

PN-ACC-921

**AIDS TECHNICAL SUPPORT PROJECT (ATSP)  
LESSONS LEARNED: PROGRAMMING  
FOR ADOLESCENTS AND YOUNG ADULTS**

PREPARED BY:

MARY LYN FIELD, CO-TEAM LEADER, AIDSCAP  
ELLEN WEISS, CO-TEAM LEADER, ICRW  
SHELLEY SMITH, PEACE CORPS

PREPARED FOR.

HIV/AIDS DIVISION  
OFFICE OF HEALTH AND NUTRITION  
CENTER FOR POPULATION, HEALTH AND NUTRITION  
BUREAU FOR GLOBAL PROGRAMS, FIELD SUPPORT, AND RESEARCH  
U S. AGENCY FOR INTERNATIONAL DEVELOPMENT

FEBRUARY, 1998

This report was prepared under the auspices  
of the U.S. Agency for International Development (USAID)

The report was written and revised by the  
Health Technical Services (HTS) Project  
(Project No 936 5974 10, Contract No HRN-5974-C-00-3001-00)  
of TvT Associates and The Pragma Corporation.

The opinions expressed herein are those of the authors and do not  
necessarily reflect the views of TvT, Pragma, or USAID

Information about this and other HTS publications may be obtained from

Health Technical Services (HTS) Project  
1601 North Kent Street, Suite 1104  
Arlington, VA 22209-2105  
(703) 516-9166 phone  
(703) 516-9188 fax  
[http //www htsproject com](http://www.htsproject.com)  
[hts@htsproject com](mailto:hts@htsproject.com)

# Contents

---

|   |     |
|---|-----|
| Contents . . . . .  | iii |
| Acronyms . . . . .  | v   |
| Introduction . . . . .  | vii |
| I Background . . . . .  | 1   |
| A Youth and the Impact of HIV/AIDS . . . . .  | 1   |
| B Youth and Sexual and Reproductive Health . . . . .                                | 2   |
| C Epidemiology of HIV/STIs In Young People . . . . .                                | 3   |
| References . . . . .  | 4   |
| II Unique Issues in Youth Development . . . . .                                     | 5   |
| A Mobilizing Gatekeepers . . . . .  | 6   |
| B Changing Social Norms, Including about Gender Roles . . . . .                     | 7   |
| C Dealing with Youth Priorities Other than Health . . . . .                         | 9   |
| D Reducing Economic and Other Barriers to Prevention . . . . .                      | 9   |
| References . . . . .  | 9   |
| III Lessons Learned in Prevention Education and Clinical Service Delivery . . . . . | 11  |
| A Peer Education . . . . .  | 12  |
| 1 Selection Criteria . . . . .  | 12  |
| 2 Structure and Methods . . . . .   | 13  |
| 3 Training . . . . .  | 13  |
| 4. Compensation and Motivation . . . . .  | 13  |
| 5. Supporting Materials and Message Content . . . . .                               | 14  |
| 6 Gender Issues . . . . .   | 15  |
| References . . . . .  | 15  |
| IV. Other Approaches . . . . .  | 17  |
| A School-Based Programs . . . . .   | 17  |
| B Communication with Parents or Older Family Members . . . . .                      | 18  |
| C Counseling and Services from Health Providers . . . . .                           | 19  |
| 1 Privacy and Confidentiality . . . . .   | 20  |
| 2 The Costs of Care . . . . .   | 21  |
| 3. Integration of Services . . . . .  | 22  |

|  |    |
|--|----|
| D. Mass Media . . . . .  | 22 |
| E The STI in HIV . . . . .   | 23 |
| F Integrating Strategies and Mobilizing Private Sector Support . . . | 23 |
| References . . . . .   | 24 |
| V. Youth Policy Development . . . . .                                | 27 |
| References . . . . .   | 28 |
| VI Additional Resources . . . . .                                    | 29 |

## ***Acronyms***

---

|         |  |
|---------|--|
| AIDS    | Acquired immunodeficiency syndrome                       |
| AIDSCAP | AIDS Control and Prevention Project                      |
| ATSP    | AIDS Technical Support Project                           |
| FHI     | Family Health International                              |
| HIV     | Human immunodeficiency virus                             |
| ICRW    | International Council for Research on Women              |
| IDDI    | Dominican Institute for Integral Development             |
| IMIFAP  | Mexican Institute of Family and Population Investigation |
| NGO     | Nongovernmental organization                             |
| STD     | Sexually transmitted disease                             |
| STI     | Sexually transmitted infection                           |
| UNICEF  | United Nations Children's Fund                           |
| USAID   | U.S. Agency for International Development                |
| WHO     | World Health Organization                                |

## ***Introduction***

---

Young men and women are vulnerable on a personal level. They take risks because at their stage of life they feel invulnerable and because they are trying to find and assert their autonomy. They seem never to get quite enough support from adults with the psychological and physiological transition they are enduring.

On a societal level, they have no rights and are continually exhorted to conform, their confidentiality is not respected, their access to information is restricted, and their sexuality is suppressed or repressed. And they find no service institutions specifically designed for their needs, they are caught in limbo between the pediatric and adult health systems, with no holistic model designed for their wide array of needs.

—from the Third USAID HIV/AIDS Prevention Conference,  
Washington, DC<sup>1</sup>

---

1 "High-Risk Settings: Structural and Environmental Influences on HIV/STD Risk Behavior," by Dr. Daniel Tarantola, Director, International AIDS Program, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, Boston. Plenary Presentation at the Third USAID HIV/AIDS Prevention Conference, Washington, DC, August 7-9, 1995.

# I. Background

---

## A. YOUTH AND THE IMPACT OF HIV/AIDS

The sexual and reproductive health of adolescents (10- to 24-year-olds) in a given population sets the stage for the sexual and reproductive health of the entire community. There are currently over a billion-and-a-half adolescents — almost a third of the global population and more than a quarter of the population in most developing countries. By 2025, their number is projected to reach nearly 2 billion, and whereas in 1990, 83 percent of all adolescents lived in developing countries, by 2020, almost 90 percent of adolescents will live in the developing world. Fostering safe sexual behavior among this group clearly is important to efforts to prevent the spread of sexually transmitted infections (STIs), including HIV. HIV can have a strong impact on the economies of affected societies, and the effects of HIV on a country's adolescents can be an important aspect of this, as noted in *AIDS in Kenya*.

The demographic structure of the population and the demand for government services are closely linked. Higher youth dependency ratios mean a greater demand for government-supported health and education services. Alternatively, the demand for education may decline as children are forced to drop out of school and enter the labor force prematurely to support themselves and their families. More single-parent households and AIDS orphans will also affect the demand for social services. The increased demand for government services will, in turn, affect the economy to the extent that investment funds are diverted to pay for increased services. The state of the economy will also feed back into the availability of funding to meet the demand for government services. In the

presence of HIV/AIDS, a smaller economy will result in a smaller tax base and thus less ability to provide these services.<sup>2</sup>

## **B. YOUTH AND SEXUAL AND REPRODUCTIVE HEALTH**

Adolescents' sexual behavior is an important variable in their overall health. The behaviors that put youth at risk of HIV/AIDS and other sexually transmitted infections (STIs) also puts them at risk for early pregnancy, which is associated with increased morbidity and mortality and a range of negative social consequences. STI prevention efforts that seek to foster healthy sexual behavior therefore can have a more profound effect on overall youth health. This is reinforced by data that show.

- By age 20, at least 80 percent of teens are sexually experienced in Sub-Saharan Africa, 50 percent are sexually experienced in Latin America, and 75 percent or more of teens are sexually experienced in some developed countries.
- In Cameroon, 80 percent of young people aged 11 to 23 years old have had sexual relations, but only one-half to two-thirds know that sexual intercourse is the main means of transmitting HIV — primarily because there was no outreach activity to inform and educate young people about HIV/AIDS, in or out of school.
- A Kenyan survey of 312 young people (12–24 years old) who regularly attend church revealed that 64 percent of boys are sexually active and that 30 percent of boys reporting having had more than five partners. Kenya's Ministry of Education has already developed programs for the 10,000 young women who drop out of school annually because of pregnancy.
- Worldwide, approximately 15 million young women, aged 15–19, give birth each year, accounting for more than 10 percent of all births. Seventeen percent of all babies are born to teens in the least developed countries. The prevalence in developing countries of pregnancy in early adolescence is common and the increased risk for women in these countries of dying in childbirth (which is 100 times greater than in

---

2 *AIDS in Kenya: Socioeconomic Impact and Policy*. Arlington, VA: Family Health International/AIDSCAP, chap. 8

industrialized countries) combine to make maternal mortality a significant proportion of overall of deaths among 10- to 24-year-olds

Gender differences also affect youth sexual and reproductive health. Evidence of gender differences in knowledge about HIV/AIDS/STIs was evident in a study conducted in Benin by AIDSCAP and the United Nations Children's Fund (UNICEF). Young males were found to mention more STIs and symptoms than females. Interestingly, two males cited vaginal discharge as a symptom of STI, while none of the females did. (Other aspects of the impact of gender are discussed later in this paper.)

Female genital mutilation also affects adolescent girls in developing countries. Each year at least 2 million girls undergo this procedure, which can result in fistulae and other psychosexual and reproductive function difficulties. In Sudan, some doctors estimate that 10–30 percent of all girls die from complications associated with this procedure.

### **C. EPIDEMIOLOGY OF HIV/STIs IN YOUNG PEOPLE**

The prevalence of STIs in young people is not clear because of a lack of data. Specifically, young people do not always use STI prevention and treatment services, there is a lack of available diagnostics for STIs, and studies often cannot use subjects under age 18. Among the data that are available:

- One in 20 adolescents and young people contracts an STI each year
- In Zambia in the early 1990s, 12 percent of adolescent girls in rural villages tested positive for HIV
- Thai women infected with HIV are up to 15 years younger than HIV-positive men in the country
- In many countries, 60 percent of all new HIV infections are among 15- to 24-year-olds, with a female-to-male ratio of 2:1
- One in every 20 African girls between the ages of 10 and 14 is infected with HIV, and nearly two-thirds of HIV infections in Africa occur in people under age 25. Worldwide, young people under age 25 now account for up to three-quarters of all new HIV infections.

- HIV infection does not occur only among young people who are just becoming sexually active; up to 60 percent of all infections among females occur by the age of 20
- Given that there may be a lag of up to ten years between initial HIV infection and the expression of HIV-related diseases, it is clear that adolescence is a critical age for potential exposure to HIV.

## REFERENCES

- The World's Youth A Special Focus on Reproductive Health* Washington, DC  
Population Reference Bureau and the Center for Population Options, 1994
- State of the World's Children, 1993* New York UNICEF, 1993
- Picture of Health* New York UNICEF, and Geneva WHO, 1995
- N'tcha, J, C. Niang, K. Andele, A. Mendoza, N Davo, T Saidel, and M L. Field  
*A Targeted Intervention Research Study to Improve the Prevention and  
Treatment of STDs in Youth in Benin* Benin UNICEF/Benin, Arlington, VA  
FHI/AIDSCAP, Dakar, Senegal University of Dakar, 1996
- AIDS in Kenya Socioeconomic Impact and Policy* Arlington, VA  
FHI/AIDSCAP.
- Ndunge K, D Dortzbach, F. Gutor, and A Wangai "AIDS Prevention and  
Kenya's Church Youth An Assessment of Knowledge, Attitudes and  
Sexual Practices." Presentation at the Third USAID HIV/AIDS Prevention  
Conference, Washington, DC, 1995
- MacNeil, J "Mitigating the Impact of HIV through Care and Support Future  
Generation." Unpublished paper, 1996.
- World Health Organization *The Current Global Situation on the HIV/AIDS  
Pandemic* Geneva. WHO, July 1994

## II. Unique Issues in Youth Development

---

Pregnancy and STD/HIV prevention programs aim to delay the initiation of sexual activity and increase the use of prevention methods for those who are sexually active by

- improving young people's access to information and services
- developing their psycho-social skills
- increasing their perceptions of risk
- improving young people's attitudes toward safe sexual behavior
- changing gatekeeper attitudes about sex education and services for youth
- changing social norms, including norms about gender roles, to be supportive of communication and safe sexual behavior among females and males
- reducing economic and contextual barriers that negatively impact on adolescent sexuality and access to information and services
- intervening in areas that affect sexual activity such as poverty and substance abuse

## A. MOBILIZING GATEKEEPERS

In most societies, multiple adults, community groups, and institutions act as “gatekeepers” in their relationships with young people. They seek to protect youth and maintain traditional family and cultural values. The perception that education about sexual matters leads to initiation of sexual practices or implies approval of sexual activity by youth is the rationale given by many gatekeepers for obstructing efforts to discuss sexual and reproductive health with youth.

The U.S. federal government serves a gatekeeper function in terms of government-sponsored research with youth. All research using U.S. government funds is subject to Title 45 of the Code of Federal Regulations (part 46, subpart D, part 46.401 – 46.409). This states that children under the age of legal consent (age 18 in most states) can participate in such research only if the government’s Internal Review Board “finds that adequate provisions are made for soliciting the assent of the children and the permission of their parents and guardians.”

Gatekeepers can also be a target of opportunity for working with youth. Once their support is mobilized, they can provide valuable resources and energy for programs that promote sexual and reproductive health among youth. For example, in India, one street drama highlighted adolescent and adult women’s lack of reproductive knowledge and the resulting negative implications for the health of the community. The drama led parents to support a sex education program for unmarried, young women. In Sri Lanka, a local nurse-midwife visited families in the community to gain their support for their daughters to participate in a group-based, peer education program (ICRW study — Silva et al., 1997).

A study of sexual decision-making among Jamaican adolescents revealed that factors that increased the risk of HIV among adolescents in the Caribbean included economic pressures to seek extended employment away from the home, low-paying jobs, and limited resources.

Churches act as gatekeepers in most societies, and reaching parents and youth through churches is one approach to mobilizing gatekeepers. In an AIDSCAP-sponsored project in Kenya, MAP International, a Christian health and development agency working through churches across Africa, has helped churches respond to the AIDS epidemic. They have done this through networking, ethnographic research on home care, behavior change programs targeted toward the general public, literature development, and training of church leaders. Together, these churches and other agencies have collaborated on a number of efforts, primarily through the Kenya AIDS NGOs Consortium. One MAP report recommended that churches identify various strategies by which sex education for youth can be promoted in the family or integrated into educational programs. In

addition, churches can sponsor seminars and workshops for couples and families on marriage and family enrichment Training in pastoral counseling for families affected by HIV/AIDS can be added to seminary curricula

Information is generally more effective when it comes from peers, although parents have a role — which they too often are not fulfilling — as providers of information and as role models on sexuality The church can help encourage parents to participate in youth education programs.

It is often counterproductive to fail to involve parents when they are the “functional gatekeeper” for a given activity For example, in Ethiopia a project sponsored by AIDSCAP and implemented by Save Your Generation, attempted initially to use peer educators Eventually 30 of the 40 young people participating dropped out because of parental opposition Once the implementers involved the parents, the youth were allowed to continue their peer education activities Experience suggests, moreover, that others and daughters are best approached, educated, and counseled together

## **B. CHANGING SOCIAL NORMS, INCLUDING ABOUT GENDER ROLES**

Social norms have a profound impact on young people’s sexual behavior Efforts to change these can be more productive than individual behavior change efforts by themselves Many societal norms conflict with each other, a situation particularly problematic in cultures that are in transition to more industrialized and less traditional patterns Shifts from urban to rural life also involve normative changes for youth

In many societies, women have less access than men to education, training, and productive resources such as land and credit The construction of male and female sexuality reflects the inequalities of the social and economic spheres of life As a result, men are more likely than women to initiate and control sexual interactions and decision-making, which has implications for women’s ability to protect themselves from HIV/STIs

These sexual power dynamics begin in adolescence A Jamaican youth study confirmed what other studies have shown, namely, that the cultural ideology for sex among women and men is quite different, with men more likely to feel that extra-union relationships are appropriate and to believe that commitment is less essential for sexual relationships

Gender roles affect young women and men’s vulnerability in several ways

- Adolescent women are often less knowledgeable than their male counterparts about reproductive functions and health Yet studies have

shown that methods and materials can be developed and imparted by a variety of communication channels to effectively increase young women's knowledge about their bodies, sex, male and female condoms, HIV/AIDS, and STIs

But information alone cannot negate the effects of gender power dynamics. For example, in AIDSCAP/Jamaica's School-Based Education project, fewer young women acknowledged receiving information in the classroom than young men, despite that the girls and boys had participated in the same programs and that the two groups showed nearly identical knowledge when asked a series of questions. The girls also retained mythical beliefs more often than the boys. Focus group data suggest that the girls' older sexual partners may have been responsible for attributing symptoms and problems to causes other than sex, perhaps in part for their own purposes

- Social norms in most countries are not supportive of women communicating about sex. Single-sex discussion groups have been found to help young women develop the skills and confidence to talk about sex and HIV/AIDS to men in mixed-sex groups, to partners, and to family members. An AIDSCAP peer education project in Tanzania found that youth often feel best in same sex groups, as voiced by one female youth who said, "You can share ideas, but if with men, you can't say much." Another young person in an AIDSCAP peer education group in Thailand said, "It may be difficult for some people (particularly girls) to discuss sexuality and AIDS in a large group, large group is good for drama sharing."

Certifying unmarried female peer educators in Thailand was found to give these young women the social license to talk about sex. Further research is needed to find out whether expanding young women's role to include serving as peer leaders can change community norms about women in a broader sense and can increase women's confidence in and social legitimacy of their sexual decision-making

- Seeking STD treatment can be a stigmatizing experience for everyone but especially for women and young people (both male and female). Interventions that integrate gender into health provider training can contribute to a change in health providers' behavior toward young people that may help decrease the stigmatization of seeking STI services and thereby increase service utilization, especially by young women

### **C. DEALING WITH YOUTH PRIORITIES OTHER THAN HEALTH**

Attitudes can have a profound effect on behavior. Prevailing attitudes among young people about their personal health and safety often conflict with messages from the adult community, whose priorities are not the same. Adolescents' concerns often overshadow their ability to hear prevention messages, making it critical to use creative approaches that draw on young people's non-health and safety values.

To be effective in HIV/AIDS prevention, discussions with youth need to cover all the difficulties and challenges they face — home life, violence, drugs, sexual and child abuse, and self-esteem. Adolescents need help to learn about their own emerging sexuality and develop adequate coping skills.

### **D. REDUCING ECONOMIC AND OTHER BARRIERS TO PREVENTION**

Young people often face economic and other barriers to information about sexual and reproductive issues. Such information may not be readily available in the schools or in the community. Young people may also have limited access to health services, including contraceptive services, STI treatment, and other primary care. Youth often cannot pay for such services on their own and are embarrassed to seek help from familiar adults.

More importantly, economic constraints may lead some adolescents to risk trading sex for school fees, food, and other necessities. The risk of HIV infection to these children may be reduced by programs that focus on policy advocacy, improving young people's income-generation abilities, or supporting education. In this sense, multi-sectoral health programs may have a broader impact on youth HIV prevention than those that are limited to the health sector.

### **REFERENCES**

Jamaica Youth Study. RTI, FHI, AIDSTECH, 1992.

Silva, T., S. Schensul, B. Nastasi, M. W. A. de Silva, C. Sivayoganathan, and P. Ratnayake. *Youth and Sexual Risk*. ICRW Phase II Research Report Series. Washington, DC: International Council for Research on Women, 1997.

- Vasconcelos, A , V Garcia, M C Mendonca, M Pacheco, G Braga-Pires, C Tassitano, and C Garcia *Sexuality and AIDS Prevention among Low Income Adolescents in Recife, Brazil* ICRW Phase II Research Report Series Washington, DC International Council for Research on Women, 1997
- Cash, K , J Sanguansermisri, W. Busayawong, and P. Chuamanochan *AIDS Prevention through Peer Education for Northern Thai Single Female and Male Migratory Factory Workers*. ICRW Phase II Research Report Series. Washington, DC: International Council for Research on Women, 1997.
- Weiss, E, D. Whelan, and G Rao Gupta. *Vulnerability and Opportunity Adolescents and HIV/AIDS in the Developing World* Washington, DC International Council for Research on Women, 1996
- “HIV and Youth: Meeting the Challenge ” Co-Chaired by Mark Connolly, UNICEF, New York, and Jecenia de Jesus, International Community of Women Living with HIV/AIDS, New York Oral sessions as the USAID Prevention Conference

### **III. Lessons Learned in Prevention Education and Clinical Service Delivery**

---

Youth HIV/AIDS prevention program strategies have focused on achieving two main objectives—delaying the onset of sexual activity, and encouraging safe sexual activity. These are not mutually exclusive. Several program approaches have been employed to achieve both:

- improving access to information about sexuality, reproduction, HIV/STI prevention, and barrier and other contraceptive methods
- building psycho-social skills
- improving access to clinical services
- changing gatekeeper attitudes about education and service access for youth
- altering the social context of young people's behavior in order to promote social norms that would support the program objectives, including intervening in areas that affect sexual activity such as substance abuse

Programs and messages must be suitable to the specific characteristics of the young people being targeted, including their gender, and whether they are in school or out of school, in rural or urban areas, literate or illiterate, sexually active or not. Ignoring these factors detracts from the effectiveness of an intervention.

## **A. PEER EDUCATION**

The norms of young people's peer groups affect their behavior. One study of northern Thai males confirmed a positive relationship between the expectations/motivation scale and consistent condom use. The study was among young men averaging 23 years in age and included Chiang Mai University undergraduates, Chiang Mai Army and Air Force recruits, and laborers based in Chiang Mai. Men who perceived that the group norm was one of non-use were the least likely to use condoms; those who did not know the norm or who perceived it to be indifferent to condom use had an intermediate level of condom use; and those who perceived the norm to support condom use had the highest use levels. This relationship held for each occupation group.

Building on this idea that peer norms are critical variables in the behavior change process, programs for youth HIV/AIDS prevention have made extensive use of peer educators. There are many variables that affect the success of these programs, including selection criteria, recruitment and retention approaches, and role definition.

### **1. Selection Criteria**

Peer educators are generally selected to match relevant characteristics in the target audience. Other criteria include attributes such as being accepted and respected, having good communication skills, being literate and charismatic, having an understanding of health problems and being interested in self-enhancement, being selected by a group of peers, and being willing to volunteer.

The continuity of peer education programs may be affected by the length of time that the volunteers are able to serve as peer educators, and this might be an important selection criterion. The AIDSCAP Peer Education Study showed that student or youth peer educators are often unavailable for longer than a year due to schedule changes or lack of interest.

In some places, the credibility of peer educators is based on their age and/or gender. For example, older male adults might be more effective with young people of both sexes.

Peer educators must have a clearly defined role, although this role can range from sharing information to counseling, referral, skill-building, peer support, or mobilizing for advocacy.

## 2. Structure and Methods

Almost all youth participants in large group activities sponsored as part of an AIDSCAP project in Nigeria were enthusiastic about such events, and most had attended more than one. Young people consider such group sessions to be a good way to learn about behavior change, including to convince those who don't believe that AIDS even exists.

Some of the reasons some people gave for not accepting the existence of AIDS is that it is an American intervention to discourage sex and this is widely held by most students. These group activities allow room for such opinions to be debunked by other people apart from the peer educators.

The youth in Nigeria hardly believe individuals; but if it is done in a larger group where others share their experiences, then the tendency is for them to believe.

—youth participants, AIDSCAP program, Nigeria

The group discussion clarifies many issues that you may not remember to raise when you are by yourself with the peer educator.

—youth participants, AIDSCAP program, Dominican Republic

## 3. Training

No given length and type for peer training has been shown to far exceed another in impact. Indeed, the length, content, and methods of peer training programs vary widely. One element that does seem to be critical to the success of peer education programs is a built-in evaluation component to assess the adequacy of the training, appropriateness of the content, and the effectiveness of methods and supervision. This data is valuable not only to assess the quality of current programs but also to develop future programs. In fact, 85 percent of the peer educators interviewed in the AIDSCAP peer education study expressed an interest in receiving more information on training and requested education materials.

## 4. Compensation and Motivation

Program designers and managers also must assess the value or necessity of using compensation as a means of improving quality and maximizing program continuity. In the AIDSCAP peer education study, 59 percent of peer educators

mentioned financial incentive and/or expenses when asked what would make their jobs easier

In Ethiopia, the most critical mechanism for supporting peer education was found to be compensating peer educators for the time they spent working, especially those with no other source of income. Initially, most projects adopted rules that prohibited such compensation in an attempt to help that the projects would be sustainable beyond the typical five-year USAID funding cycles. More recently, however, there is a growing consensus that retaining peer educators is of sufficient importance to make it worth providing them with some incentives, including, where necessary, financial compensation

## 5. Supporting Materials and Message Content

Supporting materials are vital tools for peer educators. For instance, in Recife, Brazil, female peer educators helped develop a booklet called, *The Story of Maria*, which they read and discussed with a group of friends they recruited from their peer networks. The booklet contained seven chapters, each of which was discussed in separate meetings. The chapters focused on relationships (e.g., with mothers, fathers, boyfriends) and social norms that influence young women's sexuality and HIV risk (e.g., women's subordination, virginity, and infidelity). The last chapter in the booklet covered AIDS. Training focused on how to use the booklet within a group setting and on group process skills. The booklet was a key component of the intervention, which produced a number of positive outcomes, including improved knowledge, increased understanding of gender roles and their impact on HIV risk, increased autonomy, and improved communication with their mothers and boyfriends (Vasconcelos et al., 1997).

Another successful approach is the "Fleet of Hope." The message helps young people evaluate their own risks using the image of three boats that people can board to escape the "flood" of HIV/AIDS: the abstinence boat, the fidelity boat, and the condom boat. This approach avoids direct confrontation with political and religious factions while establishing a simple model of personal risk assessment. This model seems to have provided a young population with a clear idea of risks in a new way.

According to one person involved in the program, "We teach every single prevention method equally: abstinence, fidelity and condom use. We do not advise them to use one or the other. It is up to the person to choose." Another said, "This approach makes sense because different prevention options may be appropriate for the same person at different stages in his or her life."

The success in Tanzania of the Fleet of Hope led to its adaptation for use in Ethiopia in a youth project run by Marie Stopes International. The program is also under consideration for school and workplace programs in other areas. Youth participating in the Marie Stopes project in Ethiopia liked the idea of different prevention options so much that they named their youth group, the Fleet of Hope Association.

## 6. Gender Issues

Gender is an important variable when designing peer education programs. First there is the consideration of whether peer educators will work with opposite sex peers and whether groups should be single-sex or mixed-sex. One study found that mixed-sex peer education groups that utilized a male and female peer educator were most successful when the peer leaders and the peers knew each other prior to the program (Cash et al, 1997).

Another important issue is the gender content of the program. A discussion of gender-defined roles and their relationship to sexual risk can be incorporated into materials and messages for youth (ICRW study in Thailand — Cash et al, 1997, ICRW study in Brazil — Vasconcelos et al, 1997). The Thai study showed that young women factory workers greatly increased their understanding of how gender roles influence sexual risk and strategies to reduce risk after their participation in the peer education program. Young women in Brazil reported increased autonomy in sexual decision-making as a result of their participation in a peer education program that incorporated gender into its materials and messages.

As noted previously, social norms in most countries are not supportive of women communicating about sex. Certification of unmarried female peer educators appears to give young women a social license to talk about sex. Single-sex discussion groups also have been found to help young women develop the skills and confidence to talk about sex and HIV/AIDS to men in mixed-sex groups (ICRW study in South Africa — Hadden, 1997), to partners (Cash et al, 1997), and to family members (Vasconcelos et al, 1997).

### *References*

*AIDSCAP BCC Experiences from the Field in Ethiopia* Arlington, VA.  
AIDSCAP, 1997

Cash, K, J Sanguansermsri, W Busayawong, and P. Chuamanochan *AIDS Prevention through Peer Education for Northern Thai Single Female and*

- Male Migratory Factory Workers* ICRW Phase II Research Report Series  
Washington, DC. International Council for Research on Women, 1997.
- Flanagan D , C Williams, and H Mahler *Peer Education in Projects Supported  
by AIDSCAP A Study of 21 Projects in Africa, Asia and Latin America*, 1996
- Givaudan, M. *Strengthening Intergenerational Communication. An HIV  
Prevention Intervention for Parents and Adolescents in Mexico* ICRW Phase  
II Research Report Series. Washington, DC: International Council for  
Research on Women, 1997.
- Hadden, B. *An HIV/AIDS Prevention Intervention with Female and Male STD  
Patients in a Peri-Urban Settlement in KwaZulu Natala, South Africa* ICRW  
Phase II Research Report Series Washington, DC International Council for  
Research on Women, 1997.
- Manchester, T G. "Does the 'Fleet of Hope' Hold Water? An Evaluation of a  
Controversial Campaign to Provide a Personal Assessment of Risk "  
Presentation at the Third USAID Prevention Conference, Washington, DC,  
1995
- Silva, T , S Schensul, B Nastasi, M W A. de Silva, C Sivayoganathan, and P  
Ratnayake *Youth and Sexual Risk* ICRW Phase II Research Report Series  
Washington, DC International Council for Research on Women, 1997
- van Landingham, et al , eds *Journal of Health and Social Behavior*  
36(March) 195–212, 1995
- Vasconcelos, A , V Garcia, M C Mendonca, M Pacheco, G Braga-Pires, C  
Tassitano, and C Garcia *Sexuality and AIDS Prevention among Low Income  
Adolescents in Recife, Brazil* ICRW Phase II Research Report Series  
Washington, DC International Council for Research on Women, 1997
- Weiss, E, D. Whelan, and G Rao Gupta. *Vulnerability and Opportunity  
Adolescents and HIV/AIDS in the Developing World* Washington, DC  
International Council for Research on Women, 1996
- Woelk, G , M Tromp, and P Mataure *Training Teachers to Lead Discussion  
Groups on HIV Prevention with Adolescents in Zimbabwe* ICRW Phase II  
Research Report Series Washington, DC International Council for Research  
on Women, 1997.

## IV. Other Approaches

---

### A. SCHOOL-BASED PROGRAMS

Exploring issues related to growing up, sexuality, and gender roles within the context of HIV/AIDS demands a non-didactic approach. Although many teachers are ill-prepared to use participatory methods, training programs can provide them with the skills they need. One program to conduct training workshops in participatory methods for teachers found that over 70 of the 95 teachers trained were able to successfully use participatory methods with their students in the classroom (ICRW study in Zimbabwe — Woelk et al., 1997). A key feature of the training was acknowledging and discussing the teachers' own feelings and attitudes about AIDS, sexuality, and relationships.

An important methodological question for in-school, participatory sessions led by teachers is whether the groups should be single-sex or mixed. In the ICRW Zimbabwe study, teachers conducted mixed-sex classroom discussion activities. Although there was support among the teachers and students for these mixed-sex groups (e.g., boys and girls can learn about each other's "tricks"), many felt that some topics were better suited for single-sex groups, although there was no agreement on what those topics were. Students and teachers also noted that while girls were less likely than boys to participate initially, their participation increased over time. Both students and teachers noted that older, sexually active girls were less likely to participate in classroom discussions for fear of saying something to incriminate themselves (Woelk et al., 1997).

The content of school-based program and curricula components to decrease risky sexual behavior among youth varies widely, particularly in the extent to which they discuss and promote all preventive options (including condoms), discuss

HIV/AIDS prevention within a broader reproductive and sexual health framework, and incorporate HIV/AIDS into a broader life skills approach. Curricula also vary with regard to gender issues — specifically, how they respond to the specific needs of girls and boys in light of socially sanctioned norms governing, roles, relationships, and sexual behavior.

Programs also differ in the extent to which teachers are asked to teach a standardized curriculum versus developing their own curriculum based on sample lesson plans (Woelk et al., 1997). In Zimbabwe, teachers were trained to use participatory methods with students and to conduct a number of specific activities. Data from a questionnaire, observation in the classroom, and interviews revealed that all of the lessons highlighted during the training were used by some of the teachers and that many teachers developed new lesson plans on issues that they considered to be important such as care of AIDS patients and rape. The lack of a uniform intervention for students complicated the evaluation process because there was a good deal of variation in what the students had been taught.

Teachers and others involved in such programs must be careful not to underestimate the knowledge young people already possess in this area. Teachers may be helped in overcoming cultural barriers to delivering information by co-presentations and strategic alliances with health professionals.

## **B. COMMUNICATION WITH PARENTS OR OLDER FAMILY MEMBERS**

Findings from two ICRW studies conducted in Mexico and Zimbabwe indicate that adolescents want increased communication and guidance from their parents or older relatives but that there are numerous barriers to such communication (Weiss et al., 1996). Other ICRW studies conducted in Brazil and Mexico provided additional information about how to foster intergenerational communication.

In Brazil the resource material used by the peer educators included a chapter on mother-daughter communication. In post-intervention focus groups, both the peer educators and the peers mentioned improved communication with their mothers as an outcome of being able to share the resource material (“The Story of Maria”). (Vasconcelos et al., 1997)

In Mexico the Mexican Institute of Family and Population Investigation (IMIFAP) developed a course for parents on communication and a video for use with both parents and adolescents. Participation by parents in the course has been mixed. In the schools selected for the intervention, it was difficult to get parents to participate in the ten sessions, although in the control school that received the

delayed intervention, parents (mostly mothers) participated more readily. (Mothers from the intervention schools who participated were more likely to have their first-born child enrolled in the study ) The video modeled communication about sexuality and HIV/AIDS prevention between parents and their adolescent children, including a discussion about condom use between a mother and her daughter. Most parents were very supportive of the video, including the scene on condom use. Adolescents were also supportive. The parent course (which has been modified and shortened based on the intervention trial) and the video are now part of IMIFAP's ongoing interventions with parents, which are generating great interest and demand. (Givaudan, 1997 )

Some projects recruit young participants through their parents. In the Dominican Republic, parents who visit Dominican Institute for Integral Development (IDDI ) family planning or economic development centers agree to let their children be involved in an otherwise controversial training program. Through the program, older youths called Health Messenger Leaders conduct educational sessions for other young people on topics of human sexuality, family planning, STIs, and HIV/AIDS. (Butler et al , 1996 )

### **C. COUNSELING AND SERVICES FROM HEALTH PROVIDERS**

There are few clinical services tailored or health providers trained specially to serve the needs of youth. Improving the provision of services to this group is a challenge for public and private health systems. Health providers serve a marginal role for most youth, who do not regularly attend clinics. The potential of health workers to be confidants and sources of effective treatment is relatively unexplored.

Some unmarried women face discrimination when they seek sexual and reproductive health services. Many young people fear they will be embarrassed by health providers — a fear that seems well-founded according to one study. A "mystery shopper" study conducted in Senegal showed that young people were made to feel embarrassed, given lectures about the dangers of premarital sex, and refused the requested contraceptives (Naré et al., 1966)

Several issues influence young people's interactions with health providers, including privacy and confidentiality, the costs of care, and the integration of STI services.

## 1. Privacy and Confidentiality

One primary barrier to private and confidential care for youth is frequently judgmental attitudes of health providers. Indeed, adolescents who are hiding their sexual activity from their parents and, moreover, are not yet comfortable with their own sexuality, are embarrassed to request information from health providers. This is especially true if a family member or family friend may utilize or work at the health clinic in their community.

Street youth pose a unique problem for health providers. A project in Brazil used a creative approach to providing services to these youth, as described in *AIDSCAPTIONS* 1(1)

After the closing of the drop-in center, SOS Criança began identifying health professionals in government and NGO clinics who were sensitive to the needs of street youth. This effort developed into "Movimento Saude No Verde" ("Green Light Health Movement") to improve street youth's access to public health services. Each health professional who agrees to treat or refer street youth receives a green ribbon to wear (inspired by the red ribbons used for AIDS awareness). We give these doctors and nurses additional green ribbons to distribute to colleagues or friends who are willing to join the movement.

Street youth who are treated at the clinics also receive green ribbons. At first some children were reluctant to go to government clinics, but our outreach workers helped them gain confidence in the health professionals by accompanying them on the first visit. Soon many young people were proudly wearing green ribbons and referring their peers to public health clinics.

In exchange for their support, we offer clinic staff our experience in counseling and social work, educational materials and other resources. For example, we lent our television and videocassette recorder to a clinic for use in training. The equipment stays at the clinic, where we also use it to train clinic and NGO staff and our own outreach workers in the skills needed to work with street youth. This sharing of resources has proved a very cost-effective strategy.

## 2. The Costs of Care

Youth who are in school or out of school and unemployed often find the cost of clinical services prohibitive. This is all the more complicated when their reason for attendance is one they want to keep from their parents, who might otherwise be willing to pay the fee. The Targeted Intervention Research (TIR) study by UNICEF and AIDSCAP in Benin revealed that many adolescents considered the cost of STI treatment at the clinics to be too high and self-medicated with drugs bought from street vendors (N'tcha et al, 1996). Dr. Donna Kabatesi from Uganda reports in that study that,

High costs for treatment also discourage some young people. Even at clinics where STD treatment is "free," unauthorized charges keep some away. A young person might spend 50,000 shillings (US\$50) — the equivalent of half a term's school fees — for basic treatment at a private clinic. It's little wonder that many youth turn to self-diagnosis and self-treatment, with the help of friends or family.

Young people in particular seek primary STD diagnosis and treatment recommendations from the latter. If they turn to the formal health care system at all, it may be months after they've already consulted these informal sources.

The barriers to seeking care are the cause of many STI and childbearing complications in young women, including infertility. Infertility is a serious consequence for young women in countries where childbearing is an important expectation of young women. Educational programs and health providers would be wise to capitalize on this as a motivating factor for preventing and treating STIs promptly. The scenario below (reported in N'tcha et al, 1996) could be avoided by reaching youth with messages and designing services they will use.

What motivates most young people to finally seek professional advice and treatment is what they've learned about the dangers of leaving STDs untreated. Some of the most compelling reasons include suspicion that a symptom signals HIV infection, or fear of infertility, chronic pain or even death from the STD. Because young people frequently postpone treatment, such complications are a very real threat. One 18-year-old girl I treated waited four months to come to the clinic, despite severe pain, for which she had self-medicated with antibiotics and painkillers. She had pelvic inflammatory disease (PID).

### 3. Integration of Services

A recent trend toward integrating STI services into broader reproductive health services may be especially helpful in improving youth access to care. Mugriditchian (1995) notes that

a major disadvantage of vertical STD services is their poor accessibility to women. Integration of STD services into broader “reproductive health” services could enhance their acceptability and effectiveness. Linking STD services to existing high-profile (better-funded) and more “respectable” services such as maternal and child health and family planning programs where they exist. This approach is less likely to reach youth and adolescents, single, sexually-active women including prostitutes, or women who have completed child bearing (this will likely be discussed in session on STD/HIV in Women). Integrated services are probably the most efficient means of reaching asymptomatic women.

#### D. MASS MEDIA

In Haiti, AIDSCAP listened to the implementing agencies who asserted that young people with access to messages delivered through the media tended to mirror the attitudes about condoms presented in those messages. The campaigns there aligned the use and purchase of condoms to “cool” behaviors. These changes were much less impressive among older Haitians who, according to the implementing agencies, have less access to the media. This may support the idea that attempts to change the environment through the media may be most effective when the media supports emerging norms (e.g., those of the new generation of young people), rather than established norms (e.g., those of their parents).

One Haitian involved in these programs said, “Adolescents are one of the easiest groups because they’re so openminded and close in their way of thinking to the States in that they want to adopt anything that is ‘cool’ ”

Integrating prevention interventions into the popular entertainment and community activities may help bring safe sex messages to those who may not otherwise be exposed to them. As a young peer educator reported in a focus group in Addis Ababa.

Youth like to be entertained. Whenever we tell them that there are music or dramas, we never have enough space [for all the people that come]. If radio and TV programs are arranged with music and short dramas, plus messages containing skills, they will be more acceptable by youth .

Once again, the activities must be tailored to a particular group of youth. What works for in-school youth might need to be altered to be effective with out-of-school youth. For example, the Family Guidance Association of Ethiopia identified community sites frequented by out-of-school youth and focused on disseminating messages at these locations. They mapped areas where out-of-school youth could be found, such as garages and video places. They went to recreational places and did whatever the youth were doing, after which they started their discussions about AIDS. They used traditional methods to notify youth that an event was about to take place, such as sounding the Turemba trumpet.

### **E. THE STI IN HIV**

The missing component of many youth HIV prevention activities are STI prevention and treatment messages. While the behavioral aspects of HIV prevention are similar to STI prevention, HIV prevention messages may be more effective with youth if they focused on STIs, which many youth have experienced symptomatically. HIV seems a more remote threat to them. Also, the risk of infertility due to failure to promptly treat an STI is of immediate relevance to young women and men who, in most of the developing world, are expected to produce children. Treatment instructions also are missing for both adults and youth in most clinical settings. These are important messages for STI control that will contribute to HIV prevention in the long run.

### **F. INTEGRATING STRATEGIES AND MOBILIZING PRIVATE SECTOR SUPPORT**

A study in the Dominican Republic found that although 90 percent of youth had knowledge of prevention measures, only 13 percent of females and 65 percent of males reported changing their sexual behavior. A mass media campaign targeting youth was developed to increase STI/HIV/AIDS awareness levels and risk perceptions and to promote health-seeking behavior. Three TV spots and radio messages were produced, along with other supporting materials. Private sector collaboration was actively pursued through official government requests, personal contacts, and public appearances in local media programs. A sophisticated and modern approach to communication such as an "interactive" TV spot was produced at minimal cost. These were complemented by workshops run through adolescent health organizations (Butler et al., 1996).

The result was a consistent AIDS prevention message and the development of a guide for education and counseling Dominican adolescents. The collaboration of

the private sector helped reach more youth reached The interpersonal strategies complemented the mass media approach, and helped keep youth attention focused on the issue

## REFERENCES

- Butler M, C Brito, and J De la Rosa. "Viejo Si Te Da No Llegas". Tapping In On Private Sector Collaboration for A BCC Adolescent AIDS Campaign in the Dominican Republic. AIDSCAP/FHI Dominican Republic, 1996
- Cash, K , J Sanguanserm Sri, W Busayawong, and P. Chuamanochan. *AIDS Prevention through Peer Education for Northern Thai Single Female and Male Migratory Factory Workers* ICRW Phase II Research Report Series Washington, DC: International Council for Research on Women, 1997.
- Filgueiras, Ana "Defending Children's Rights An AIDS Prevention Strategy," *AIDS Captions* 1(1)
- Descriptive Analysis of AIDSCAP/Haiti BCC Projects Some Lessons from the Field* 1996
- Flanagan D., C Williams, and H Mahler *Peer Education in Projects Supported by AIDSCAP A Study of 21 Projects in Africa, Asia and Latin America* 1996
- Givaudan, M *Strengthening Intergenerational Communication An HIV Prevention Intervention for Parents and Adolescents in Mexico* ICRW Phase II Research Report Series Washington, DC International Council for Research on Women, 1997
- Hadden, B. *An HIV/AIDS Prevention Intervention with Female and Male STD Patients in a Peri-Urban Settlement in KwaZulu Natala, South Africa* ICRW Phase II Research Report Series Washington, DC International Council for Research on Women, 1997
- Mugrditchian, D "Sexually Transmitted Diseases with Limited Resources," *Venerology* 8 251-55 (1995)
- Naré C, K Katz, and E Tolley *Measuring Access to Family Planning Education and Services for Young Adults in Dakar, Senegal* Arlington, VA. FHI, 1996.
- N'tcha, J., C Niang, K. Andele, A Mendoza, N Davo, T Saidel, and M L. Field *A Targeted Intervention Research Study to Improve the Prevention and*

- Treatment of STDs in Youth in Benin* Benin UNICEF/Benin, Arlington, VA  
FHI/AIDSCAP, Dakar, Senegal University of Dakar, 1996
- Silva, T , S Schensul, B Nastasi, M W A de Silva, C Sivayoganathan, and P  
Ratnayake *Youth and Sexual Risk* ICRW Phase II Research Report Series.  
Washington, DC International Council for Research on Women, 1997
- van Landingham, M., Suprasert, S , Grandjean, N. and Sittitrai, W. "Two Views  
of Risky Sexual Practices among Northern Thai Males The Health belief  
Model and the Theory of Reasoned Action " *Journal of Health and Social  
Behavior* 36 (March) 195–212, 1995.
- Vasconcelos, A , V Garcia, M C Mendonca, M Pacheco, G Braga-Pires, C  
Tassitano, and C Garcia *Sexuality and AIDS Prevention among Low Income  
Adolescents in Recife, Brazil* ICRW Phase II Research Report Series.  
Washington, DC International Council for Research on Women, 1997.
- Weiss, E, D. Whelan, and G Rao Gupta *Vulnerability and Opportunity  
Adolescents and HIV/AIDS in the Developing World* Washington, DC:  
International Council for Research on Women, 1996
- Woelk, G., M Tromp, and P Mataure *Training Teachers to Lead Discussion  
Groups on HIV Prevention with Adolescents in Zimbabwe* ICRW Phase II  
Research Report Series Washington, DC International Council for Research  
on Women, 1997.

## V. Youth Policy Development

---

Part of the failure to develop a policy response to the threat of HIV disease involves society's ambivalence about sexual matters. Consider the insufficient attention to the HIV risks among adolescents. The median age at which individuals are becoming infected with HIV has decreased from more than 30 years old in the early 1980s to 25 years old from 1987 to 1991. During this latter period, one of every four newly infected individuals was younger than 22 years.

Policy changes are needed to protect all sexually active youth, as well as youth who engage in experimental (or addictive) drug and alcohol use. Abstinence remains the most certain way to avoid infection with HIV or other STDs and should be emphasized in the education of young people about sexual risk taking and responsibility. This is no reason, however, to withhold from young people the frank and explicit advice they need to protect themselves should they become sexually active, as a substantial majority do by the time they leave high school.

—Stryker et al, 1995

The AIDSCAP/Jamaica School-Based Education Program in Jamaica showed the importance of providing multiple points of access to condoms. Youth in rural Jamaica were more likely to purchase condoms at shops than were urban youth, and focus groups revealed that youth found shops to be convenient, anonymous sources of condoms. This overcame the barriers of potential embarrassment due to the stigma around youth and sexual issues and potential parental knowledge of their sexual activity. Urban youth reported receiving condoms primarily from friends or siblings, demonstrating another way of avoiding potential family conflicts.

The question of where to integrate HIV/AIDS/STI education may require policy decisions at higher educational levels, perhaps by the Ministry of Education. Because curricula reflect larger societal values and ideologies, this will be a complex process. Curriculum innovation also requires in-service and pre-service teacher training.

One example of pro-active policy reform in support of youth comes from Colombia, whose UNICEF office was an active participant in the Technical Support Group on Sexual and Reproductive Health Promotion, on which AIDSCAP participated as part of its technical support to UNICEF. The National Plan for Sexual Education has been incorporated by the Presidential Programme for Youth, Women and the Family into the government policy for social development. This plan is a joint effort between the Ministries of Education and Health and the Colombian Institute for Family Welfare (ICBF), with technical support from the Foundation for Human and Social Development (CRESALC). The National Ministry of Education enacted the National Project for Sexual Education which included development of a progressive curriculum that was implemented in 1994 at the preschool, primary, and secondary levels.

Developing policy and legislation of relevance to school-age children, including adolescents, requires having information on current policies relating to sex education, school-age girls who become pregnant (whether they are allowed to return to the system), sexual harassment by teachers, and access by young people to tobacco and alcohol. Other issues that may be relevant are the types of support provided to destitute youth, including AIDS orphans, the overall economic well-being of the country, training available to youth entering the job market, and accelerating specialized training programmes for workers in key sectors and industries likely to be most affected by HIV/AIDS.

## REFERENCES

- World Health Organization and United Nations Educational, Scientific and Cultural Organization. *School Health Education to Prevent AIDS and STD. A Handbook for Curriculum Planners*. Geneva: WHO and UNESCO, 1994.
- Rau, B., and S. Forsythe. *Policy Dimensions of HIV/AIDS in Kenya*. Arlington, VA: AIDSCAP/FHI, May 1994, updated in 1996.
- Stryker, J., T. J. Coates, P. DeCarlo, K. Haynes-Sanstad, M. Shriver, and H. J. Makadon. "Looking Back, Looking Ahead," *JAMA* 273:1143-48, 1995.

## VI. Additional Resources

---

### *The AIDSCAP Electronic Library*

This is a CD-Rom that is searchable for conference abstracts, journal articles, and manuals on youth issues, research, projects, and resources addressed during the AIDSCAP project

### *AIDS Health Promotion Exchange. The Royal Tropical Institute in The Netherlands*

Each issue of this international quarterly newsletter focuses on a specific theme of HIV/AIDS-related health promotion and education. Past issues have addressed the use of theater, planning information provision to meet the needs of the target audience, and incorporating social influences into AIDS education. In 1994 the themes were out-of-school youth, sensitization and training for health promotion, health promotion for people living with AIDS, and programs in institutional settings. This English-language newsletter is sent free to individuals and organizations in developing countries or to others for an annual subscription fee of 45 Dutch guilders. For information, contact the AIDS Health Promotion Exchange, Royal Tropical Institute, Mauritskade 63, 1092 AD Amsterdam, The Netherlands

***Learning about AIDS: Everybody's Job. Popular Education in Health, the Lutheran Evangelical Church in Chile***

Published in 1992 in Spanish, this is one of 10 participatory games designed to educate people on health. With a board, counters, dice, and question cards, this game provides information on AIDS, creates awareness of the impact of AIDS and the need for prevention, and promotes discussion about sexual behavior. It is available for US\$20 from Educación Popular en Salud, Iglesia Evangelica Luterana en Chile, Casilla 360-11 Santiago, Chile.

***Action for Youth AIDS Training Manual. League of Red Cross and Red Crescent Societies, World Organization of the Scout Movement, 1990.***

A manual on developing AIDS prevention programs for people who work with youth in their mid-teens and older. Available in English, Spanish, French, and Arabic for 20 00 Swiss Francs from the International Federation of Red Cross and Red Crescent Societies, P.O. Box 372, CH-1211 Geneva 19, Switzerland.

***Resource Pack on Sexual Health and AIDS Prevention for Socially Apart Youth. The Appropriate Health Resources and Technologies Action Group (AHRTAG) and the Brazilian Center for the Defense of Children and Adolescents (SOS Criança), 1993.***

A manual and resource list for youth workers and educators working with young people living in the streets or in refugee camps, out-of-school youth, and other "socially apart" youth. Distributed free to groups concerned with socially apart youth in developing countries and for £5 00 sterling/US\$10 00 elsewhere from AHRTAG, 1 London Bridge Street, London SE 1 9SG, United Kingdom, fax: 44 71 4036003, or SOS Criança, Caixa Postal 4884, Ag. Central, CEP 20 100, Rio de Janeiro - RJ, Brazil, fax: 55 21 2274029.

***Karate Kids. Street Kids International***

A 20-minute adventure cartoon and accompanying materials designed to promote discussion about health and AIDS among street youth. The Karate Kids package, which includes one copy of the video in any format (VHS or Beta, PAL, NTSC, or SECAM), two copies of a handbook for educators, and six copies of a pocket comic book, is available in 17 languages for US\$60 (includes shipping).

Additional handbooks are US\$3 00 per copy, and pocket comic books are US\$40 00 for a pack of 144. A "no charge" option is available for groups that cannot afford to pay, requiring a letter explaining the nature of their work, whom they serve, and why payment is impossible. Street Kids International, 55 The Esplanade, Suite 202, Toronto M5E 1A7, Canada, fax 1 416 8619386

***Unmasking AIDS, International Planned Parenthood Federation***

A 40-minute video with a teaching guide describing how drama can be used to educate young people about HIV/AIDS. Available in English (NTSC or PAL format) for £30.00 sterling; £20 00 sterling for developing countries, including postage) from the International Planned Parenthood Federation, P O Box 759, Inner Circle, Regent's Park, London NW1 4LQ, United Kingdom, fax: 44 71 4877950

***WHO Publications***

Allgeier, E *HIV/AIDS and Sex Education Strategies* Geneva WHO, 1993

*Comprehensive School Health Education* Geneva WHO, UNESCO, and UNICEF, 1992

*Counseling Skills Training in Adolescent Sexuality and Reproductive Health, a Facilitators' Guide* Geneva WHO, 1993

Ford, N, et al *Review of Literature on the Health and Behavioral Outcomes of Population and Family Planning Education Programmes in School Settings in Developing Countries* Geneva WHO, 1992.

Grunseit, A and S Kippax *Effects of Sex Education on Young People's Sexual Behavior* Geneva WHO, 1993.

*Guide for Developing Health Promotion Projects for Aids Prevention among Out-of-school Youth* Geneva WHO, 1994

King, A J C and N P Wright *Aids and Youth an Analysis of Factors Inhibiting and Facilitating the Design of Interventions* Geneva WHO, 1993

*School Health Education to Prevent AIDS and STD* AIDS Series #10 Geneva WHO and UNESCO, 1992 (Swiss Francs 12 60 in developing countries, Swiss Francs 18 00 in developed countries.)

*School Health Education to Prevent AIDS and STD a Resource Package for Curriculum Planners* Geneva WHO, 1994.

*A Study of the Sexual Experiences of Young People in Eleven African Countries the Narrative Research Method* Geneva WHO, 1992

### ***AIDS Educational Game. Teaching-Aids at Low Cost (TALC)***

This game is a sexual health teaching tool for children, youth and adults. Players move around the board, which is designed to resemble "Snakes and Ladders," after correctly answering questions about HIV/AIDS. The game contains two sets of questions--one for children of upper-level primary school age, the other for adolescents and adults. The cost is £5.25 (including surface postage). Contact TALC at P O Box 49, St Albans, Herts AL1 5TX, United Kingdom, fax 44 172 784 6852

### ***Working with Young People on Sexual Health and HIV/AIDS. AHRTAG & Hand-in-Hand Network***

This 64-page illustrated resource pack is designed to help health workers, community educators, and teachers address sexual health and HIV/AIDS issues with youth. It includes a list of more than 80 key resources, which range from training manuals and teaching tools to games and comics. All are adaptable for use in developing countries and are available at low cost or for free. This resource pack is free to people in developing countries and £5/US \$10 for readers elsewhere. Contact the Hand-in-Hand Network, c/o AHRTAG, Farringdon Point, 29-35 Farringdon Road, London EC1M 3JB, United Kingdom, fax 44 171 242 0041; or e-mail [ahrtag@gn.apc.org](mailto:ahrtag@gn.apc.org)

### ***AIDSCaptions Articles***

Abang, Mkpe. "Promoting HIV/AIDS Prevention On Nigerian Campuses: Students Take the Lead."

Baldo, Mariella. "OPINION: Time to Act: Sex Education for Adolescents."

Black, Bill "Award-Winning Mass Media Campaign Hits Home with Dominican Youth "

- Filgueiras, Ana "Defending Children's Rights. An AIDS Prevention Strategy."
- Henry, Kathleen "AIDS and Adolescents Protecting the Next Generation "
- Henry, Kathleen "Positive Vibes in Jamaica' Drama Helps Teens, Parents and Teachers Discuss Sexuality and AIDS "
- Henry, Kathleen. "Saving a Generation' Ethiopian Youth Rally to Prevent HIV/AIDS "
- Henry, Kathleen. "Straight Talk for Youth Ugandan Girls and Boys Learning to Escape Gender Stereotypes "
- Rau, Bill "Influencing HIV/AIDS Policy in Kenya NGOs Build Consensus "
- Sharifin, Halima "AIDS Education Efforts Begin to Address Plight of Tanzanian Youth "

***Oral Sessions on HIV and Youth: Meeting the Challenge, from the USAID Prevention Conference***

- "Perspectives on AIDS Education in Primary Schools Evaluation of the HIV/AIDS Education Orientation for Primary School Teachers in Malawi " Presenter Ruth Kornfield John Snow Inc - STAFH, Washington, DC
- "Youth Peer Education An HIV Intervention Strategy in Rakai District, Uganda " Presenter Eddie Mireego, Rakai AIDS Information Network, Kalisizo, Uganda
- "Knowledge, Attitudes, Beliefs, and Behaviors Regarding the Sexual Activities of Girls in Traditional Authority Kalolo, Lilongwe District, Malawi " Presenter Marjorie Ngaunje, Society for Women and AIDS in Africa-Malawi Branch, Lilongwe, Malawi
- "Attitudes towards Virginity and Their Effects on Sexual Behavior in a Sample of Sri Lankan Youth " Presenter P U Ratnayake, Faculty of Medicine, Department of Psychiatry, Mahayana, Kandy, Sri Lanka
- "Mothers and Daughters How the Relationship Affects HIV Risk of Low-income Adolescent Females in Recife, Brazil " Presenter Ana Vasconcelos, Casa de Passagem, Recife, Brazil