision for payments can then be determined on the basis of the benefit which peer educators bring to the project in terms of achieving the outputs. Cost benefit analysis are particularly important in resource poor settings as well as to guide decisions with respect to sustainability and scaling up. The cost benefit analysis should compare the effectiveness and costs of different combinations of interventions/services in different contexts bearing in mind young people's limited ability to pay for services.

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<sup>1</sup> Family Planning Association of Nepal, Working with Young People on SRH (EC/UNFPA).

<sup>2</sup> Valley Research Group, Baseline Survey on Sexuality and Reproductive Health Awareness, Attitudes and Practice of Adolescents/Youth in Five FPAN Project Districts, June 2000.

<sup>3</sup> Ibid.

<sup>4</sup> Jeanet van de Korput, 'Working with Young People': An Assessment on Adolescent Sexual Reproductive Health Needs, European Union, FPAN and UNFPA, 1999.

<sup>5</sup> Valley Research Group, op cit.

<sup>6</sup> Centre for Integrated Community Development, Report on Sexual and Reproductive Health Focus Group Discussion of Adolescents and Youth in 72 VDCs of Achham, Kailali, Kanchanpur, Kavre and Dang, 2000.

<sup>7</sup> Personal communication, Hari P. Khanal, Project Director and Deputy Director General of FPAN.

<sup>8</sup> Evert Ketting, Working with Young People to Improve SRH of Young People's Project: Final Evaluation Report, August 2002.

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.



# The Young Star Club Nepal

Location: Dorpu village, Salleri VDC, Solukhumbu District, Nepal  
Target groups: Children and young people  
Strategic approach: Participatory decision-making process by children and young people in planning and implementation of community development activities  
Area of operation: Solukhumbu District (population: 120,000)



# The Young Star Club: for young people by young people

## Background and rationale

Solukhumbu District seems as far removed from the HIV/AIDS pandemic as any place on earth could be. Situated high in the Himalayas in eastern Nepal, it boasts 20 snow-capped peaks higher than 6,000 metres, including the mighty Mt. Everest (Sagarmatha). The population of 120,000 is scattered thinly, in small settlements, over the rugged terrain. To reach the district headquarters, Salleri, from Kathmandu involves a one day bus trip followed by a three day trek through the mountains, at one point crossing a pass more than 4,000 metres above sea-level.

Because of their geographical isolation, the people of Solukhumbu District are not yet in the frontline of the HIV/AIDS epidemic in Nepal. No deaths due to HIV/AIDS have been officially reported, and few people in the area know much about the epidemic.

But Solukhumbu is by no means immune to HIV/AIDS. Most young men and many young women leave

the area to seek work abroad or in Kathmandu, where they might find themselves in situations which make them vulnerable to the risk of HIV infection through unsafe practices. Many young women are trafficked to work in the sex industry in India. There are already unofficial reports from health and development workers in Solukhumbu of chronically ill young people with AIDS-like symptoms returning to the area and dying within a short period of time, but so far these cases have attracted little official or public notice.<sup>1</sup>

Yet the rapid spread of HIV/AIDS is not inevitable. HIV infection is preventable, provided people are informed and empowered to protect themselves against it. Young people themselves can play a major role in preventing the spread of HIV and other STIs. Indeed, their participation in the design, planning, implementation and evaluation of HIV prevention activities is vital. Through their own organisations - sports teams, local youth groups, student councils, clubs and national organisations -

<sup>1</sup> Buddi N. Shrestha, Young Star Club, personal communication.



they can help to empower other young people with the knowledge, skills and self-confidence they need to protect themselves against HIV and other STIs.

The Young Star Club is a case in point. It started in 1977, when a group of 11 children - nine boys and two girls aged between 12 and 14 - in the village of Dorpu, Solukhumbu District, decided to form a volleyball team. Later they added other sports - athletics, table tennis and badminton - to their activities.

Many parents, however, were deeply sceptical about the group, and wanted their children to spend their time helping with household chores or doing agricultural work rather than playing sport. The children gradually won their parents over by inviting them to sporting competitions and other meetings, and by doing even more household chores than before. They also began extending their services into the community, for example, by transporting sick people to hospital (using a home-made stretcher) and cleaning the market place. These activities helped to build up community understanding and support for the group.

The group was organised in an informal way until 1985, when its members drew up its first proper Constitution and it became officially registered as the Young Star Club. This meant that the Club was able to accept financial contributions from donor organisations and could carry out larger projects, such as levelling the school playground and building small bridges. The Club's activities evolved in response to local problems and needs. In 1989, for example, after an earthquake caused considerable damage to local schools and homes, the Club expanded its aims to include

assistance and rehabilitation in the wake of natural disasters.

The basic strategy of the Club, however, was to promote the participation of young people themselves in the process of development through training, opportunities for leadership and service to the community. This approach was based on the recognition that young people do not develop simply by being given information. Only through active participation in planning, decision-making and community-based activities do young people develop the social and practical skills, the self-confidence and the experience they need to gain greater control over their own lives and to contribute to the health and prosperity of their community.

The Club's 205 members are organised into two groups. The 'child members', aged between 7 and 13, make up about half the total membership and pay a token membership fee. They discuss the rationale, strategies and goals of the Club, and develop ideas for the activities they would like to carry out in local communities. They also decide on how to spend the funds raised through their own small membership fees.

The 'child members' propose their ideas to the 'youth members', who are aged 14 and above. These members pay a modest membership fee and have the right to vote at general meetings and in the election of office-bearers. All are eligible for election to the various committees and the 11-person Executive Committee, which meets once a month under the chairmanship of Buddi Shrestha, one of the original founding members. Members of the Executive Committee are elected for a three year term of office.

Senior Club members are responsible for managing special projects, ongoing activities and are also responsible for training and supervising junior members of the Club. Assignments are rotated so that everyone has a chance to work on different aspects of programme management, and to develop leadership skills by accepting greater responsibilities. This also provides them with the opportunity to enhance their personal and professional growth.

Decisions on new projects are made only after exhaustive consultation with the members of the Club. Whatever activities the Club decides to take up, the leadership is totally committed to promoting the participation of young people. The Club chairman, Buddi N. Shrestha, says: "The main factor will never change, and that is the involvement of young people. They are the most important element, and whatever we do is for them."

Monthly meetings of the Club, open to all members, are held to monitor the progress of projects and review other activities. Even the work of the department heads and the members of the Executive Board are monitored to ensure that they are discharging their responsibilities correctly.

## Objectives

The objectives of the Young Star Club, which reflect its concern with the development of young people, are to:

- provide local young people with learning opportunities for personal and professional growth.
- improve the physical and mental health of local young people.

- help local schools and communities improve their health, sanitation and environmental conditions.
- improve the social and economic status of women and children, empowering them within society.
- help under-privileged families educate their children, and to provide non-formal education for their parents.
- preserve the local culture and heritage.
- mobilise the organisation's resources in the case of natural disasters and to launch rehabilitation programmes for affected individuals and families.

## Programme components

The Club pursues its objectives through a wide-ranging programme, which currently consists of nine main components. These are carried out in partnership with local communities, international NGOs and local government departments.

1. Awareness-raising activities: Monthly meetings are organised for young people to learn about and discuss issues such as health, family planning, HIV/AIDS, women's empowerment, the environment and even political issues. The speakers are either senior members of the Club or outside experts, for example, from the district hospital or a government department such as forestry. Longer workshops - lasting for two or three days - are also held from time to time, usually with the participants paying their own costs.
2. Leadership training: Special training workshops of three to four days are held several times a year to enable Club members to develop

leadership skills and expertise in particular fields, for example, non-formal education, participatory development planning techniques, environmental protection and sanitation. The workshops, held in mixed groups of boys and girls, use participatory techniques to encourage participants to express themselves and ask questions. At first girls are usually too shy to speak during workshop sessions, but they gradually gain in self-confidence and express themselves more openly.

3. Health care activities: The Club has helped to construct health posts and has organised health camps in collaboration with local government health officials and NGOs. Short-term health projects are also carried out. In 1999, for example, the club implemented an Safe Abortion Project, with support from a local NGO, CRIPA Nepal.

4. Non-formal education: A particular focus of the Young Star Club's activities in recent years has been non-formal education, particularly for mothers and sisters of young children. This began in 1998 in partnership with CARE Nepal, and has been extended in collaboration with a UK-based NGO, Global Action Nepal and the Danish NGO, DIALOGOS. Over 200 mothers' groups have benefited from non-formal education so far. Significantly, the partnership with Global Action Nepal is managed by two young local women, who have acquired valuable skills, experience and self-confidence by taking on this responsibility.

5. Sanitation and environmental improvement: In collaboration with the UK-based NGO, Student Partnership Worldwide (SPW), Young Star has helped to establish 'Green Clubs' in 12 secondary schools in

Solukhumbu District. The Green Clubs involve students in campaigns and practical action to improve public awareness of environmental and sanitation issues through rallies, marches and street theatre. The students, together with members to work with SPW volunteers, clean schools and maintain gardens in schools and in local communities. They also construct smokeless stoves and dispose of waste. Initially some parents were reluctant to allow their daughters to become involved, but the obvious benefits of the experience persuaded them to drop their objections. A senior member of Young Star is also assigned to monitor, supervise and assist each Green Club.

6. Primary school education: The Club constructed a primary school for a remote community, raised funds for improving the facilities of several schools, and also constructed toilets in schools. With support from Global Action Nepal, the Club also supports a scholarship scheme which enables over 100 children from poor families to attend primary school.

7. Community development: In partnership with other like-minded local organisations, the local Government Development Office, and with funds raised locally, Young Star has also implemented a wide range of community development projects, including road-building, bridge construction, installing water supplies, and the construction of health posts. The Club also implements a scheme to help farmers improve their productivity and incomes through improved farming techniques and government loans for equipment and fertilisers.

8. Sports: Although sports has been overtaken in Young Star's

priorities by health, environmental and community development issues, Club members still attach great importance to physical fitness and team sports. The Club has ten volleyball teams - eight children's teams and two each for men and women - and also promotes table tennis, football, badminton, basketball and indoor games.

9. Income-generating activities (IGAs): The Club has started several income generating activities (IGAs) as a strategy for both generating its own income and to provide local people with employment. These activities began in 1989, when the Social Welfare Council gave the Club a grant for a water mill to grind corn and wheat. The mill was moderately successful, and was later electrified to increase its capacity. In 1992 Redd Barna donated a photocopier, which was used for office purposes and also to raise a modest amount of income.

Several other IGAs were launched during the 1990s. These included a fruit drying project supported by the American Peace Corps, a workshop making iron grilles, a scheme to market solar panels, and a micro hydro service centre which installs small hydro-electric turbines. None of these activities ever turned a large profit, and all have been severely affected by the insecurity caused by the insurgency throughout the district. By the end of 2002 most of the Club's IGAs had stopped, and it was deriving very little income from those still functioning. The flour mill had reverted to using water power rather than electricity, but with its output greatly reduced.

HIV/AIDS, an emerging priority: The Young Star Club made HIV/AIDS a priority, though little data exist on the HIV/AIDS situation in

Solukhumbu District. Bapu Shrestha, one of the founders of the Club, explained the reason: "Sometimes we are too cautious about responding to people's needs, but they might not realize their needs because they lack information. This is the case with HIV."

The Club, with support from the National AIDS Programme, has taken several initiatives to make HIV/AIDS information more easily available especially to young migrants or those who recently returned from abroad. In addition, the Club has established an HIV/AIDS project group and has introduced HIV/AIDS into health workshops and non-formal education sessions for mothers. Club members try to meet people who have recently returned from working abroad and encourage them to be tested for HIV, but they believe that few people have yet acted on their advice.

## Funding

The cost of running the Club's office - including routine meetings and leadership training workshops - is about NRs 200,000 (approximately US\$3,000) per year, which is covered by income from membership fees, income generating activities, donations from supporters, and administrative support from partner NGOs. The Club also receives occasional grants from government departments for particular projects or activities.

Most of the Club's funds are derived through partnerships with international NGOs, who through partnerships with a local NGO partner, are interested to work in local communities. The Norwegian NGO, Redd Barna, was one of the Club's first foreign partners. In 1989 Redd

Barna supported the reconstruction of schools and houses damaged or destroyed by an earthquake. This involved undertaking a systematic assessment of community needs - the first time that the Club had carried out an exercise of this kind - which was in itself a capacity building experience for the Club. Other international partner NGOs are Student Partnership Worldwide (SPW), CARE Nepal, Global Action Nepal, the Intermediate Technology Development Group and DIALOGOS.

## Achievements and lessons learned

Given its modest beginnings as a children's volleyball team in one of Nepal's most remote rural areas, what the Young Star Club has achieved over the past quarter of a century is remarkable:

1. **Community development:** The Club has carried out literally scores of small-scale development infrastructure projects (roads, bridges, health centres, schools, water supplies, latrines), as well as environmental improvements (smokeless stoves, waste disposal, tree planting), health projects and non-formal education for low-income families. It has also helped poor farmers to increase their production and incomes, and brought appropriate, innovative technologies (solar panels, hydro-electric turbines) into remote areas. The success of these community development activities has won the trust of the local people and demonstrates that young people are capable of making a constructive contribution to their communities.

2. **Increased knowledge in the community** through workshops and outreach activities in schools and

community centres. The Club has disseminated information and ideas about topics as diverse as maternal health, child care, community forestry, children's rights, women's empowerment, political awareness and HIV/AIDS. In the past, there was little or no local awareness of the importance of these issues to the health and well-being of individuals, families and whole communities.

3. **The Young Star Club has demonstrated how young people - if properly trained, encouraged and supported - can participate meaningfully in decisions and activities affecting their own lives and the development of their community.** The Club has trained many hundreds of young people in leadership and social skills, and given them opportunities to take responsibility for organising community service activities. Particularly significant has been the importance which the Club has attached to promoting the participation of girls in community development activities - not just as ordinary members but as leaders of projects. Although girls need longer than boys to cast off their inhibitions about speaking in public and taking on leadership roles, allowing them extra time to do so pays off in the long run.





The experience of Young Star Club in promoting participation of young people demonstrates that:

- **Age is no barrier to participation.** Children as young as 12 are capable of founding their own organisation and building it up into a successful community development NGO.
- **Enabling true participation:**
  - **requires training in participatory skills:** Young people do not 'naturally' have the ability to participate in decision-making, planning and other development activities. These are skills that need to be acquired through training in participatory methods, but also through enabling young people to apply their knowledge and practice their skills. This is the rationale behind the Young Star Club's policy of providing young members with training in methods of Participatory Rural Appraisal and the opportunity to participate in decision-making about the activities to be carried out by the Club.
  - **requires time investment:** Democratic decision-making cannot be done in a hurry - it requires time and patience, especially when the participants include children and young people. Young Star devotes a great deal of time to holding meetings, and the membership appreciates the opportunity to participate in the affairs of the Club.
  - **means trusting young people with responsibilities:** Young people need not only information and training, but also the opportunity to take practical responsibility for their decisions

and actions. This means showing them trust and support, even when they make mistakes. The Young Star Club accepts that, in the course of learning to handle new responsibilities, young people will sometimes make errors. These, however, are a small price to pay for the experience and leadership skills which young people acquire in the process.

- **giving everyone opportunities to take on leadership responsibilities:** Young Star makes a point of rotating leadership responsibilities so that all members develop all-round leadership and decision-making skills in various fields - not just only in, for example, environmental improvement but also in health education and income generation.
- **linking activities to young people's interests:** Young people need to be offered a choice of activities. The Young Star Club has built up a huge range of activities from which young people can choose things that particularly appeal to them.
- **means respecting basic principles of participation:** It is important that young people can propose activities to the leadership, and that they can quiz their leaders on proposals for new activities. Young Star's monthly meeting system allows this two-way exchange of suggestions and opinions to take place.
- **ensures democratic accountability:** Young people generally dislike and distrust authoritarian attitudes and organisational structures. The Young Star Club, through its structure and working methods, allows all members a voice in the



running of the Club and the decisions about whatever activities are decided to take up. Periodic election of members of the Executive Committee also enhances accountability.

■ **encourage partnerships:** Young people can achieve much through their own creative energies, but they also need guidance, expertise, practical support and resources from other sections of society. The Young Star Club has benefited enormously from forming working partnerships with local schools, health facilities, the forestry service, village development committees, and international health and development organisations.<sup>ii</sup>

4. **Sustainability through participation:** What is remarkable about Young Star's achievements is that the organisation has never had paid staff, but is run entirely by volunteers, who receive no more than travel expenses from donor organisations. Moreover, the Club's finances are precarious and young people often have to pay themselves to participate in a workshop. There is also a high level of turnover amongst the Club's leaders, since most young men - and many young women - leave the area for long periods of time in search of work. Yet the Club has managed not only to survive but to develop and start new initiatives, such as the HIV/AIDS project, even when funding is not always available.

The Club's sustainability is due, in large part, to the fact that it is owned by its members, who are actively involved in its management. Their participation ensures not only that the Club is in touch with young people's hopes and aspirations, but

that it also benefits from their long-term commitment to its continuation and success. It is no coincidence that, of the Club's original 11 members, the majority are still involved in the affairs of the Club, even if they no longer live in Solukhumbu District.

To be noted too, is despite the fact that Young Star Club has entered into partnership with several international NGOs, it has never lost its local roots. The people of Solukhumbu District still perceive it as a valuable local initiative which they are willing to support, for example, by donating food or cash to support the Club's activities. Local government departments, in particular the Health and Forestry department also support the Club with material contributions and staff time whenever possible.

## Challenges for the way forward

■ **Serving the whole community:** There are still significant social and economic differences within the community in and around Dorpu village. School enrolment and school attendance by the children of low-caste families, for example, have traditionally been low. The Young Star Club has tried to address this issue by constructing a primary school for the children of a community consisting entirely of low-caste families. However, while enrolment has improved, attendance is still poor and the drop-out rate is high. Advocacy with the parents of the least privileged children in the local community to raise school attendance is one of the main challenges still facing the Young Star Club.

<sup>i</sup> Annex 10: 'At a Glance: Participation of Young People'

- **Partnerships for local needs:** Working in partnership with foreign NGOs has undoubtedly brought many benefits to the Young Star Club. Although the Club has only limited material resources of its own, the partnership strategy has enabled it to diversify its activities and expand its outreach over the whole of Solukhumbu District. The partnership with international NGOs has resulted in the club having a good office and communication facilities. In addition, the experience of working with international NGOs has enabled many Young Star Club members to improve their own skills and to grow in self-confidence.

The downside of these partnerships, however, is that it is generally the international NGO which decides how the project should be implemented and - most importantly - how the funds will be spent, rather than consulting with the Young Star Club on major policy decisions. This is a severe limitation on the Club's capacity for managing its activities based on its principles of serving the community based on its needs. The challenge is to influence donor agencies' policies so that the Young Star Club can follow its own policy of "making local needs a priority" and at the same time not jeopardise its funding support and partnership opportunities.

**Volunteerism and professionalism:** The Young Star Club is basically a voluntary organisation. Although project leaders receive a small travel allowance, and some members receive small payment for the duration of particular projects, the Club has no salaried staff members. In its early years, when the Club was owned and managed entirely by young people, there was never any question of its members being anything but unpaid volunteers. The

strategy of volunteerism today, however, is not so much a deliberate choice as a resigned acceptance of the inevitable. It now constrains the organisation's development.

The voluntary nature of Young Star's work is attractive to international partner NGOs because it keeps the Club's running costs low, but it also limits the nature and scope of the work which the Club can carry out. The Club cannot afford to employ the qualified staff it would need to become a professionally managed organisation. Turnover of Club members holding senior positions is high, so new members have to be trained and given time to orient themselves.

It is particularly difficult for Club members with young families to devote sufficient time to the Club. The senior members, who hold full-time jobs, work for the Club only outside of office hours. "If you go into our office," says co-founder Babu Kaji Shrestha, "you won't find anyone there during the day - only early mornings, evenings and on Saturdays. The chairman's workplace is 20 minutes drive away, so visitors go and see him there."

The strategy of volunteerism has served the Young Star Club well, but the Club has reached the limits of what a voluntary organisation can achieve. If the Club is to fulfil its full potential, it will have to be managed in a more professional way, while still retaining its strategic approach of promoting the participation of young people in the development process. It is important, that future partnerships allow Young Star to hire and retain local staff with professional development planning and management skills, so the organisation is not in a perpetual state of dependence on expertise and financial support from abroad.

**HIV/AIDS Prevention, care and support:** The leadership of the Young Star Club has demonstrated critical foresight by making HIV/AIDS a priority for the organisation at an early stage of the epidemic. The Club is now well placed to move beyond providing only information about HIV/AIDS to empowering young people with 'life skills'<sup>iii</sup> necessary to protect themselves against HIV and other STIs. It could also help communities to develop informed, caring and supportive responses to people living with HIV and their families.

One possible starting point would be the 60 schools throughout the district, where students and teachers could be trained as peer educators in HIV/AIDS and in promotion of sexual health.<sup>iv</sup> Members of the Club are already working with Green Clubs in 12 of these schools, which could serve as ready-made entry points for HIV prevention based on life skills. Another potentially effective entry point would be the recently formed groups of young people who listen to the weekly broadcasts of the radio programme 'Chatting with my best friend'<sup>v</sup>, which covers aspects of HIV/AIDS and sexual health from the point of view of teenagers. The Club could serve as an effective distribution point for the printed materials on life skills, which UNICEF distributes in support of the radio programme.

Linking up counselling services with information dissemination and life skills based education would further strengthen the prevention activities. This would not only support HIV prevention but also promote HIV

testing as well as care and support for those affected.<sup>vi</sup>

The strategy of partnerships with local and international NGOs, which Young Star used so successfully in other fields, could also be used to strengthen and extend the Club's HIV/AIDS activities. Such partnerships can bring not only an injection of funds but also professional planning and management skills which is still limited among the Club members.

Situation analysis is an area in which the Club is particularly in need of technical support. It should be possible, for example, for a suitably qualified partner NGO to help the Young Star Club establish and implement an HIV prevention programme in secondary schools, with operational research, monitoring and evaluation as built-in programme components.

The Young Star Club demonstrates that young people can participate fully in the design, planning and implementation of development activities at community level, and to share their knowledge and skills with their friends and families. By mobilising, training and entrusting young people with leadership responsibilities, the Young Star Club has helped them to realise and develop their capacity for participation in and contribution to their health and development and to the overall development of their community. The lessons learnt by the Young Star Club in promoting true participation of young people in community development can be applied to HIV/AIDS prevention and care among young people.

<sup>iii</sup> See case study 2: 'Chatting with my best friend' in this report.

<sup>iv</sup> See case study 1: 'School-based Family Life Education and HIV/AIDS Prevention in this report.'

<sup>v</sup> See case study 2: 'Chatting with my best friend' in this report.

<sup>vi</sup> Annex 9: 'At a Glance: Young People Friendly Health Services Framework'

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# The Humsafar Trust India

Location: Mumbai, Maharashtra State, India

Target groups: Men having sex with men (MSM), including transgenders (hijiras)

Strategic approach: Comprehensive and holistic care, support, information and advocacy for MSM

Area of operation: City of Mumbai



# The Humsafar Trust: grounded in its community

## Background and rationale

Very few men in India are open about their sexual orientation. There are some young men in India, especially in large cities like Mumbai, Chennai and Calcutta, who engage in sex with other men before marriage. Many continue to have sex with men after marriage. There are also men who have sex only with men and regard themselves as 'gay' or 'homosexual'. Equally well established a substantial transgender (hijira) community<sup>i</sup>. In the city of Mumbai alone, according to estimates by the Humsafar Trust, there may be as many as 350,000 men who have sex with men (MSM).<sup>1</sup>

Sex between men is proscribed by the Indian Penal Code. Being 'gay' or 'homosexual' is widely regarded as deviant and morally reprehensible. The illegal status and public disapproval of their sexual orientation drives Men having Sex with Men in India 'underground' for their sexual needs. This heightens

their vulnerability to sexually transmitted infections (STIs) and HIV/AIDS.

In the city of Mumbai, HIV prevalence amongst Men having Sex with Men is estimated at around 20 percent,<sup>2</sup> compared with the national average of 0.8 percent of the adult population.<sup>3</sup>

HIV can also spread from Men having Sex with Men<sup>ii</sup> into the general population. Infection trends indicate that more women are being infected. There is evidence to indicate that growing numbers of monogamous women in India are being infected with HIV from their husbands - some of whom could have acquired HIV through sex with men.

Because of their marginalised position in society, Men having Sex with Men in India find it extremely difficult to access the health information and services they need to protect themselves - and their partners - from HIV and other STIs. They also have little access to the

<sup>i</sup> The term 'transgender' is used to describe people who were born biologically male, but who identify themselves as female and dress as women. Some have undergone castration or a sex-change operation.

<sup>ii</sup> The term 'MSM' is used because in India (as well as in other countries) many men who have sex with other men do not identify themselves as 'gay' or 'homosexual'. Many MSM are married and lead a bisexual life.



support they need to mitigate the impact of HIV/AIDS on their own community and on wider society. A small number of Indian NGOs and government agencies have begun to respond to this challenge. In the city of Mumbai, for example, the Humsafar Trust has pioneered a 'holistic and comprehensive' approach to care, support, information and advocacy for Men having Sex with Men.

Grounded in the community itself, the Humsafar Trust has developed strategies and services which are helping to meet urgent health and social needs of MSM. Through the Trust, and in collaboration with public and private health institutions, about 8,500 men - mostly in their twenties - have been able to access vital health information, care and support, especially with regard to HIV/AIDS and other STIs. Many thousands more have benefited from information provided by the Trust.

The Humsafar Trust has its origins in India's first gay magazine, *Bombay Dost*<sup>iii</sup>, first published in 1990. The first issue of the magazine provoked a flood of letters from readers in different parts of India. "We then realised," says Ashok Row Kavi, editor of the magazine and founding chairman of the Humsafar Trust, "that there were networks of men having sex with men throughout the country. They were all waiting to come out, but there was no support system, no access to health facilities, and no access to simple advice and counselling. So we decided to start a support system for ourselves."

Ashok Row Kavi and a small group of friends decided that, to respond

to the needs of the Men having Sex Men community for information, health services and social support, they would have to form a legally constituted organisation. In February 1994, after years of legal wrangling, the Humsafar Trust<sup>iv</sup> was officially registered.<sup>4</sup> It was another year, however, before the Trust was able to rent one floor of an office block from the Mumbai Municipal Corporation - an early sign of the Trust's success in breaking down the wall of prejudice and misunderstanding between this marginalised group and the government.

Operating with money from friends at home and abroad, the Trust started to hold meetings once a week. The numbers were small - four or five people at first - but they kept growing steadily. People shared information about their experiences and problems, and also discussed what services the Trust should be offered and how it should develop as an organisation. The Trust also set up a voice mail service, on which people could call up and leave a message. A volunteer would then phone back and agree to meet the caller somewhere in the city, where they would discuss his problems over a cup of tea or coffee.

Alongside these activities, members of the Humsafar Trust were also engaged in advocacy work with State government officials. These efforts were rewarded when, in 1998, the Director of Health Services of Maharashtra State agreed to provide funds for the Trust to do a 'sex map' of MSM sites in Mumbai city. Operating through their contacts within their own circles, the Trust identified 76 places where the

<sup>iii</sup> Dost means 'friend' in Hindi.

<sup>iv</sup> The Hindi word humsafar means a companion on a journey.

Men meet, either to seek sexual liaisons or simply to exchange information and socialise. Most of these sites were either train stations or bus terminals. However, the Trust did not inform the government of their exact location, which could have resulted in police raids and punitive legal action.

Based on this study, the Mumbai District AIDS Control Society gave the Trust funding for an outreach programme for a target population of 1,000 Men having Sex with Men. Based on their survey findings, Humsafar's programmers drew up plans for a much larger project entitled 'Comprehensive and Holistic Care & Support Project in the Sector to Stabilize STIs and HIV in Mumbai Metro'. This now constitutes the strategic approach underlying the Trust's work.

## Objectives

The Humsafar Trust's Comprehensive and Holistic Project has the following objectives:

- To motivate Men having Sex with Men to adopt safe sex practices and to reduce high-risk behaviour.
- To provide high quality STI services at the Humsafar Trust and/or enable Men having Sex with Men to seek other appropriate services through a system of referral linkages.
- To provide a safe space and a non-judgmental meeting ground for Men having Sex with Men to participate in group discussions on safe and healthy sexual behaviour.
- To develop a model for continuum of care for those living with HIV/AIDS within this group.

The project aims to meet these objectives through five main programme components: advocacy, outreach work, a drop-in centre, access to counselling and STI/HIV services, and operational research.

## Programme components

### 1. Advocacy through a multi-faceted strategic approach

From the outset, the Humsafar Trust has attached great importance to advocacy on behalf of Men having Sex with Men<sup>6</sup>. In purely public health terms, the rationale for this strategy is clear. The stigma and secrecy surrounding homosexuality in India contribute to the continuation of high-risk sexual behaviour amongst Men having Sex with Men, and between them and their female sexual partners. Their health and well-being require greater openness about same-sex relationships. Organisations which are grounded in and trusted by the community of Men having Sex with Men have a leading role to play in helping to reshape public and official attitudes towards same-sex relationships.

Humsafar's advocacy efforts have been most successful at local and State government level. Humsafar has good working relations with the State and Municipal AIDS Societies, both of which have provided financial support to its activities. Relations between government agencies and NGOs in India are often fraught with tension and mutual distrust, but Humsafar has established a reputation for integrity, technical competence and accountability.

Equally important is the success of Humsafar's advocacy with doctors, nurses, counsellors and other health professionals, especially at Sion

Hospital and Cooper Hospital. "One community that really needs to be sensitised on MSM issues is the medical community," says Humsafar Chief Executive Officer, Vivek Anand. "The doctors at the hospitals where we work are thoroughly sensitised. They treat MSM as real human beings, whereas before we began there were issues. Some wouldn't even touch an MSM, let alone give treatment. But we found two doctors who were willing to work with us. So we started a sensitisation programme with them, and they in turn do advocacy for us with their colleagues."

Humsafar's advocacy work takes many other shapes and forms - some so small and discreet as to be almost invisible. For the Humsafar outreach worker on his 'beat' at night, advocacy means establishing good rapport with the local police, the pan wallahs, the newspaper vendors, the tea sellers and other small traders in the neighbourhood. It may also involve giving condoms or referring them for STI/HIV counselling and testing. Advocacy also means being good neighbours, for example, with the street children's organisation with whom Humsafar shares office space. The two organisations jointly celebrate important occasions - such as Divali, Karwa Chauth, Christmas and Id - and once a week children in need of medical care come to the Humsafar clinic. In the eight years that the two organisations have been neighbours, there has not been a single case of a man from Humsafar molesting a child.

Advocacy also means accepting speaking engagements and running workshops for college and university students, industrial workers, the police, lawyers and journalists. Sometimes these

meetings bring no immediate, visible result. On other occasions, the results exceed expectations. For example, in October 2002, the all-women's S.N.D.T. University in Mumbai hosted an international gay and lesbian conference organised by Humsafar. This was the direct result of a talk to 150 students at the university by Vivek Anand, Humsafar's Chief Executive Officer.

Relations with the police remain strained in many places, and much more advocacy needs to be done in this area. Yet there are small signs of progress. Some outreach workers, for example, say that police come to them for condoms, and others report that police are protecting them from attacks by thugs. The attitudes of police towards transgenders are also changing. Some police are now allowing transgender persons to travel in the ladies' compartment of trains. This followed a nasty incident in which police arrested and stripped two transgender outreach workers, who were travelling in a ladies' compartment. The policemen concerned later apologised.

## 2. Outreach work: promoting safer sex

More than half of the 54 people who work for the Humsafar Trust in Mumbai are engaged in outreach activities. Twenty young men - all of whom are themselves Men having Sex with Men - and four transgenders, all aged in their early twenties, are the outreach workers of the programme. Based on the Trust's research on cruising sites and other meeting points for these Men, the outreach workers are assigned specific 'beats' which they visit six nights of the week, from approximately 7 p.m. until 11 p.m. Most 'beats' are located in or near railway stations and bus terminals.

Transgenders work mainly in particular houses. Before setting out to their 'beat', the outreach workers come to the Humsafar Trust office to write a report on the previous evening's work and to replenish their supplies of condoms and informational materials, which they carry in a shoulder bag.

While on their 'beat', the outreach workers chat informally with individuals and small groups of the Men about their problems, steering the conversation whenever possible to STIs, HIV/AIDS and safer sex. They carry out discreet demonstrations of how to put on a condom with each outreach worker distributing 70-80 free condoms per evening. They also distribute informational materials and invite people to visit the Humsafar Trust drop-in centre. In addition, they encourage people who have been involved in risk behaviour to be counselled and tested for STIs and HIV - either at the Humsafar Trust clinic or at one of two government hospitals. Between February 2001 and March 2002, Humsafar outreach workers made a total of 50,961 outreach contacts, including 6,949 people who were new to the programme.

Each outreach worker tries to meet a target of eight new referrals for STI/HIV counselling and testing per month. To help people overcome their fears about testing, the outreach workers usually accompany clients to the testing centre in the mornings, outside their working hours for which they have to pay their own travel costs.

Part of the work of every outreach worker is to build up good rapport with other people on or near their site, such as the police, pan wallahs and teashop owners, because these people can either assist or

obstruct their work. This is not always easy, especially with the police. Every outreach worker has a card identifying him or her as a staff member of the Humsafar Trust. However, the card does not state that the outreach workers are working with Men having Sex with Men, nor do the informational materials they distribute indicate that Men having Sex with Men are the main focus of their work. Says Anand, a 21 year-old outreach worker whose 'beat' includes many truck drivers and transport police: "We can't say directly that we are working only for MSM. How could we, when MSM sex is against the law? They would kick me out tomorrow."

Some outreach workers also have to cope with threats and physical attacks by gangs of thugs demanding money. The Humsafar Trust maintains a Crisis Management Cell to act as a Rapid Response Unit to help sort out any problems that may occur at the outreach sites. A Monitoring Cell also visits sites on a random basis to check on the presence and performance of the outreach worker.

The outreach workers are paid a modest, monthly salary and receive a small travel allowance. After recruitment, they receive three days intensive training in HIV/AIDS, STIs, communication skills, advocacy and legal issues. They are also instructed on the ethical standards expected of them. No outreach worker, for example, is allowed to have sex on their 'beat'. Neither are they allowed to bribe people, or to recruit friends or family members, in order to meet their monthly targets for counselling and testing.

In the course of their work the outreach workers take part in bi-monthly team meetings with project

staff to discuss issues and problems, and identify possible solutions. They also participate in quarterly refresher training workshops, which serve to update their knowledge, improve their skills and sustain their motivation.

### 3. The drop-in centre: providing a 'safe space'

The Humsafar Trust drop-in centre is located close to its office, in an anonymous-looking building on a busy road running through North West Mumbai. The centre is one of the few 'safe' spaces in Mumbai where Men having Sex with Men can meet to relax and socialise. For legal reasons, however, the centre does not admit people below the age of 18.

Between February 2001 and March 2002, a total of 3,365 people visited the Humsafar centre, which is open from 12 noon until 8 p.m., Monday to Friday, with Tuesdays reserved for transgenders. There are newspapers, pamphlets and magazines to read, health information materials to take away, and a well-stocked library on sexual



health, homosexuality, HIV/AIDS and STIs. Visitors can also watch TV or videos, and listen to music. They can make cups of tea or coffee in the office kitchen. Bottles of filtered water can be collected and taken home - a greatly appreciated service, because many people do not have access to safe drinking water in the boarding houses or other places where they live.

A basket of condoms is conveniently located near the entrance, and visitors can help themselves. There is a strict rule, however, that no one is allowed to have sex in the Humsafar drop-in centre or office. "This centre is not a sexual space," says Humsafar Chairman, Ashok Row Kavi. The first supervisor of the drop-in centre was sacked for contravening this rule.

Most visitors coming to the centre have heard about it first from an outreach worker or via the Humsafar telephone information line. There is no pressure on anyone to disclose their real name. Neither is there any pressure on anyone to discuss their sexuality: transgenders, for example, are just as welcome as the others.

As they become more familiar with the centre, visitors also become aware of the various services offered by the Humsafar Trust. These include, for example, free HIV and STI counselling and testing, and lectures, discussions and social events on Friday nights (sometimes attended by over 200 people) on the first floor of the same building. The centre therefore serves as a means of encouraging health-seeking behaviour, while also serving as an entry point for people who might become staff or volunteers of the Trust.



#### 4. Access to services: Counselling, Voluntary Counselling and Testing and STI treatment

For Humsafar staff, the 'counselling' process usually starts with a discussion of high-risk sexual behaviour on the telephone information line or between an outreach worker and a client at a cruising site. In such cases the 'counsellor' is a lay person with some basic training in communication skills and some practical experience in matters related to sexual behaviour and sexuality. The process moves onto a different level when the client visits either the Humsafar clinic, or Sion Hospital, for counselling from a professionally qualified counsellor.<sup>v</sup>

Both counselling and testing are provided free of charge to the client. During the period February 2001 - April 2002, a total of 1,308 Men having Sex with Men were counselled and referred for STIs and HIV testing, of whom 289 (22 percent) tested HIV-positive and 161 (12 percent) were diagnosed with syphilis.<sup>5</sup> HIV care and prevention go hand-in-hand. Regardless of whether the outcome of their HIV test is positive or negative, all clients counselled at Sion Hospital or the Humsafar clinic receive sexual health education and two condoms. Some 50 of those positive attend Sion Hospital for regular follow-up, health monitoring, nutrition supplements and dietary advice. The Trust also provides their members who are living with HIV/AIDS free supplies of filtered water.

Sion Hospital provides Men having Sex with Men with free treatment

for bacterial STIs, as well as some common HIV-related opportunistic infections such as candidiasis. Anti-retroviral treatment is also available, but not affordable to most of Humsafar clients or staff.

#### 5. Research: informing programming and evaluation of impact

Although the Humsafar Trust began without a baseline survey or any other kind of systematic research, the involvement of the organisation's leaders in Bombay Dost magazine gave them valuable insights into the problems and needs of Men having Sex with Men. The baseline survey carried out by the Trust in 1999/2000 was the first quantitative assessment of the scope and nature of MSM activities in India. The survey was carried out by Humsafar outreach workers, with training, technical support and supervision from professional market researchers. This experience provided valuable information which helped Humsafar's planners to better understand the knowledge, attitudes and behaviour - as well as the problems and needs - of MSM in Mumbai, and to plan their strategies and activities accordingly. Two years later, in 2001/2002, a second survey was undertaken to assess the changes that might have occurred in the meantime.

The follow-up survey identified an additional 49 places where the Men meet, making a total of 125 known sites in Mumbai. The survey also found some significant, and generally encouraging, changes compared with two years earlier. For example, 84 percent of respondents who were involved in receptive

<sup>v</sup> The End of Project Review carried out by Family Health International in May 2002 points out that these two processes are qualitatively different, and suggests that the term 'counselling' should be reserved for "psychological, behavioural and sexuality assessment associated with a clinical intervention, like STI/HIV testing or psychotherapeutic care (sometimes called therapy)".

anal sex reported that their partners always used a condom, compared with 41 percent two years earlier. The average number of sex partners was seven, compared with 11 two years previously. As in 1999/2000, about half of the respondents also had sex with female partners, but the proportion that used condoms rose from 34 percent to 47 percent. Most respondents were young, with 54 percent were aged between 18 and 25.<sup>6</sup>

Although these were positive trends, some findings of the 2001/2002 survey gave cause for concern. The report comments: "The average number of male partners being seven still indicates that there is a heavy turnover of partners, which implies a very high risk of transmitting infections. Moreover, the high number of partners implies more of a casual approach towards the relationship, which raises the fear of not following serious health practices."<sup>7</sup> In addition, 35 percent of respondents admitted to having suffered from a sexually transmitted infection in the previous six months, compared with 21 percent in the baseline survey two years earlier. This increase may be due, however, to more people reporting their STI as a result of greater awareness of the problem.

### Funding and sustainability

The Humsafar Trust has come a long way since 1995, when it started with US\$1,000 begged and borrowed from friends and supporters. By 2002 the Trust had an annual budget of US\$150,000 and a staff of 61 (54 in Mumbai and seven in Goa). Its main sources of funds were Family Health International, the Elizabeth Taylor Foundation, the Mumbai District AIDS Control Society and the

Maharashtra State AIDS Control Society.

The Trust's main activity, the Comprehensive Project, was funded by Family Health International between February 2001 and July 2002. After being favourably reviewed in May 2002, the project entered a second phase of 18 months.

However, the Trust has devised ways of generating income from its own resources. In one scheme, for example, it will contact everyone who has received services and support from the organisation and ask them for an annual contribution of Rs 1,000. This scheme is modelled on the Indian tradition of giving an annual dakshma to one's personal guru at the time of Divali (the Hindu Festival of Lights). Another scheme in the making is the production and delivery of lunches and dinners to people in their homes. Given that 30 percent of the population of Mumbai are single people, this service should find a ready market. A third scheme is a health insurance fund, to which Humsafar staff will make monthly payments to help to cover the cost of anti-retroviral treatment for staff with HIV/AIDS.

### Achievements and lessons learned

Since its inception in the early 1990s, the Humsafar Trust has weathered many storms, learned a number of lessons and notched up some significant achievements:

1. **The Trust's first achievement is its very survival:** Many other similar organisations working with Men having Sex with men and gays in India have withered and died in the face of relentless hostility from many different sections of

government and society, or lack of financial support. Yet the Humsafar Trust, after several years of slow and painful progress, has gone from strength to strength since receiving support from the Government of Maharashtra in 1998.

Continuity in leadership and being **grounded in the community** they support are the major reasons for the survival and staying power of Humsafar. All the board members, outreach workers, office staff and other non health professional staff of the Humsafar Trust are themselves MSM or transgenders. This strengthens their commitment to the aims of the Trust, and also enhances their personal credibility and effectiveness. The Trust has created and maintained amongst its staff and volunteers **high morale and ethical standards** which help to protect the Trust from outside criticism. This is, in itself, a considerable achievement, since MSM are not a homogeneous group. The transgender (hijira) community, for example, are a highly visible group who do not identify themselves with the MSM community. In Humsafar, however, they work in harmony alongside the MSM majority, who do not question their unique sexual identity.

The Humsafar Trust offers an alternative 'family, providing not only an emotional home but also practical help in times of illness or other need. Concern for the welfare of individual staff members and volunteers is extremely important for survival, the organisational morale of all NGOs, particularly those working with stigmatised and marginalised groups such as sex workers, injecting drug users and people living with HIV/AIDS, many of whom are rejected by their own families.

Thirty seven year-old Vivek leads a double life. From morning until mid-afternoon he works in his successful film and video production company. He then travels to the Humsafar office, where he works until late evening as the organisation's Chief Executive Officer. For Vivek, what is unique and distinctive about Humsafar is its family ethos:

"Humsafar was set up as a support system and an alternative family system. We call it the Humsafar family (parivaar). At the beginning, when I first met Ashok, I was not looking for sexual contacts. I was looking for a support system. Over a period of ten years all my straight friends had got married and started leading their own lives. My sister and brother also got married. Not that they don't love me - they do, and they care for me, but they have their own lives. I was the one who didn't have a support system. And in Ashok I found a parent figure who could understand me.

"We have a core group of about 12 friends, six in Mumbai, some in other parts of India, some in the USA. Those of us in Mumbai meet every weekend - it could be in my house, or Ashok's house, or someone else's house. We meet just to chat and discuss our problems - what's going on. Sex doesn't play any role. And this is something we want to pass on. Sex is a very important aspect of your life, but it's not everything. You have to learn to look beyond that. Sex is available outside - who's stopping you? But here we are promoting a kind of family culture.

"What happens some day, when I turn 60, and I'm not too hot about sex, and I get unwell and take time to recover? Who do I turn to? I turn to my family. This is my family and this is where I will go."

Vivek Anand, Chief Executive Officer of the Humsafar Trust

Vivek Anand.

2. **Humsafar has succeeded to bring about safer sexual behaviour:** Research carried out by the Humsafar Trust, with technical sup-

port and supervision from professional market researchers, has reported a large increase - from 41 percent to 84 percent - in consistent condom use among their clients engaged in anal sex. This is an impressive and encouraging finding, which - if confirmed by independent research - would mean that a good start has been made in breaking the chain of HIV transmission, not only within the community of Men having Sex with Men but also with their female sexual partners and their infants.

The Humsafar Trust has demonstrated the importance of operational research to guide programming. Although the Humsafar Trust began without any formal research, the baseline studies carried out just before the project began to expand in 1999 provided reliable data for the programming process which led to the strategic approach of providing comprehensive health information, care and support. They also helped to convince the local government authorities of the size of the population of Men having Sex with Men and of their importance in the epidemiology of HIV/AIDS. The data also provided a bench-mark against which the achievements of the project are being measured as time progresses.

The analytical and self-critical approach and willingness to be open about shortcomings and weaknesses, and to consider new strategies and working methods has contributed to a certain flexibility in approaches. The management and staff of Humsafar learn from the people they are trying to serve partly through the pages of Bombay Dost, which still circulates widely within MSM circles in India. Regular meetings and workshops at which Humsafar staff can exchange

experience and discuss problems is a part of this learning process. Additional opportunities for learning are provided by the external evaluations carried out from time to time by the donor organisations which fund the work of the Trust.

**3. Succeeded in influencing positively official attitudes:** Only a few years ago, government policy makers in Mumbai were unaware of the large number of this group in the city and the extent to which they are at risk of both contracting and transmitting HIV and other STIs. Through its research and sustained advocacy work, the Humsafar Trust has convinced government policy makers of the importance of reaching Men having Sex with Men with information, services and support in order to stabilise and reduce prevalence and incidence of STIs and HIV among them. It is now recognised by government and international agencies, not only as champion of 'gay rights', but also as a viable partner in strengthening community-based responses to the HIV epidemic. This is a remarkable development, especially given the fact that sex between men is still proscribed by the Indian Penal Code. Through advocacy at many levels and in different areas of official and public life, the Trust helps to create a social environment in which the Men are able to play an active and effective role in preventing the spread of HIV and mitigating the impact of AIDS.

**4. Provision of support and services to those who otherwise have no access:** The Trust found that rather than attempt to provide everything itself, it has worked in partnership with other organisations, especially with the governments of Maharashtra State and Mumbai city, and with government hospitals which provide sexual health and

HIV/AIDS - related services. This is more sustainable - and managerially simpler - than trying to provide a wider range of specialist services under Humsafar's own roof.

Through this partnership, some 8,500 Men having Sex with Men have received support and services of various kinds, mostly free of charge, either through or directly from the Humsafar Trust. Several thousand more have received printed materials produced and distributed by the Trust. The health care services which Men having Sex with Men can access through Humsafar are of high quality and delivered in a sensitive, non-judgmental manner by well trained and experienced professionals. The counselling provided at the Humsafar office and at Sion Hospital is an important contribution to HIV prevention, especially amongst the young Men, who constitute the majority of clients who come for counselling. The Trust's drop-in centre in Central Mumbai provides a safe and secure space where Men having Sex with Men can meet to exchange information and share experiences, or simply to relax and socialise.

**5. Staff capacity building and support is critical for quality services:** Humsafar Trust has very few professionally trained staff, but it offers training courses to all its office staff and outreach workers. These are reinforced by regular workshops to upgrade staff knowledge and skills, combined with on-the-job support and supervision. As a result, Humsafar staff generally feel confident about their own knowledge and skills. The modest financial support provided helps to maintain staff morale and maintain staff continuity and consistency in performance standards. Outreach staff also appreciate the regular

visits and 'crisis support' which they receive from their colleagues at the Humsafar office.

## Challenges for the way forward

To continue meeting the needs of Men having Sex with Men on a long term basis, the Humsafar Trust would need to carefully review what is currently not working as effectively as it should:

- **Strategic planning:** The review carried out by Family Health International (FHI) in May 2002 noted that, although strong at community level, Humsafar Trust finds it difficult to engage in long-term strategic planning. The review recommended "increased technical support in the development of management systems, up-scaling of activities and research".<sup>8</sup> The long term strategic plan should also include monitoring and evaluation. The FHI review also noted that there was a need for better monitoring and evaluation of project activities, which have expanded rapidly since 1998.
- **Partner notification:** A particularly thorny problem is that of partner notification, especially of female partners. As noted by the Family Health International review: "The failure of MSM with HIV or another STI in this project to notify their female and male partners has been well-documented in project reports and was reiterated during the review. Whilst everyone agreed that it was an important issue and many proposed some possible solutions, there was a general feeling that it was too difficult."<sup>9</sup>

It is easy to understand why the Men find it difficult to disclose their



HIV-positive status to their partners: HIV and MSM are both associated with stigma, discrimination and secrecy in India. Notifying the wives of men about their HIV-positive status is particularly difficult. But a solution will have to be found, not least because non-notification encourages the spread of HIV to women and their babies. The Humsafar Trust has tried to respond to this challenge by appointing a special counsellor in a hospital, but so far not a single one of these Men has come with his spouse for counselling. The Trust is still considering alternative ways of addressing this difficult issue.

- **Reaching younger males: Humsafar does not provide services and support to boys under the age of 18,** since this is the legal age for adulthood in India. To become involved with 'under-age' boys would risk the reputation of the organisation, especially as it operates on government premises. "We've had kids of 16 and 17 coming to us," says Humsafar Chief Executive, Vivek Anand, "and they've been very clear and self-confident about their sexuality, but they are under-age so we just keep in touch with them on the phone and tell them to come here after their 18th birthday if they still want to. We also refer them to psychologists for consultations if they want professional advice." However, this is a critical group of young men who need access to information and services.
- **Establish a support system for those affected:** Increasing numbers of Humsafar Trust clients, staff and volunteers who are already HIV-positive are likely to develop clinical symptoms of AIDS in the foreseeable future. In

the absence of affordable anti-retroviral treatment, many will die prematurely. This will place a heavy emotional and economic burden, not only on their relatives and friends but also on everyone involved in the Trust as well. Support systems need to be put in place for maintaining a high level of staff morale and addressing likely burn-out when the numbers of AIDS-related deaths increase. HIV-positive men associated with the Humsafar Trust have not yet established a support group to reduce isolation and provide a focus for support aimed at addressing their specific needs. There are, however, enough Men having Sex with Men to establish such a group and it is likely that such a group will be started in the near future.

- **Meeting unmet needs of many MSMs :** The Men who have come to the Humsafar Trust for information, services and support are only a small fraction of the men in Mumbai who have sex with men. Some are involved with other NGOs, but most still keep their sexual orientation secret from their families, work colleagues, neighbours and spouses. Humsafar aims to increase the number of clients coming to its clinic by focusing more on the 'hot spots' where there is a greater concentration of Men having Sex with Men. But all these efforts by Humsafar will contribute to meeting the protection needs of only a fraction of this group in the country.

Much more needs to be done in terms of:

- Continued advocacy to advocate with National AIDS programmes to address and incorporate the

special requirements of Men having Sex with Men into the design and of their STD/HIV prevention and AIDS care Programmes. Some have included it but implementation lags behind. Governments and donors need to prioritise the long term funding of implementation and evaluation of projects as a main component and not just an add on.

- More determined efforts must be made to change public perceptions to get rid of denial and prejudices. Serious and concerted lobbying is needed with policy makers for the

implementation of anti-discrimination and protective laws to reduce human rights violations against Men having Sex with Men which impede the provision of HIV/AIDS prevention and care services.

- Lack of, or unreliable epidemiological data are an obstacle to promotion of sexual health and HIV prevention. For the development of strategic approaches for advocacy and for evidence-based programming more research towards understanding same sex behaviour, its prevalence and relation to HIV/STI risk, should also be carried out.

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<sup>1</sup> Ashok Row Kavi, personal communication.

<sup>2</sup> Ibid.

<sup>3</sup> WHO/UNAIDS, Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update: India.

<sup>4</sup> Deed of Trust No. DYCC/902/94, dated 12 February 1994.

<sup>5</sup> Family Health International, Report of End of Project Review of 'Comprehensive and Holistic Care and Support project in the sector to stabilize STIs and HIV in Mumbai Metro', May 2002

<sup>6</sup> The Humsafar Trust, Knowledge, Attitude, Behaviour and Practice among Men Having Sex with Men in Mumbai and Thane in 2001-2002, 31 March 2002.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

# The Girl Child Shield Project Girl Guides Association/ UNICEF, Pakistan

Location: All 4 provinces, Federally Administered areas of Azad Jammu Kashmir, Islamabad, Northern Areas, Pakistan

Target groups: Adolescent girls between the ages of 11 and 16; schools, families and communities.

Strategic approach: Rights based approach to girls' education and health

Area of operation: 800 schools in rural and urban areas throughout Pakistan



# The Girl Child Shield Project in Pakistan: The Right to be Equal

## Background and rationale

"For the women of most houses in Pakistan, sadly the age of enlightenment has not yet dawned. A woman's role is always conceived to be a light one, not of an actor in a serious real life drama but of a pretty demure character...that my friends are not right! Should we womenfolk not be free to do, as we like and to say what we like? Men might not be ready to hear us but it's about time we take a stand and make ourselves heard!" This is how Sobia Yaqub, a nineteen-year-old young woman who participated in the project three years ago, ended her winning speech to an audience of 600 people on Women's Liberation Day in Islamabad. Not only did she get a deafening applause her pictures got printed in all the local dailies.

Sobia has a vibrant personality, full of confidence and determination to excel. Her aim in life is "to fight against all sorts of gender discrimination"... "I wasn't like this a few years back...I was actually quite different. I lacked confidence and was an extremely introverted

person, getting around expressing my feelings was a major feat. Public places and large gatherings scared me."

She says that the project "empowered me in such unique ways. I actually felt good about being a woman. It made me realize that all the power I used to yearn for is right within me and not with my father, brother or future husband."

But most women and girls in Pakistan suffer from discrimination throughout the life cycle, and adolescent girls often suffer the most. Already as young women, they are often confined to the home without opportunities for education, knowledge, skills or even the company of other young girls. Facing discrimination from the time of birth, more girl children than boys die before reaching the age of five, fewer girls are enrolled in schools than boys, and more girls drop out before completing five years of education. Skills training and income generation opportunities for girls are almost non-existent. The lack of opportunities prevents girls

and women from rural areas or urban slums from breaking out of the stereotyped roles to which they have been relegated. Thus they continue to be seen as having lesser abilities than boys and men, and are given a lower status in the family and community, further continuing the vicious cycle of discrimination and preference for sons.

In 1997, after several years of informal co-operation and following the development and testing of a pilot program, the Pakistan Girl Guides Association (PGGA) and UNICEF launched a Girl Child Shield Project. The goal of this project is to improve the status of women and girl children in Pakistan. By May 2001, the project had involved an estimated 100,000 girls in over 800 schools in lower and middle income urban and rural communities, trained them as role models on girl child issues, child rights, affirmative communication and team building. It had also reached an impressive number of peers (1,000,000) and families (100,000).

## Objectives

The overall goal of the project is to improve the status of girls and women in Pakistan. It seeks to increase the Girl Guides' awareness of the problems girls face in their communities, raise their self-esteem, confidence, communication skills and increase their ability to engage in community service. The acquisition of new knowledge and skills by girls is intended to demonstrate to peers, families and communities the potential of girls and their abilities to act as role models and change agents, and thus to positively influence attitudes towards girls and reduce gender discrimination.

The specific objectives of the project are to:

- Increase awareness of child rights, girl child issues and importance of health, hygiene and education in the survival and development of children.
- Encourage participation in activities to improve health, nutrition and education of girls, women, families and communities.
- Empower girl guides to communicate with others and address the problems faced by girls in Pakistan.

## Programme components

### Gender-based awareness-raising

The project builds awareness among girls about child rights, girl child issues, education and health. The Pakistan Girl Guides Association (PGGA) and UNICEF have developed and produced a variety of communication kits, the content of which shows evidence of careful preparation, being based on situation analyses and pre-tested before widespread use. Full use is also made of the Meena multimedia package, an animated film and cartoon series produced by UNICEF, to promote the rights of the girl child.

The project is designed around six proficiency badges, which the Girl Guides have to 'earn'. The badges are activity based and encourage girls to learn about their rights, responsibilities, and opportunities to improve the status of girls. Four of the badges increase awareness about the status, education, health, and rights of the girl child; the two others enable girls to learn about participation, interpersonal relations, and collective planning and action.



Each guide in the project has to complete two compulsory badges: Facts for Life and Interpersonal Communication Skills, and two of the remaining four optional badges: Child Rights, Education, Girl Child Issues, or Team building. Once 12 girls in any Girl Guide Company complete four badges each, the



Company receives a special shield, the Guider a special certificate, and each girl an additional Shield badge.

#### [Advocacy and participation](#)

Girls are trained to develop advocacy skills and participate in school, family and community activities. The project also works with the girls to become role models and change agents. The Compulsory Communications badge and the optional Team-building badge aim to develop effective interpersonal skills and to help Guides work together toward collective goals. An important principle of the project is for girls to identify communication barriers and learn to work together with their families and communities to effect positive change.

In 2002, a new component was piloted and introduced: 'Senior Guides' (14 years and older girls) can obtain a 'Mashal' (torch) badge. After having been trained on HIV/AIDS along with advanced training on issues covered in the other badges, these Senior Guides are responsible for conducting 5-10 day camps in their communities to educate about children's rights and health related topics. The younger, regular Guides are working to increase their communities' awareness levels, while Senior Guides are conducting community training as a means of bringing sensitive issues to the forefront of their communities' agendas. Such training in several conservative communities where the program is being implemented, has significantly contributed to reduce the initial resistance among community members to discuss any controversial topics.

#### [Community-based activities](#)

By applying a participatory methodology and undertaking individual and collective activities, Guides can acquire experience in community-based activities, plan-development, and conflict resolution. Most activities take place in regular weekly meetings, during vacation weeks, and at service and work camps. In keeping with the practice of the International Guide Movement, the project relies on activity-based learning and participatory methodologies to build on existing knowledge, develop skills and demonstrate practical applicability. The project is designed to include Girl Guides in all levels of decision-making and to be flexible and receptive to changes in the implementation.

#### [Capacity building at all levels](#)

The project emphasis training of national and provincial officers,

teachers and Guiders. This has ensured a valuable pool of master trainers and experienced Guiders.

#### Monitoring and Evaluation

To monitor and evaluate the project, PGGGA and UNICEF have developed a set of indicators to measure progress. The project also conducts focus group discussions with girls who participate, others who do not participate, mothers and other community members to monitor any changes and progress.

In June 2001, the project was evaluated by an outside expert.<sup>1</sup> The evaluation found evidence of extensive monitoring of the project components, using both quantitative and qualitative indicators, to assess the proficiency and quality of the various activities and to ensure uniformity of knowledge, skills, efficiency and value across the project.

The evaluation report suggests that 'the project has achieved its objectives in raising awareness, participation and empowerment, in the acquisition and advocacy of knowledge and life skills and in effecting positive changes in family and community perceptions of girls.' The positive results were attributed to the well-developed implementation strategies. The commitment and quality of the services by the PGGGA's national officers and Guides were highlighted as well developed. National officers and the Guides were seen as good role models for girls and women themselves.

#### Funding

Funded by UNICEF and the Swiss Development Corporation, the project has been brought to scale, a process begun in 1998. The first

project phase (1998-2001) has been completed and the second phase (2002-2004) focuses on consolidating the results. The second phase of the project also involves networking with NGOs, CBOs, government bodies and other groups that can serve as potential employers for the young women when their time as Girl Guides is over.

#### Achievements and lessons learned

- **Increased awareness among the girls about child rights and responsibilities and the ways in which these rights might be realized.** The evaluation showed that the girls were familiar with the provisions of the Convention on the Rights of the Child (CRC) and the importance of these rights for their survival, development and protection. Likewise they were actively aware of discriminatory attitudes and practices that were affecting girls in their own homes and communities. They were encouraged to take action to improve their status, and showed a special awareness of their right to equality in education. They understood how discriminatory practices inhibited their full development as individuals and reduced their abilities to contribute to their families and to society. Many reported how they had attempted to win freedoms for themselves or others.
- **Rights and responsibilities go together.** Awareness of rights and responsibilities has not only increased among the girls, but also among their families and communities. The girls showed an understanding of their rights

and their responsibilities, including the importance of educating their families and communities. The equal emphasis on responsibilities meant that the project enjoyed widespread support by parents, teachers and community leaders despite a social context in which family and community leaders retain considerable authority and control - often to the detriment of the development of the child, and particularly the girl-child. Schoolteachers, family and community members reported many positive findings, for instance that Guides had persuaded their families, schools or communities to upgrade their health and hygiene practices.

- **Using innovative strategies to raise awareness among the wider community.** The Guides became aware of the conditions of others, engaged in outreach activities to benefit others, and acted as role models and change agents. In particular, Senior Guide community camps offered an important opportunity for raising the Guides' awareness about rural conditions, the conditions of girls and women from low income families, and their own confidence in their abilities to help and teach in poor villages. The communities in which they work benefited from the presence of Guides in both tangible and intangible ways.
- **Harnessing broad community support to address possible resistance by community and religious leaders.** Accusations that the project was promulgating a 'western' agenda by supporting women's rights were made but effectively counterbalanced by the local support for the project.

- **Participatory training methodologies have been successful.** The evaluation found that that the Guides were able to discuss and express their opinions effectively, with confident words and attitudes. A number of girls reported on their new status as visible and responsible members of their families and communities. Many described how they had to be quite assertive to overcome the initial opposition by their fathers and brothers. Given that all Guides were school-going girls, it is difficult to ascertain how much confidence and self-esteem was evident before entry into the project and how much was acquired during the project. However, there was consensus among girls, teachers, parents and community leaders, that the project has helped the girls to overcome shyness, insecurity and feelings of inferiority. Guides were also seen as more confident in their own knowledge and abilities and seemed more cooperative.

- **Partnership between UNICEF and PGGGA,** the collaboration of the both agencies has been crucial. PGGGA's organisational infrastructure, well-developed documentation skills, and careful and creative management have been attributed to the project success.

### Challenges for the way forward

Despite the effectiveness and influence of the methodologies and materials of the Girl Child Shield Project on Pakistan's national Girl Guide movement, it has been estimated that only about half the Girl Guide companies and between 25 to 50 percent of all Guides have

participated in the project. Although the numbers of master trainers and experienced Guiders is growing slowly, a major challenge for the project is to **fast track the training and increase the pool of trainers and Guides**. If the project wants to strengthen its current operations and meet the demand by many other girls to become girl guides, the project might have to either expand the number of training programs for the Girl Guide Shield Project or integrate specific training sessions into the general training provided for the regular guiding movement.

It has also been recommended to **extend the project to younger girls in Junior Guides and to older girls in Senior Guides and to expedite this development to increase the project's reach**. Practical constraints on the supply of materials and training for the project will have to be addressed to continue and enlarge its reach.

**Further, it has been recommended to identify formal ways to extend the messages and methodologies of the Girl Guide Shield Project to other girls in Pakistan outside the Guide movement. Incorporating the project into school curricula, school assemblies or classroom meetings could prove to be very beneficial. However, consideration should also be given to reach and involve young girls who are not in school. Reaching these girls will be challenging, but critically important.**

Given the abysmally low status of women and girl children in Pakistan in general, projects such as these, which **build skills at the individual level and seek to change family and community norms**, should be replicated at a much larger scale. Building **partnerships, networking**

**and increasing advocacy efforts** with policy makers are vital in this regard.

Like many other projects which work with young people, the project faces challenges to sustain the benefits which the young women have obtained from participating in the project. **Identifying employment opportunities** for young women who have completed the Girl Guide project, could significantly contribute to enable these young women to continue to positively impact on their families and communities – and themselves.

In addition, the project has started to **recognize the importance of HIV prevention**. In 2002, 'Senior Guides' (14 years and older girls) were trained on HIV/AIDS along with advanced training on issues covered in the programme. However, there appears to be a critical need to strengthen the integration of HIV prevention, along with sexual and reproductive health awareness. Incorporating regular **life skills based education for HIV prevention**<sup>1</sup> could build on the strengths of the project. The project is in a good position to link the development of psycho-social competencies and interpersonal skills with HIV content information so that young girls can make informed decisions, solve problems, think critically and creatively and communicate effectively about matters related to their sexual and reproductive health. In a country, where women and young girls are faced with enormous lack of access to knowledge and services, good quality, gender sensitive, interactive teaching and learning methods combined with HIV/AIDS information could make a critical difference in reducing their risk and vulnerability to HIV infection.

<sup>1</sup> Annex 4: 'At a Glance: Life Skills Based Education and Young People'

Although HIV prevalence is so far considered to be relatively low in Pakistan, the country has already an estimated 78,000 persons living with HIV. About 16,000 of them are women. It is estimated that the total number of young people infected with HIV is about 21,500.<sup>2</sup> As such, the project could [provide creative entry points](#) to work with young girls to increase not only their knowledge about HIV/AIDS, but importantly to build on their well developed self-esteem raising project components and integrate for instance decision making and communication skills about matters related to sexuality, sexual and reproductive health into the training.

Building on the project's experience with participatory training methodologies, [Participatory Learning and Action \(PLA\) assessments](#) will be valuable, not only to determine individual knowledge, beliefs, attitudes, availability of services and sources of sexual health information, but also to identify community norms and attitudes towards HIV/AIDS, sexuality and reproductive health. The project has already well established links with the Girl Guides, parents, teachers and community leaders, who could easily be involved in a PLA assessment. Such a participatory assessment would have many benefits. Most importantly the involvement of parents, teachers, girls and boys in conducting and analyzing the assessment can be an empowering process in itself, increase ownership and reduce potential opposition towards integrating HIV and sexual health information.

Further, the project has a valuable pool of trainers and Girl Guides,

who could also be trained to become [peer educators for school going girls](#).<sup>ii</sup> However, barely 40 percent of girls in Pakistan are enrolled in schools and of this only 54 percent complete their primary education.<sup>3</sup> Girls who are out of schools have even fewer opportunities to access information on HIV/AIDS and sexual health. As such, the Girl Guides could become [valued peer educators for young girls who are out of schools](#) too.

Moreover, increased [networking with organizations working with boys and young men](#)<sup>iii</sup>, such as the Boys Scouts, will likely contribute to a considerable mass of young people who could be engaged in advocacy efforts for HIV prevention among young people, religious leaders and the community.

[Clarifying organizational values and attitudes towards HIV and people living with HIV](#) will also be essential. This may be most useful if undertaken as part of broader strategy to build the organizational capacity in developing and implementing a stronger HIV prevention component. Given the already existent challenge to find further master trainers and Guides this will require significant commitment inside the organization as well as outside support. However, compared to the severe threat which HIV and AIDS pose to the health and development of the country, such proposed early and community based responses can make a significant difference.

The [rights based approach](#) of the project to girls' development and education does provide the critical framework as well as the rationale to make HIV prevention efforts avail-

<sup>i</sup> Annex 9: 'At a Glance: Young People and Peer Education'

<sup>ii</sup> Annex 7: 'At a Glance: Gender and HIV/AIDS'



able to young women and men and children - as stipulated by the Convention of the Rights of the Child.<sup>4</sup>

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<sup>1</sup> Croll, E (2001) The Girl Child Shield Project. Assessment Report. Commissioned by UNICEF and PGGA

<sup>2</sup> UNAIDS (2002) Report on the Global AIDS Epidemic. Geneva.

<sup>3</sup> South and West Asia Regional Technical Advisory Group and UNESCO (2000) Education for All in South Asia and West Asia: A Decade after Jomtien: An Assessment. Synthesis Report. Prepared by Jandhyala B G Tilak, National Institute of Educational Planning and Administration, New Delhi.

<sup>4</sup> Committee on the Rights of the Child (2003) General Comment No 3. HIV/AIDS and the Rights of the Child. CRC/GC/2003/1. 32nd Sessions



# Annexes

# Annex 1

## South Asia Regional Forum for Young People on HIV/AIDS, Kathmandu, Nepal, 15-18 December 2002

### Outcome Document: 'Young South Asians Assert their Rights'

We the children and young people from South Asia know that our governments from South Asia promised at SAARC meetings, the UNGASS on HIV/AIDS and the recent Special Session on Children to work with children and young people in the fight against HIV/AIDS. In our South Asia Regional Forum for young people on HIV/AIDS we agreed to work with our governments, to help them keep the promises they made.

We therefore call on our governments (at national, sub-national and local levels) to respect and realize the following rights:

We assert our rights to participation in influencing policy making and making political commitment.

- Governments to commit themselves to involve children and young people in developing and implementing policies that affect us. This will ensure a children and young people friendly policies, the effects of which will be multiplied throughout the nation.
- National government should initiate a high level council including children, young people and key adults such as planners

and policy makers to form a strong committee and network.

- Government should allocate special funds in their budgets on HIV/AIDS programmes for the involvement of children and young people. They must ensure children and young people's participation while making budgets.
- We assert our rights in influencing and mobilizing key adults (parents, teachers, religious and community leaders).
- Governments to ensure that Parents, teachers, community and religious leaders are given the proper training in providing sexual reproductive health education, including HIV/AIDS, the use of condoms and protection from drug use, to students before young people are sexually active and students drop out of school.
- Government must ensure that young people's committees (parliaments, clubs, children's organisations, etc.) are established at village, sub-national (district, provincial and state) and national levels. This will enable young people to express themselves and to participate in decision making fora.

We assert our rights to participation in ensuring access to information on sexual reproductive health, HIV/AIDS, life skills education and young people friendly services.

- Governments to include sexual reproductive health education, including HIV/AIDS, in formal and non-formal curricula starting from grade 5.
- Recognise that young people have special needs and therefore provide health facilities to children and young people so that they can speak openly in a confidential environment.
- Governments should provide free HIV voluntary counselling and testing at sub-national levels and also provide follow-up support services.
- Government should be responsible for providing training to children and young people (in and out of school environment) on life skills to become peer educators/facilitators.
- Government should ensure that correct and complete information is provided at all levels to remove fear about HIV/AIDS.
- Children and young people should be involved in the development of children and young people friendly HIV/AIDS resource materials.

We assert our rights to participation in using media as a tool for spreading information and producing children and young people friendly programmes.

- Government should ensure that young people have opportunities to produce television and radio programmes, and provide spaces

in newspapers, magazines and websites.

- Governments should support media programmes that include popular personalities who can talk about issues that concern children and young people, such as healthy life styles and HIV/AIDS.

We assert our rights to participation in reducing stigma and discrimination and increasing care and support.

- Government, community and religions leaders should ensure participation of children and young people affected by HIV/AIDS in all related committees and HIV/AIDS related issues.
- Local government bodies should allocate funds for care and support of affected families.
- Government to introduce laws and polices against discrimination and stigma of people affected by AIDS.

Finally we assert our rights to participation in HIV/AIDS programming, including research, design, implementation, monitoring and evaluation.

We commit ourselves to form our own organisations and networks that will work towards educating children and young people and adults as well, about child rights and especially on their right to be protected from HIV/AIDS.

We and our governments must work together in arranging follow-up forums - to ensure monitoring and evaluation of the work done in involving children and young people.



South Asia High Level Conference  
'Accelerating the Momentum in the Fight Against  
HIV/AIDS in South Asia'

3 –4 February 2003, Kathmandu, Nepal

Outcome Document:

'The Kathmandu Call Against HIV/AIDS in South  
Asia: Accelerating Actions and Results'

**W**E the participants from South Asia – Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka – representing governments, parliamentarians, religious leaders, private sector, non-governmental organisations, people living with HIV/AIDS, young people, activists and partners from bilateral and international agencies met at the South Asia High Level Conference on "Accelerating the Momentum in the Fight Against HIV/AIDS" in Kathmandu on 3-4 February 2003.

**W**E recall and reaffirm the commitments on HIV/AIDS made, inter alia, in:

- The UN Millennium Declaration of 8 September 2000, and the Millennium Development Goals;
- The Regional Call for Action to fight HIV/AIDS in Asia and the Pacific adopted by the Economic and Social Commission for Asia and the Pacific, April 2001;
- The UN Declaration of Commitment on HIV/AIDS adopted at the 26<sup>th</sup> Special Session of the General Assembly in June 2001;

- The 11<sup>th</sup> SAARC Summit Declaration, January 2002; and
- The World Fit for Children document adopted at the UN General Assembly Special Session in May 2002.

**W**E note that there are an estimated 4.2 million people in South Asia living with HIV/AIDS. Although several of the countries in the region have low prevalence rates, there are concentrated and even generalised epidemics in some countries. The epidemic can grow quickly – all countries are at risk. Strong leadership and overcoming stigma and discrimination are key elements for controlling the spread of HIV/AIDS in South Asia.

**W**E acknowledge the potential of a large-scale epidemic in South Asia and its devastating consequences for human development and security. Poverty, illiteracy and gender inequalities increase the vulnerability of people to HIV/AIDS, and heighten its impact. People who are marginalised such as sex workers, men who have sex with men, and injecting drug users are especially vulnerable and require special

protective measures. Migrants, mobile workers and refugees are exposed to serious risk. Women and girls are particularly vulnerable, especially those who face violence and abuse, including trafficking. Gender equality and the empowerment of women are fundamental elements in the reduction of HIV/AIDS. Education, information and awareness leading to behaviour change, with expanded access to essential commodities, are critical for combating the disease. The multiple factors underlying the spread of the disease make it an issue beyond the health sector alone, calling for a multi-sectoral response as a national priority.

**W**E understand the sensitivity of matters related to sexuality, but also recognise that increased openness around these issues is a pre-requisite for successful preventive actions.

**W**E note that the potential for escalation and spread of the disease is great among young people with roughly half of all new infections occurring in this age group globally. The face of HIV/AIDS is becoming young and younger.

**W**E further note that lessons from countries within and outside the region show the devastation that a large scale HIV/AIDS epidemic can cause in the lives of people and the threat of reversal in economic and social development.

**W**E also note that the epidemic can be halted and reversed, and that South Asia is at a critical juncture with an important 'window of opportunity' to accelerate actions.

**W**E acknowledge that the Governments of South Asia,

non-governmental organisations, employers, trade unions, network of people living with HIV/AIDS, marginalized groups, women and young people are taking a number of actions to fight HIV/AIDS. Successes exist on a small and localised scale, but these are not enough to halt the epidemic. Halting the epidemic and its reversal is a collective responsibility of the government and leaders at all levels, including religious and private sector, media, civil society, educational institutions, communities, families and individuals. While the responsibility to protect people from HIV/AIDS is universal, accountability must rest with the government and leaders.

**W**E agree that:

- Prevention, including availability, affordability and proper use of condoms and voluntary counselling and testing, care and treatment, including anti-retroviral drugs and harm reduction programmes for injecting drug users, are fundamental elements of an effective response;
- Creation of an enabling environment by the government, civil society, private sector, and communities, working in partnership, and provision of services for the most vulnerable groups, is a priority for achieving large-scale reductions in the number of people infected and affected;
- Young people have a right to information, access to services, and means to protect themselves. Educational and vocational institutions have an important role to play in imparting information on reproductive health. Young people should be provided youth-friendly and gender sensitive psy-

cho-social support services at all levels;

- Every child has a right to be born free of HIV. The prevention of transmission of HIV from mother-to-child and anti-retroviral treatment, is the responsibility of fathers, mothers, civil society and governments who must, in particular, provide a supportive environment;
- Special attention is required to ensure that children orphaned by AIDS receive care, support, education and are protected from abuse, exploitation and discrimination;
- Children who are trapped into the worst forms of child labour are often exposed to the risk of HIV/AIDS and require increased attention and protection;
- Participation of marginalized communities, persons living with HIV/AIDS, women and young people is critical for developing strategies and decision making on actions needed to halt and reverse the epidemic;
- Regional co-operation in South Asia should be strengthened for the prevention of the spread of HIV/AIDS across borders. International agencies can facilitate such bilateral and regional co-operation;
- Co-infections to HIV/AIDS, especially tuberculosis, should be addressed through the provision of cost-effective and comprehensive services;
- Sexually transmitted infections should be addressed through the provision of effective prevention and treatment services;
- All people living with HIV/AIDS have the right to affordable care, treatment and support;

■ The media has a critical role to play in disseminating information, being sensitive to the concerns of the different groups and encouraging leaders at all levels to be more proactive and accountable in the fight against HIV/AIDS.

**WE**, the participants, noting all the above, commit to:

- Speak out and break the silence and denial on HIV/AIDS and stop the stigma and discrimination. Leadership at all levels should use every opportunity, including working with the most vulnerable groups and young people, to openly discuss the issues surrounding the spread of HIV/AIDS. This should include issues of gender inequalities and human rights violations, especially the abuse and exploitation of women, and young girls and boys, which fuels the epidemic;
- Accelerate actions at the national level to meet the goals and targets set in the international, regional and national commitments, specifically actions to ensure that there is equitable access to prevention, care and support services, including voluntary counselling and testing, particularly for the vulnerable and young people in South Asia;
- Giving special emphasis to widen and facilitate educational opportunities in the pursuit to educate all as a key to combat HIV/AIDS, development and quality of life.
- Accelerate actions to address the main determinants of the rapid spread of the epidemic such as stigma and discrimination, gender inequalities, poverty, illiteracy, lack of awareness,

inaccessibility to services and non-fulfilment of human rights;

- Accelerate the development and effective implementation by government, private sector and trade unions of rights-based policies and programmes on HIV/AIDS and the world of work giving particular attention to women and young workers;
- Take steps to widen and include government and NGO partners from all sectors, especially education, health, religious affairs, defence, social welfare, youth, women development, and information in the fight against HIV/AIDS;
- Mobilise and allocate adequate resources from government, private sector, donors and international agencies, to be used effectively and in a co-ordinated manner, to ensure that the epidemic is halted and reversed at an accelerated pace;

- Set up effective national monitoring and reporting mechanisms for timely follow-up on progress towards the goals and targets committed to by the governments of South Asia;

**W** E call upon SAARC countries to include reporting on progress in fighting HIV/AIDS at the Council of Ministers meetings and in the Summit and set up the required mechanisms in this regard.

**W** E pledge to work towards the implementation of this “Kathmandu Call Against HIV/AIDS in South Asia: Accelerating Actions and Results”.

**W** E adopt this “Kathmandu Call Against HIV/AIDS in South Asia: Accelerating Actions and Results” as the outcome of this Conference.

# Annex 2

## Summary Matrix of Programme Interventions included in this Document

Country	Interventions/case studies	Target Group
Bangladesh	International Peace Keeping and HIV Prevention: a value-based approach for HIV prevention among the young peacekeepers who go abroad on a mission. Components of the program include awareness raising, HIV/STI testing facilities, development of peer-support and involvement of religious figures.	Peace keepers (mostly young people)
	APON: a BRAC project to promote non-formal and basic education, primarily targeted at girl children.	Girls in rural areas
	CMES's Basic School System's AGP – an innovative non-formal education program with technology based life-skills training.	Disadvantaged girls from rural communities
	Bangladesh Girl Guide Association: Mobilization of young girls for awareness raising activities against HIV/AIDS and for service oriented community outreach.	Young people from community based local association and poor/slum communities
India	ARH Working Group – information tools/IEC materials; radio programs; BCC focus	In-school-youths and out-of-school youths both in urban and rural areas
	Swaasthya: - study patterns of sexual expression and influencing factors among adolescent boys and girls as well as to understand their networks regarding SRH	Adolescent boys and girls (and community members) of slum resettlement colony of Tigri in New Delhi
	MAMTA: Advocacy/Networking – influences adolescent health policy development	Young people both in and out-of school and in urban slums; policy makers
	Sevadharm/ UNICEF peer education in secondary schools in Pune, Maharashtra, India	Young people in secondary and higher schools
	SHAHN Adolescent Center: provides preventive counseling and emotional support to adolescents. (WHO supported)	Young people from Delhi area, mostly from schools, colleges and NOGs working with adolescents.
	AIDS Online Counseling (Madras) – innovative AIDS counseling throe' internet. (UNFPA supported)	College Students, AIDS experts and NGOs
	AGI (Mumbai): The main feature of the program is to provide non-formal education to out-of-school adolescents girls.(UNICEF supported)	Out-of-school girls in Mumbai.
	PEEP (Maharashtra): This project aims to provide education to every child through involvement of young people as key implementers and through mobilization of the community to sustain the demand for education. (UNICEF & other donor supported)	Primary target group: vulnerable children (mostly laborers from lower socio-economic background) Secondary target group: rural young people.
Jag-Jagi Kendra (Bihar): These are centers of education at village level for those women and girls who have been forced to stay out of schools due to various domestic and social reasons.	Women and girls (out-of-school) at village level in Bihar	

Country	Interventions/case studies	Target Group
India	INP+ : helps people living with HIV to form self-help groups and fosters bonding within and between the groups to inspire emotional strength and hope. They also advocate on issues of PLWH.	PLWHAs
	After Care Center of TTK Hospital (Chennai): The project provides extended care in a supportive environment to persons who have completed primary treatment for their chemical dependency. (identified by UNDCP)	IDUs of Chennai
	HUMSAFAR – an organization that offers comprehensive health services including outreach services to men having sex with me. Evaluation completed	Maharashtra – MSM community
Nepal	Chatting with My Best Friend – a radio program for & by young people with life-skills approach (UNICEF supported)	Young People from both Rural and Urban
	National Adolescent Health and Development Policy (WHO supported the process of development of the policy)	Young People
	Working with YP on Sexual and Reproductive Health (FPAN) to improve SRH status of YP through awareness raising activities and service-related activities. (UNFPA supported)	Rural youth population in 5 VDCs
	Young Star Club: is a hub for local youth in Salleri. It provides learning opportunities, edu-entertainment programs for YP's personal and professional growth as well as mobilizes them for community outreach and community development by enhancing their leadership skills	Local Young People from various VDCs of Solokhumbu (both, in-school and out-of-school)
	SPW: offers young people training on leadership, peer education, and practical life-skills. The peer educators, in turn facilitate the activities of in-school green clubs at community levels.	In-school young people from all parts of Nepal.
	Young Asia Television – infotainment and edutainment programmes to inform, educate and give a voice to the future leaders of Asia.	Young People – mostly in-school- youth
Pakistan	Guide Shield Project – A right-based approach to equip girls with tools for self-reliance and to foster their self-esteem, UNICEF supported	Girls mostly from rural and lower-income community
	AMAL: advocacy/Networking/Capacity building – to increase awareness on HIV/AIDS through youth participation/mobilization, (UNICEF supported)	In-school-youth and young people from urban slums.
	Brothers Join Meena: The project aims to promote and protect children's rights to health and girls' right to education by increasing participation of adolescent boys scouts, (UNICEF supported)	Boys scouts from Balochistan province
Sri Lanka	ADIC – an NGO involved in drug demand intervention.	School and out-of-school young people



# Annex 3

## Main influences on young people's sexual and reproductive health, either as protective (+) or risk (-) factors<sup>1</sup>

Communities & Local Institutions	Schooling and Employment
<ul style="list-style-type: none"> <li>■ + Community support for ARH programs</li> <li>■ + Participation in sports, music, drama activities</li> <li>■ - Access to media portraying violence, pornography</li> <li>■ + Access to media on educational and vocational issues, reproductive health issues</li> <li>■ + Mentoring from supportive adults available</li> <li>■ + Religious beliefs and practices (except when so rigidly pro-abstinence that sexually active youth are marginalized)</li> <li>■ - Breakdown of extended family and village support systems and traditional protective social norms</li> <li>■ - Harmful traditional practices</li> <li>■ + Institutional infrastructure (youth-friendly service organisations for primary health care, sexual and reproductive health, violence, sexual abuse, counselling, entertainment, etc.)</li> <li>■ - Settings of armed conflict, violence, sexual violence, and extreme poverty</li> </ul>	<ul style="list-style-type: none"> <li>■ + Access to employment/ vocational training, and other income generating opportunities (often correlated with urban location)</li> <li>■ + Access to primary, secondary and higher education, with no financial barriers for low-income youth</li> <li>■ + Literacy, Educational attainment, &amp; Educational aspirations</li> <li>■ + School attendance</li> <li>■ + Extracurricular activities</li> <li>■ + Sexual and reproductive health education in schools</li> <li>■ - Discrimination against girls either in schooling or in employment/income/ vocational opportunities</li> <li>■ - School leaving (including that due to pregnancy/marriage)</li> </ul>
Families and households	Policy Environment
<ul style="list-style-type: none"> <li>■ + Family structure including more than one supportive adult</li> <li>■ + Positive communications with parents (about reproductive health and other concerns)</li> <li>■ + Family values educational attainment for both sexes</li> <li>■ + Family promotes sexual and reproductive health</li> <li>■ - Physical and/or sexual violence within the family</li> </ul>	<ul style="list-style-type: none"> <li>■ + Institutional policies that promote sexual and reproductive rights of youth:               <ul style="list-style-type: none"> <li>+ making resources available for ARH services</li> <li>+ legalisation of contraception for youth</li> <li>+ enforcement of laws affecting youth (rape, violence within home, sexual abuse, legal age of marriage)</li> </ul> </li> <li>■ - Policies that exclude young people from S&amp;RH information, education and services because of age, marital status, gender, or other reasons.</li> </ul>

Individual characteristics and behaviours	Peers and partners
<ul style="list-style-type: none"> <li>■ + Knowledge about sexual and reproductive health</li> <li>■ + Knowledge of and ability to utilise sexual and reproductive health services</li> <li>■ + Attitudes &amp; intentions promoting sexual &amp; reproductive health and reducing risks</li> <li>■ - Risk-taking behaviour: non-use of condoms, multiple partners, dry sex</li> <li>■ + Self-esteem and self-efficacy</li> <li>■ + Attitudes favouring gender equity</li> <li>■ - Adherence to traditional sexual double standard (multiple partners and domination for men, submission &amp; lack of sexual desire/activity for women)</li> <li>■ - Victim of sexual abuse, coercion or rape</li> <li>■ - Exchange of sex for money or goods</li> <li>■ - Drug and Alcohol Use</li> <li>■ - Mental health problems (depression, suicidal tendencies)</li> </ul>	<ul style="list-style-type: none"> <li>■ - Peer or partner pressure to engage in sexual activity</li> <li>■ + Peer and partner attitudes favouring sexual and reproductive health, and gender equity</li> <li>■ + Communication with peers about sexual and reproductive health</li> <li>■ - Risk-taking behaviour by peers</li> <li>■ - Age differences with partners</li> <li>■ + Communications with partners (about reproductive health and other concerns)</li> <li>■ - Partner(s) having multiple partners</li> </ul>

<sup>1</sup> Source: Shepard B.L.(2001) ' Youth programmes in the SADC Countries: Sexual and Reproductive Health and Rights' Technical Paper for the 1st Youth Conference of the Southern Africa Development Community Region. June 13-16,2000. Mozambique. UNFPA/Pathfinder International.

# Annex 4

## At a Glance Life Skills Based Education and Young People

### What are Life Skills?

- Life skills are a group of psychosocial competencies and interpersonal skills that help young people to make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others and cope with and manage their lives in a healthy and productive manner.<sup>1,2</sup>

### Why Life Skills Based Education (LSBE) for HIV/AIDS Prevention?<sup>3</sup>

- There is growing recognition and evidence that as young people grow from their earliest years through childhood, adolescence, and into young adulthood, developing psycho-social and interpersonal skills can protect them from health threats, build competencies to adopt positive behaviours, and foster healthy relationships.
- Life skills based education for HIV/AIDS prevention combines good quality, gender sensitive, interactive teaching and learning

methods with HIV/AIDS content – it combines the knowledge, attitudes and skills relevant to reducing risk and promoting positive behaviour that is needed for HIV/AIDS prevention.

### LSBE for Whom and How?

- LSBE for HIV/AIDS prevention focuses on young people within the age group 10 - 19 years, with particular emphasis on 12 -14 year olds.
- A critical part of LSBE objectives is behaviour change. As such, content and methods are an integral part of the process to facilitate change in knowledge, attitudes and skills. LSBE has to provide young people with the opportunity to practice and reinforce the communication and interpersonal skills that are learnt. A behaviour is affected by an understanding of what needs to be done (knowledge), a belief in the anticipated benefit (motivation), a belief that particular skills will be effective (outcome expectancy), and a belief that one can effectively use these skills (self-efficacy).

<sup>1</sup> UNICEF/WHO (2002) Skills for health, A reference tool for skills-based education. Draft.

<sup>2</sup> UNICEF ROSA (2003) Life skills based education and HIV/AIDS prevention. Regional Office for South Asia. Fact Sheet. Nepal. See also for further information WHO (1999) Programming for Adolescent Health and Development. Report of a WHO/UNFPA/UNICEF Study Group. Geneva.

<sup>3</sup> Source <http://www.unicef.org/programme/lifeskills/>

- LSBE for HIV/AIDS prevention is likely to be most effective when complemented by related policies and services and synchronized with other interventions attempting to bring the epidemic under control and creating healthy environments.
- School resources and facilities are often used.
- Facilitated by somebody trained in the content and methods, usually with teacher support, e.g. peer educators, guidance counselors, social workers.

### How Can LSBE for HIV/AIDS prevention, care and support be implemented?<sup>4</sup>

Schools provide an ideal opportunity to ensure girls' and boys' access to good quality skills-based AIDS education, at an early age before they become sexually active. (see Model 1) However, schools do not reach all children. Models 2, 3 and 4 demonstrate how schools can help broaden the reach of prevention education.

#### Model 1 Formal Education

In the formal primary or secondary school curriculum:

- Facilitated by a teacher trained in the content and methods.
- Delivered through a relevant "carrier subject", with time designated in the schedule for skills-based HIV/AIDS education.
- May or may not be assessed.

May be complemented by:

- Guest speakers and outside resource people.
- Extra-curricular projects and activities.

#### Model 2 Cross Over

Extra-curricular programme affiliated with schools but not necessarily delivered in schools:

- Participants may be reached through schools.

#### Model 3 Non Formal

Programme delivered and participants reached through community settings and organizations, such as health centers, drop-in centers, churches, street programmes, women's/young people's groups and clubs (e.g. girl guides/boy scouts).

- Typically target out-of-school youth, but may include students as educators, counselors or learners.
- Curriculum typically developed by NGOs, rather than government agencies.

#### Model 4 Technology/Media

Educational messages, stories and activities delivered through local or national communication channels, including TV, radio, videos, comic books, storybooks, audiocassettes, posters, the Internet, newspapers, etc.

- May provide educational materials that can be used in schools.
- Can supplement all of the above models.

#### Model 5 Piggy Back

HIV/AIDS addressed within a programme designed for another purpose, e.g. livelihood skills building:

- Most effective when facilitators are experienced in both areas, e.g. livelihoods and HIV/AIDS, or when different experts are used

<sup>4</sup> Source <http://www.unicef.org/programme/lifeskills/starting/imp.html#formal>

### Who can facilitate LSBE?<sup>5</sup>

- Anybody, with good training and support, can implement a LSBE programme. Teachers in their capacity have obvious potential. Both within the school and outside of school, young people can be involved as peer educators. Others such as religious leaders, community agency workers or NGO workers can also contribute to LSBE.
- One important factor to remember is ongoing support to facilitators/ teachers. This is essential to ensure that implementation can be achieved with quality. Many programmes provide only brief or one-off training workshops and expect the trainees to go back to their schools or communities and implement, in effect, single-handedly. At the school setting, the support of Principals in the school environment is also essential.

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<sup>5</sup> UNICEF ROSA (2003) Life Skills Based Education & HIV/AIDS Prevention. Regional Office for South Asia. Fact Sheet. Nepal.

# Annex 5

## Alternative Approaches for Discussions on HIV/AIDS Related Issues

### The Stepping Stones Approach<sup>1</sup>

The common 'ABC' approach to HIV and AIDS consists of instructing people to Abstain, Be faithful and use Condoms. Usually this is accompanied by vigorous dissemination of information about how HIV is transmitted and how it can be prevented, on the false assumption that information leads automatically to behaviour change. Of course access to information and to sexual health commodities such as condoms is important. The mistake is to assume that they are sufficient on their own to bring about change.

### What is Stepping Stones and how is it different?

It was from ActionAid's recognition of the drawbacks of the ABC and the information = behaviour change recipes that the Stepping Stones approach was born. First developed in Uganda in 1995, it has since spread to over 2,000 organisations in 104 countries. It is based on the following principles:

- The best solutions are those developed by people themselves.
- Men and women each need private time and space with their peers to explore their own needs

and concerns about relationships and sexual health.

- Behaviour change is much more likely to be effective and sustained if the whole community is involved.
- The Stepping Stones training manual (Alice Welbourn, ActionAid, 1995) sets out a series of participatory activities for use in parallel men's and women's workshops, as described later.

### How does the Stepping Stones process work?

Rather than concentrate on individuals or segregated 'risk groups', Stepping Stones works in groups of peers of the same gender and similar age (younger women, younger men, older women and older men) drawn from the whole community. The groups work separately much of the time so they have a safe, supportive space for talking about intimate issues, then periodically meet together to share insights. Throughout, they use participatory methods such as songs, games and role plays which are enjoyable and empowering. The process builds on people's own experiences, needs and priorities. It enables the exploration and

<sup>1</sup> Source: ActionAid Alliance (2003) The sound of silence, Difficulties in communicating on HIV/AIDS in schools: Experiences from India and Kenya.



negotiation which is essential for sustained behaviour change by individuals and communities.

### Progression of themes

In order to provide the necessary time and skills to create this ideal brew, the Stepping Stones process goes through a progression of themes. First, time is devoted to developing skills of co-operation and communication. This helps each peer group to bond together and creates a safe, friendly atmosphere in which to explore sensitive issues. The facilitator or trainer of each group should also be of the same gender and age as the members, so that everyone can feel comfortable together as peers. Ideally facilitators come from the same community as the participants. No special expertise is needed, and all activities are designed to be used without the need to read or write.

Next, participants explore facts and feelings about relationships, HIV and safer sex (including but by no means limited to condoms). The men's and women's groups each have a chance to assess their own priorities in sexual health and family life, in the context of a greater understanding of their potential vulnerability to HIV.

The third set of activities enables participants to understand what influences us to behave the way we do - including, crucially, society's expectations of us as men and women (gender roles), which are often closely tied up with cultural traditions. Involving men in this sort of reflection is key to transforming gender relations and harmful practices. But it is not a directive 'thou shalt not' approach. Participants - male and female - evaluate for themselves the advantages and

disadvantages of the factors influencing them. For example, it is not up to facilitators to judge cultural traditions such as wife inheritance, polygamy, initiation and cleansing rites, and so on. Rather, community members are encouraged to question for themselves: what are the benefits of this practice that we want to retain? what are the risks we want to avoid? what alternatives can we devise? Other influences on behaviour, such as the pressures on us to make a living, the use and abuse of alcohol or drugs, and so on, are also taken into account.

Finally, participants explore how to practise and sustain change. The culmination of the process is a special request from each peer group to the whole community, presented in the form of a role play which illustrates the change each group sees as its top priority. The fact that these requests are collectively made, and collectively heard, makes them far more effective than a request by a single individual could possibly be. Men's groups appealing to other men in their community for change - such as reducing alcohol abuse or wife-beating - can have a powerful impact on changing collective norms of behaviour.

### The Reflect Approach<sup>2</sup>

Reflect is an innovative approach to adult learning and social change, conceived by ActionAid and piloted in El Salvador, Bangladesh and Uganda in 1993-95.

HIV/AIDS is often a significant issue for analysis in Reflect circles, especially in areas where prevalence rates are high. Some Reflect practitioners (e.g. in Burundi and

<sup>2</sup> Source: ActionAid Alliance (2003) The sound of silence, Difficulties in communicating on HIV/AIDS in schools: Experiences from India and Kenya.

Mozambique) have developed special modules to help participants discuss HIV/AIDS. In Uganda almost any graphic includes reference to the impact of HIV/AIDS, whether participants are discussing an economic, social, political or economic problem. This crosscutting analysis is important as it prevents HIV from being pigeonholed as just a health issue or just a social issue. However, it does depend on facilitators who are confident enough to discuss such issues with their peers. Increasingly it is recognised that facilitator training needs to start with facilitators going through their own intensive learning process.

There has been active interest in developing a fusion of Reflect and Stepping Stones for several years. Some initiatives have started to work on this in practice (e.g. in Zimbabwe and India). A systematic capacity building programme is now planned by Pamoja (the Africa Reflect network), bringing Stepping Stones and Reflect practitioners closer together.

There are many other developments with Reflect from which relevant learning can be drawn for teaching on HIV/AIDS. In Burundi for example, Reflect has been used as an approach in mixed circles with both Hutu and Tutsi participants - helping them to work towards peace and reconciliation. After years of violence the capacity to create a sustained space for people to come together is crucial. Whilst some sensitive issues cannot be addressed head on, for example in the first week or month, the growing trust and confidence within the group enables them to work towards ad-

ressing even the most difficult of issues over a one or two year period.

Another relevant example is in Peru where CADEP organised an intensive Reflect process with indigenous communities in the Andes, focused on breaking the taboos around domestic violence. Mixed groups of men and women used a range of visualisation processes to break the silence, almost invariably speaking for the first time in public on domestic and sexual violence. An integral part of the process involved the participants producing materials based on their analysis for publication in the local media (local radio and TV adverts, newspaper articles and posters). By creating new private and public spaces for communication between people around domestic violence, other boundaries were also broken, with much more open discussion then developing around gender and power relationships.

### A Decentralized Intersectoral Program Model for Youth Empowerment: Conversational Workshops on Relationships and Sexuality ("JOCAS")<sup>3</sup>

This model has mainly been implemented in various Latin American countries, and recently had its first pilot experiences in Africa in Angola under the name of "Kikemba," all with the support of UNFPA and local governments. The original pilots in Chile were scaled up to be held in 600 secondary schools as of December 1999, and 40 communities. The method has also been applied in programs on prevention of drug abuse, domestic violence, and violence in the schools.

<sup>3</sup> Source: Shepard B.L.(2001) ' Youth programmes in the SADC Countries: Sexual and Reproductive Health and Rights' Technical Paper for the 1st Youth Conference of the Southern Africa Development Community Region. June 13-16,2000. Mozambique. UNFPA/Pathfinder International.

JOCAS is a decentralized and participatory educational model designed first to break the taboos on conversations about relationships and sexuality, second to put the school community in touch with resource people who can help meet the needs of youth in these areas, and third, to enable participants—especially adolescents—to use conversations among peers to analyze common problems and possible courses of action.

The theory of pedagogy and social change underlying JOCAS is that mutually respectful and uncensored conversations in a group of peers will strengthen the ability of each participant to put words to unspoken emotions and sensations, to discern the action that best fits his or her values and goals, and enable him or her to negotiate needs and desires. JOCAS is based on ideas about health education in which the learner acquires the skills to make informed autonomous decisions. As one of the JOCAS designers said: “People not only have the right to information; they have the right to learn. These rights are distinct.” The goal is empowerment, not just disciplining emotions and urges.

One of the important side-benefits of the model is that it encourages a more horizontal relationship between adults and adolescents in the school setting, the family and the community. This “democratization” is a pre-condition for true involvement of young people in sexual and reproductive health programs. The other important side benefit is that the model demands intersectoral cooperation and enables the action of local officials, communities and youth in a decentralized model of organization. In Chile, the Health,

Education, Women’s and Youth Ministries were all involved at the national, provincial and municipal levels.

JOCAS is a series of three events (called “moments”) in which the whole community is involved. In the schools, the participants and organizers are students, administrators, teachers, and parents. These three events (or moments) completely break the school’s routine for two-hour workshops. When the model is run as a community event, there are many simultaneous activities on three successive weekend days organized by both public and private entities in the community.

THE “MOMENTS”: 1) Talking it over: Led by a peer facilitator, small groups of students (no more than 20 each) meet from one to two hours to converse in an unstructured way about relationships and sexuality. Teachers and parents meet separately. 2) Gaining insight: In the second workshop, the resource people meet with groups of students of the same age to respond to the questions that they raised in the first workshop. 3) Discerning options: The third workshop has two stages. The first includes discussions within the same small groups as in the first workshop. The group chooses a previously discussed problem or topic and imagines themselves in the place of the various protagonists (parents, boyfriend, girlfriend). They then discuss at least three different ways to respond. The aim is not to arrive at a consensus but to help members reflect on their options. This phase ends with a dialogue with parents, and then skits with the whole community. When JOCAS is held in the community setting, there is a resource fair and murals constructed by youth.

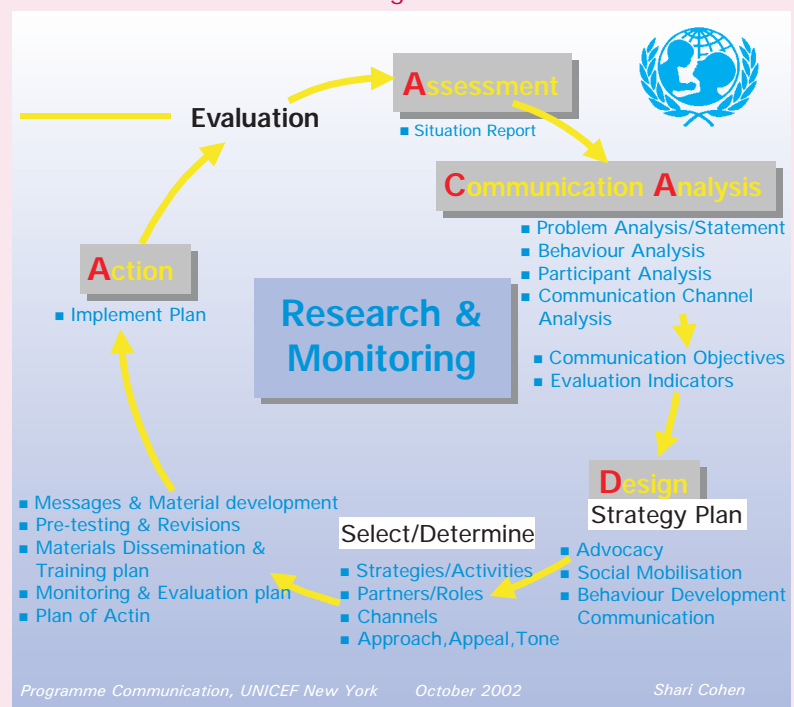
# Annex 6

## At a Glance Programme Communications and HIV/AIDS Prevention for Young People

### Planning principles for communication programmes:

- Formative research of the audience's culture, socio-economic situation, gender relations, spirituality, as well as organizational strengths and needs and the policy environments. Regular feedback has become an essential part of communication programming, and is used as a tool to monitor programmes.
- Research and assessments inform the development of objectives, strategies and indicators. Objectives have to be specific, realistic, measurable and time-bound.
- The communication strategy includes an innovative and integrated approach, specific activities, partners and roles, message, media mix, implementation as well as a monitoring and evaluation plan.
- Pre-testing (and revising) culturally appropriate and context specific communication materials, messages and communication channels is critical.
- Choice of communicators: Many people can be effective communicators, but there are two particular groups that should be mentioned in communications strategies for any given society. First, where possible, opinion leaders should be mobilized and involved in communications strategies. Second, members of

### ACADA Communication Planning Process



the target group are often the most appropriate and effective communicators when they have been trained for the work.

- Monitoring and evaluation to identify whether the programme meets its objectives, changed knowledge, attitudes and behaviour among the intended target audience, influenced societal norms or affected policy change.
- Sound management of all the programme stages with clearly assigned roles and responsibilities and effective coordinating mechanisms.

### Important points to remember when working with young people

- Involve young women and men early on, including those living with HIV, in formative research to plan an appropriate communication strategy.
- Recognize young people's differences, needs, interests and context and ensure that young people who are involved in the programme are trained carefully so not to perpetuate negative gender norms and stigma associated with HIV/AIDS.
- Encourage and foster participation of parents, community leaders and other stakeholders involved in HIV/AIDS prevention in the research, planning, development and

implementation stages of the strategy. This element of the strategy is important as it is in the process of communication and participation that social change is often initiated.

- A wide range of media can be used to reach young people. The choice of a particular medium should be directly relevant to the groups being targeted. Innovative media that have been used include: drama and dance (puppet theatre, street theatre, modern ballet, television soap opera); music (live or broadcast concerts, song writing competitions, and recordings on audio cassettes, CDs, and videos); humour (comedians, comic books, and cartoons) and the visual arts (films, videos, paintings, photography, and sculpture).<sup>1</sup>
- Ensure that communication professionals are trained and have good supervision in developing appropriate materials and messages in HIV prevention and sexual and reproductive health.
- Entertainment-education<sup>2</sup> approaches have shown to increase knowledge and access to information, to create favorable attitudes, and to change overt behavior among the audience.<sup>3</sup> The approach capitalizes on the appeal of popular media and show young people how they can live healthier and safer lives. To be effective seven standard rules for persuasive communication have been identified:<sup>4</sup>

<sup>1</sup> UNAIDS (2000) Best Practice Summary Booklet - Introduction to Communications Programming. Geneva.

<sup>2</sup> Entertainment-education has many labels: enter-educate, edutainment, and infotainment are also often used terms.

<sup>3</sup> Singhal, A and Rogers, E (1999) Entertainment-Education: A Communication Strategy for Social Change. LAE Publishers, Mahwah, New Jersey, London.

<sup>4</sup> Piotrow PT et al (1997) Health Communication: Lessons from Family Planning and Reproductive Health Programmes, Westport, C.T, Praeger.

1. Command attention
2. Cater to the heart and head
3. Clarify the message
4. Communicate a benefit
5. Create trust
6. Call for action, and
7. Convey a consistent message

Good quality entertainment-education can not only increase knowledge and change young people's individual attitudes and behaviour related to HIV/AIDS, but also transform community norms and contribute to social change that cuts across all sectors.<sup>5</sup>

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<sup>5</sup> Singhal A and Rogers, E (1999) Entertainment-Education: A Communication Strategy for Social Change. LAE Publishers, Mahwah, New Jersey, London.



# Annex 7

## At a Glance Gender and HIV/AIDS

### Why is a gender focused approach needed?

- Gender is a social construct shaped by society's expectations of how males and females should look, behave, feel and live.<sup>1</sup> Gender norms differentially influence women's and men's access to such key resources as information, education, employment, income, land, property and credit.
- In most societies gender norms influence individual and societal risk and vulnerability to HIV/AIDS.<sup>2</sup> Gender roles determine how and what men and women are expected to know about sexual matters and sexual behaviour. As a result, girls and women are often poorly informed about reproduction and sex, while men are often expected to know much more.<sup>3</sup>
- Working with men and women at an early age can influence and change gender roles and reduce their vulnerability to HIV infection.<sup>4</sup>

### Factors which increase risk and vulnerability

- A variety of factors increase the vulnerability of women and girls to HIV. They include social norms that deny women sexual health knowledge and practices that prevent them from controlling their bodies or deciding the terms on which they have sex.
- Compounding women's vulnerability is their limited access to economic opportunities and autonomy, and the multiple household and community roles they are saddled with.<sup>5</sup>
- The female body is also more vulnerable biologically to infections. Rape and sexual abuse during childhood or adolescence greatly increases a girls' risk to HIV infection because of the potential for damage to the tissue in the genital tract.<sup>6</sup>
- Men, and especially young boys, are vulnerable too. Social norms reinforce their lack of understanding of sexual health issues and at the same time

<sup>1</sup> UNAIDS (2000) Gender and AIDS Almanac. Resource Packet on Gender and AIDS. Geneva.

<sup>2</sup> Vicci Tallis (2002) Gender and HIV/AIDS, Overview Report. BRIDGE Report, Institute for Development Studies, UK.

<sup>3</sup> UNIFEM East and South Asia Regional Office and UNDP East Asia HIV and Development Programme (2000) Women, Gender and HIV/AIDS in East and Southeast Asia.

<sup>4</sup> UNAIDS (1999) Gender and HIV/AIDS: Tacking Stock of Research and Programmes. Best Practice Collection - Key Material.

<sup>5</sup> UNAIDS (2001) Gender and AIDS Fact Sheet. Prepared for the UN Special Session on HIV/AIDS.

<sup>6</sup> UNICEF ROSA and UNAIDS (2003) Gender Based Violence, Sexual Abuse and Exploitation in South Asia increases Risks and Vulnerabilities to HIV/AIDS. Issue Paper 4. Prepared for South Asia High Level Conference "Accelerating the Momentum in the Fight Against HIV/AIDS." Nepal.

celebrate promiscuity. This vulnerability is further increased by the likelihood of engaging in substance abuse (such as alcohol and other drugs) and of opting for types of work that can entail mobility and family disruption (such as migrant labour or the military). Only limited data is available on how gender roles and societal pressure put men at risk.<sup>7</sup> However, involvement of males in HIV prevention programmes has become evident.<sup>8</sup>

### Recommendations for approaches to reduce vulnerability to HIV/AIDS of young girls, boys and women due to violence, sexual abuse and exploitation

#### Do no harm

- Do not perpetuate gender stereotypes – design interventions based on data on women’s and men’s lives in particular community or setting
- Do not assign blame to men as perpetrators

#### Gender sensitive programmes

- Address the gender specific needs of men and women, boys and girls
- Recognize and respond to diversity and different needs of young men and women.

#### Transformative programmes

- Community based
- Couple counselling as a method to transform gender relations

### Interventions to address violence against women

- Legislative actions and improved enforcement
- Counselling cells, shelters, legal aid services
- Psycho-social services
- Public advocacy

#### In General<sup>9</sup>

- Encourage and foster young people’s participation in programmes and address specific barriers young girls face to participate.
- Create safe spaces and work in a climate of openness that recognizes young people’s realities.
- Focus on the positive aspects of sexual health as well as unwanted pregnancy and sexually transmitted infections.
- Promote greater awareness of sexual and reproductive health rights.
- Offer improved access to education and health services.
- As small-scale individual risk reducing strategies are expanded, it is essential to complement them with efforts to reduce societal vulnerability.
- Collect and analyze sex and age disaggregated data to monitor and evaluate the programme.

<sup>7</sup> Whelan, D. (1999) Individual and Societal Risk to HIV/AIDS from a Gender Perspective. Joint United Nations Programme on HIV/AIDS (UNAIDS).

<sup>8</sup> WHO (2000) What about boys? A Literature Review on the Health and Development of Adolescent Boys. Geneva.

<sup>9</sup> Adapted from Rivers, K. and Aggleton, P. (1999) How do Gender Concerns Affect Young People’s Vulnerability to HIV/AIDS? HIV and Development Programme, United Nations Development Programme (UNDP).

# Annex 8

## At a Glance

### Young People Friendly Health Services Framework

The tool was developed based on reviews of literature on young people's reproductive health status and experience to date (Senderowitz 1999). The framework includes three categories of characteristics dealing with issues at health facilities: 1) provider characteristics, 2) health facility characteristics, and 3) program design characteristics. The tool also takes into account young people's psycho-social characteristics. These factors influence whether or not young people decide to use reproductive health services and if they "reach the door" of a health facility. These characteristics may vary greatly from one setting to the next, and even within one community youth may have different perceptions about what makes services appealing and accessible to them.

	Health Facility Characteristics	Provider and Staff Characteristics	Administrative/ Program Design Characteristics	Young People's Psycho-social Characteristics
Youth-Friendly Service Characteristics	<ul style="list-style-type: none"> <li>■ Convenient hours</li> <li>■ Convenient location</li> <li>■ Adequate space and sufficient privacy</li> <li>■ Comfortable surroundings</li> </ul>	<ul style="list-style-type: none"> <li>■ Specially trained staff</li> <li>■ Respect for young people</li> <li>■ Privacy and confidentiality honoured</li> <li>■ Adequate time for client and provider interaction</li> <li>■ Peer counsellors available</li> </ul>	<ul style="list-style-type: none"> <li>■ Youth involvement</li> <li>■ Boys and young men welcomed and served</li> <li>■ Group discussions available</li> <li>■ Delay of pelvic examination and blood tests possible</li> <li>■ Necessary referrals available</li> <li>■ Drop-in clients welcomed and appointments arranged rapidly</li> <li>■ Wide range of services available</li> <li>■ Affordable fees</li> <li>■ Educational material available</li> <li>■ Publicity and recruitment inform and reassure youth</li> </ul>	<ul style="list-style-type: none"> <li>■ Perception of privacy at a facility</li> <li>■ Perception that boys and young men are welcome</li> <li>■ Perception that confidentiality is honoured</li> <li>■ Perception that youth are welcomed regardless of marital status</li> <li>■ Perception that surroundings are comfortable</li> <li>■ Perception that providers are attentive to youth needs</li> </ul>

<sup>1</sup> Source: Shepard B.L. (2000) Youth Programmes in the SADC Countries: Sexual and Reproductive Health and Rights. Technical Paper for the 1st Youth Conference of the Southern Africa Development Community Region. June 13-16. Mozambique. UNFPA/ Pathfinder International.

# Annex 9

## At a Glance Young People and Peer Education

### Benefits and Advantages of Peer Education<sup>1</sup>

- Many young people often prefer to receive information about HIV/AIDS from their peers. If well-designed and properly supervised, a peer-led intervention can positively influence young people.
- Serving as a peer educator provides a challenging, rewarding opportunity to young people to develop their leadership skills, gain the respect of their peers, and improve their own knowledge base and skills. Peer educators often change their own behaviour after becoming a peer educator.<sup>2</sup>
- School based peer education can foster fulfilling relationships between teachers, young people and community members.
- It can give girls the space and legitimacy to talk about sex without the risk of being stigmatised as sexually promiscuous, particularly when peer led activities take place in single-sex groups.
- Peer educators can often reach more easily young people who are not in schools, through for instance clubs, sport or faith based organizations.
- If linked to health services and programmes, peer education can expand the reach and scope of HIV prevention, care and support programmes.
- Peer education provides an opportunity for active participation of young people in project planning, implementation and assessment.
- Peer educators have shown in some cases to be more effective than adults in changing community norms and in changing attitudes related to sexual behaviour. However, they are not necessarily better in transmitting factual health information. Peer educators and adult-led education can thus complement each other.
- Monitoring and evaluation are integral parts, including monitoring the activities of the peers (process evaluation), for example: progress reports submitted by the peer educators on number of people expected compared to reached, who they were and what was discussed; and satisfaction surveys; as well as measuring the impact of the education (outcome evaluation), for example: looking at HIV-related knowledge, attitudes, skills and

<sup>1</sup> Adapted from <http://www.unicef.org/programme/lifeskills/starting/peer.html> and <http://www.fhi.org/en/youth/youthnet/program/faq/peereduc.html>

<sup>2</sup> Population Council (2000) Peer Education and HIV/AIDS, Past Experiences, Future Directions. Horizons Project. USA.

behaviours, and/or health outcomes such as STI incidence.<sup>3</sup>

Tips for building a successful peer education component into HIV prevention programmes:<sup>4</sup>

- Link the peer education program (content and methods) with other programs to form a comprehensive strategy.
- Ensure that a quality control process is in place.
- Ensure that a trained adult or teacher supports the peer educators.
- Consider incentives for peer educators to attract and maintain their participation. For example, recognize their contribution through: public recognition; certificates; programme T-shirts; food; money/credit stipends; or scholarships.
- Establish criteria for the skills and qualities that peer educators should have, and then have students volunteer or nominate others for the peer educators.
- Have clear and achievable expectations for the peer educators.
- Provide thorough training and regular follow-up workshops and practice sessions (this is particularly important as turnover of peer educators can be high).
- Monitor the needs of the trainers and educators.
- Prepare the peer educators for community resistance and public criticism, should it arise. At the same time, inform and involve the community in the programme, to alleviate any fears and to garner their support.

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<sup>3</sup> UNAIDS (1999) Peer Education and HIV/AIDS, Concepts, Uses and Challenges. Geneva.

<sup>4</sup> Source <http://www.unicef.org/programme/lifeskills/>

# Annex 10

## At a Glance Participation of Young People

### What is Participation?

- In its most basic sense, young people's participation can be defined as young people partaking in and influencing processes, decisions and activities.<sup>1,2</sup>
  - In the Convention on the Rights of the Child (CRC), participation is enshrined as a legal right for all adolescents and is not a matter of good will. But it is not an obligation, thus participation must always be voluntary and never coerced.
  - The context of young people's lives often determines barriers and opportunities to participate. Socio-economic factors, domestic responsibilities, language, physical distance, and importantly gender inequity issues need to be addressed to enable young people's meaningful participation. Particularly, girls are often not able to take part if e.g. their parents believe that there is little benefit.
  - Partnerships with parents and community leaders to create a supportive environment are critical to enable and facilitate genuine participation of young people.<sup>3</sup>
- HIV prevention efforts are more likely to be effective if young people actively participate in programmes and policies because:
- Participation fosters learning, builds life skills and builds on the strength of young people.
  - Young women and men needs can be identified more effectively.
  - It helps to ensure higher relevance of policies, messages and use of communication channels.
  - It builds ownership and increases sustainability.
  - It can draw young people into productive activities.
  - When properly trained and supported, young people can be effective in reaching other young people, providing relevant information, distributing condoms and IEC materials as well as making referrals to health and social services.
  - Tools and indicators to measure the quality and level of young people's participation need to be integrated in the monitoring and evaluation process of HIV prevention programmes and policies.

<sup>1</sup> UNICEF (2001) The Participation Rights of Adolescents: A Strategic Approach. Working Paper Series. New York, USA.

<sup>2</sup> A useful resource is also the website of the Institute for Development Studies [www.ids.ac.uk/ids/particip/](http://www.ids.ac.uk/ids/particip/)

<sup>3</sup> Family Health International (2003) Youth-Adult Partnerships Show Promise, Youth Involvement Expands from Local Projects to Institutional Levels. YouthLens, No 4 (Youth Net Project).



## REAL ADOLESCENT PARTICIPATION CHECKLIST<sup>4</sup>

What is REAL participation?	What is FALSE participation?
Is it voluntary? Real participation is something a young person should want to do.	If adolescents are made to demonstrate against their will, or forcibly “volunteered” into committees.
Is it equitable? Real participation is inclusive; it does not discriminate on the basis of sex, wealth, rural/urban location, ethnicity, disability, etc.	If activities are only practically accessible to rich or urban adolescents, or only boys are asked questions, or only the smart ones are selected for meetings.
Is it valued? Real participation requires all participants, including adolescents, to be valued, listened to and taken seriously.	If adolescents are present, but get little chance to participate. When they do, people don’t listen carefully or take adolescents’ views into account.
Is it respectful? Real participation means addressing each other with respect and care, not derision or paternalism.	If the chair of the meeting ignores the adolescents or speaks to them in a way that shows s/he does not value their presence or what they have to say.
What’s the point of it? Real participation requires young people to see the value of doing the exercise.	If adolescents are simply told what to do, they don’t really know or understand why they are doing it
Does it matter? Real participation happens when the area or issue is important or of interest to young people.	If adolescents are made to participate in something that they don’t care much about and feels like a waste of their time.
Does it make a difference? Real participation means young people’s contributions have an influence and make a difference.	If adolescents are asked for contributions that make no difference whatsoever in influencing thinking or changing conditions.
Are the physical arrangements fair and conducive? How the seating is arranged makes a big difference.	If the adults sit in chairs while adolescents are on the floor, the room’s periphery or under the hot sun.
Is it done in a language that adolescents understand well? Real participation requires adolescents to feel competent and comfortable in the medium of communication.	If discussions are held in English in a rural district, or the manner is very formal and full of “big words”.
Are the rules fair for all? Real participation is done in a manner in which everyone can participate equally and comfortably, and often involves adolescents in making the rules.	If some adults dominate, while adolescents don’t get a chance or are cut off too early. People are made to contribute in ways they do not know or like.
Are the child participants adequately informed and prepared? Real participation means adolescents have had enough time, opportunity and support to prepare.	If adults have experience and information whereas the adolescents are just pulled in with little sense of what is happening and time to prepare.
Are the allowable roles fair? Real participation assigns roles and responsibilities fairly, and allows everyone to play a role they are capable of whenever possible.	If teachers make all the decisions and rules while adolescents just answer questions, or only adolescents are made to park bicycles and serve tea.
What’s the level? Real participation goes beyond show and allows young people to initiate ideas, make decisions and take actions to the maximum extent of their capability.	If adolescents are told to participate in certain ways without having a say in the content or method of participation, or adolescents are only consulted when they are also capable of responsible decision making.
Is it honest? Real participation respects ethics, avoids manipulation and is clear in its purposes and methods.	If adolescents are not told the truth or deliberately left in the dark about what is happening.
Is it safe? Real participation takes all necessary steps to ensure no participant is endangered.	If confidentiality is not maintained where appropriate, such as when the adolescent who tells the truth about something is punished.
What happens afterwards? Real participation is clear and transparent about how the output of the participation will be taken forward, and how it connects with other processes. It often aims to institutionalise participation for sustainability.	If adolescents participate actively on something important but it is not clear what follow-up will take place or what will be done with their contribution. Session report is not shared checked with adolescents.

<sup>4</sup> Rajani R (2000) quoted in UNICEF (2001) The Participation Rights of Adolescents: A Strategic Approach. Working Paper Series. New York, USA.

# Annex 11

## Proposed indicators for young people 10 - 24 years<sup>1</sup>

Following is a list of suggested indicators for HIV prevention programmes with young women and men (10-24 years) that might be used at country level, which will also give an indication of overall progress towards the UNGASS goals:

- % with correct knowledge of HIV prevention methods
- % with no misconceptions about HIV/AIDS (includes healthy looking person)
- % know of HIV prevention amongst IDU
- median age first sex among young men and women
- % young people having pre-marital sex in past year
- % Pregnant women 15-19 with HIV and +/- changes over time
- % Young men/women using a condom during pre-marital sex
- % Young men/women having multiple sex partner in last year
- % Young women/men using condom at last risk sex
- % condom use at first sex
- % age mixing in sexual relationships
- % IDU users sharing equipment at last injection
- % with accepting attitudes toward those living with HIV
- % schools with life skills based HIV education programmes

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<sup>1</sup> Source: UNICEF (2002) Programme Working Note HIV Prevention Among Young People.

