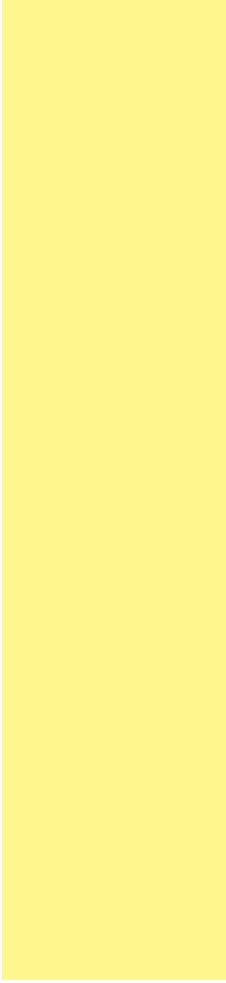


Hands on!

A Manual for Working with Youth
on Sexual and Reproductive Health



4320 Health and Population

Supraregional Project: Innovative Approaches in Reproductive Health



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Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ) GmbH

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BMZ	Federal Ministry of Economic Co-operation and Development
CIFRA	International Course for Action Research Training
DHS	Demographic and Health Survey
FGM	Female genital mutilation
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH (German Technical Cooperation)
HIV	Human Immune-deficiency Virus
IEC	Information, Education, Communication
KAP	Knowledge, Attitude, Practice
NGO	Non-governmental organisation
PRA	Participatory Rapid Appraisal
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Introduction: Working with Youth on Sexual and Reproductive Health

Context¹

Today's generation of young people is the largest in history: 1.7 billion 10-24-year-olds make up more than one-fourth of the world population. In many developing countries the same age group accounts for about 30% of all inhabitants representing an enormous momentum for population growth. But youth² are not only important as a demographic factor. In the face of widespread poverty, socio-cultural transformation and AIDS-struck families they carry heavy socio-economic responsibilities, too. How well they can perform these socio-economic tasks depends largely on their health and skills.

While the spontaneity, enthusiasm, openness and readiness to take risks inherent in adolescent behaviour can represent an important impulse for development processes of the community they live in the very same characteristics frequently result in adverse health outcomes. Among the main causes of mortality and morbidity in young people are violence, accidents and sexual and reproductive ill-health:

- More adolescent girls (15-19 years) die from complications of pregnancy, abortion and childbirth than from any other cause
- 15-24-year-olds have the highest rates of sexually transmitted infections including HIV (60% of new HIV infections with 2/3 of them in girls)
- One to two thirds of rape victims worldwide are age 15 or younger and many first-time sexual experiences in developing countries are non-consensual
- Each day an estimated 600 girls are at risk of being genitally mutilated.

Adolescence is a crucial phase for the development of behaviours and practices, which greatly affect the health status of adults,³ and thus makes young people the ideal target of health promoting interventions. Attitudes and behaviours formed in the physical and psychological maturation process are crucial to the current and future Sexual and Reproductive Health (SRH) of individuals, and affect the well-being of their families and communities. The importance of addressing young people in particular lies not only in their perceived improved behaviour as future adults. As trained "youth promoters" they are also instrumental in sensitizing adults and peers alike. This is one way of young people being true "agents of change".

The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH has been actively promoting young people's reproductive health and rights previous to but especially since the 1994 International Conference on Population and Development. This promotion takes the form of support and technical advice to local governmental and non-governmental organisations supplemented by cooperation with international partner organisations. Currently, GTZ is supporting some 40 projects, which address adolescent SRH at different levels and scales in the contexts of health, education or youth promotion and with a special focus on prevention.

¹ Figures: The World's Youth 2000, PRB/Measure

² International discourse differentiates adolescents (10-19 years), youth (15-24 years), young adults (20-24 years). All of them make up young people (10-24 years)

³ According to WHO, approx. 70% of premature deaths among adults are due to behaviours initiated in adolescence.

Interventions range from direct distribution of informational materials, capacity building and the provision of comprehensive services to the steering of complex multisectoral networks and policy advice. The challenge lies in marrying up macro and micro level.

Some of the experiences drawn from such interventions have been compiled by GTZ's supranational project *Innovative Approaches in Reproductive Health* in this recipe-like manual with a view to disseminating lessons learnt. The publication at hand aims to facilitate the replication and scaling up of successful interventions thereby improving young people's life perspectives and access to adequate SRH information and services.

Content

Hands On! A Manual for Working with Youth on Sexual and Reproductive Health lays out useful methods and approaches to support technical co-operation personnel and their partners in the development and implementation of SRH measures with young people in a practical way. It consists of 16 separate yet complementary papers written largely by practitioners from the field. Instead of long theoretical discourses, authors use examples and checklists. All methods and approaches described can be adapted to different settings and various topics.

Part one, Methods, consists of a step-by-step guide to a situation analysis, description of methods for baseline data collection, tools for participatory rapid appraisal and indicators for monitoring and evaluation. Part two, Approaches, contains among others checklists for peer education, guidelines for the development of IEC material, theatre plays, or sports activities, and how to support youth organisations and cross-sectoral networking.

The ensemble of articles is not meant to be exhaustive on the topic. However, they reflect major experiences from technical cooperation projects supported by GTZ. Further contributions are currently being developed which will subsequently be distributed to those who wish to obtain this resource.

Part One – Methods: A situation analysis provides a quantitative and qualitative description and analysis of the target group youth and their life worlds, which may inform the project planning or implementation phase. Elisabeth Girrbaach identifies steps and key players involved in conducting a situation analysis and draws up a detailed checklist what issues and questions ought to be tackled with regard to adolescent SRH.

Regina Görden explores select methods for baseline data collection to ascertain the knowledge, attitudes and behaviour of young people on SRH issues. She finds that these methods are useful for designing effective youth programmes, raise the community's willingness for action, and provide a baseline for further evaluation.

Based on the planning of a non-formal education project in Uganda, Julika Rollin offers guidelines and tools to empower adolescents to express their opinions and describe their life worlds using Participatory Rapid Appraisal (PRA). The research results have the scope to be highly relevant to the development of project activities, raise the enthusiasm and skills of the young people involved, and change their attitudes beyond the research setting.

In the process of Action Research health personnel, social workers, teachers and staff of NGOs investigate into their own field of work. They identify barriers for the access of youth to information or services and develop appropriate solutions for the major problems identified. Petra Ruth, Doris Popp and Annette Gabriel lay out the practical steps that are taught and applied by the International Centre for Action Research Training (CIFRA) in Burkina Faso.

The monitoring of programme progress and the evaluation of project success is based on the repeated measurement of indicators for Monitoring and Evaluation. Cordula Schümer discusses and defines useful input, output and outcome indicators for adolescent SRH.

Part Two – Approaches: Youth Policies consist of public actions that seek to generate and maintain conditions under which young people can maximise their potential and participate in society in as varied and self-reliant a way as possible. Miguel Abad warns of the difficulties of effective implementation and develops an alternative to conventional youth policies in Latin America.

Anja Nina Kramer and Regine Meyer discern from their experiences in Nicaragua the development of inter-sectoral youth promotion in the form of a commission made up of the target group youth, non-governmental and governmental organisations. Such systemic intervention can affect attitude and behaviour change within institutions through capacity building, reorientation of health services, support of joint SRH-related activities, and the promotion of a health-oriented overall policy.

Babette Loewen proposes how to either strengthen existing or initiate new youth organisations, with reference to numerous examples. Co-operation with institutionalised youth groups is useful for socio-political youth representation, and the development of SRH activities relevant to the adolescents' needs.

Sexuality education should be introduced into the school curriculum before young people become sexually active, and ideally progresses gradually, with appropriate values, information and skills conducive to promoting SRH conveyed at different ages. The paper by Gabriele Gahn offers tips and a checklist how to initiate sexuality education.

In her paper, Gaby Supé outlines the principles that guided the setting up of an information centre on youth health in the Central African Republic. Such centre tends to be a welcome place for leisure activities combined with information and counselling facilities. For multiple relevant considerations, the author describes the criteria and decisions taken, and identifies the strengths and weaknesses of her experience, in a manner easy to replicate.

Public health facilities have a responsibility to offer services and counselling regarding sexually transmitted diseases, HIV/AIDS, family planning, etc. to young clients. Christina Neckermann explains why and how to make health services attractive to youth.

Peer education combines several crucial factors in adolescent SRH promotion, namely strong identification of the facilitators with the socio-cultural environment of the target group, promotion of positive attitudes and healthy behaviours, and youth participation in programmes targeted at them. David Blankhart presents some of the features, advantages, challenges and limitations of the approach, and provides practical tips and “to-do” checklists for the implementation of peer education programmes.

In Theatre for Development young people develop a play for instance on SRH, and in an interactive performance with the audience spark off impulses for attitudes and behaviours conducive to SRH. Marita Klink considers the approach in the project context, ranging from the key players and logistics required to evaluation.

On the one hand, sport can have a positive impact on the body and fitness, and on the other hand it promotes a positive self-perception and identity, a sense of solidarity and trust, representing a useful platform to address issues of SRH. Tanja Kreiß and Babette Loewen first conceptualise the multiple useful effects of sports, and then identify various possibilities of sports activities in the project context.

An active involvement of adolescents in Information, Education, Communication (IEC) media development is indispensable for ensuring that SRH messages are appropriate and effective. Regina Görden, Babette Pfander, Juma Bakari and Akwillina Mlay present their experiences of successfully involving youth in Tanzania in the design and production of two kinds of SRH education materials: question and answer booklets, and a youth soap opera.

Finally, Petra Ruth’s paper deals with a particular sub-group among adolescents: Identifying particular characteristics of rural youth, such as insufficient infrastructure, and a traditional hierarchical social structure, she proposes four approaches to promote their SRH.

Each paper can obviously be read on its own, and you can take any one out of the folder for easier handling. The format of a file also allows for easier revision and additions. We would be grateful for comments, recommendations or criticism, which we will attempt to incorporate in future editions.

We would finally like to thank – first and foremost - the authors who bore with us through several versions and shared with us their valuable knowledge. Our thanks goes also to Joanna Kotowski for her review and valuable comments, and – last, but not least – to Julika Rollin for orchestrating and editing this oeuvre.

We trust that this handbook meets your interest and requirements.



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I Methods

1.1 Situation Analysis

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Introduction

This paper provides a themes and question checklist that will support professionals wishing to work in the field of sexual and reproductive health (SRH) of young people in the planning and implementation of a situation analysis. It concentrates on the description of the methods, procedures and main content of a situation analysis. According to the focus of a given measure the need for information varies, as does the availability of resources, personnel, time and financial means which determine the conceptualisation of a situation analysis.

The Situation Analysis in the Project Cycle

The situation analysis serves primarily to clarify the initial situation of a target group regarding a particular matter during the planning phase of a project. It can also be used before the introduction of new components into the project, or during the implementation of a project with the aim of improving or adapting the previous planning, intervention and activities (GTZ 1995). Frequently, however, a situation

Definition: Situation analysis

The situation analysis offers a quantitative and qualitative description and analysis of those concerned/the target group(s) and their living situation. It should take into consideration both the emic or target group's perspective, 'from the inside', and the etic or scientist's viewpoint, 'from the outside'.

analysis is carried out neither with the necessary quality nor at the ideal time (BMZ 1995). As a situation analysis primarily answers the need for concrete information concerning a particular project, only those data should be collected which are genuinely meaningful in relation to planned project activities and provide a database for the monitoring of indicators in the future.

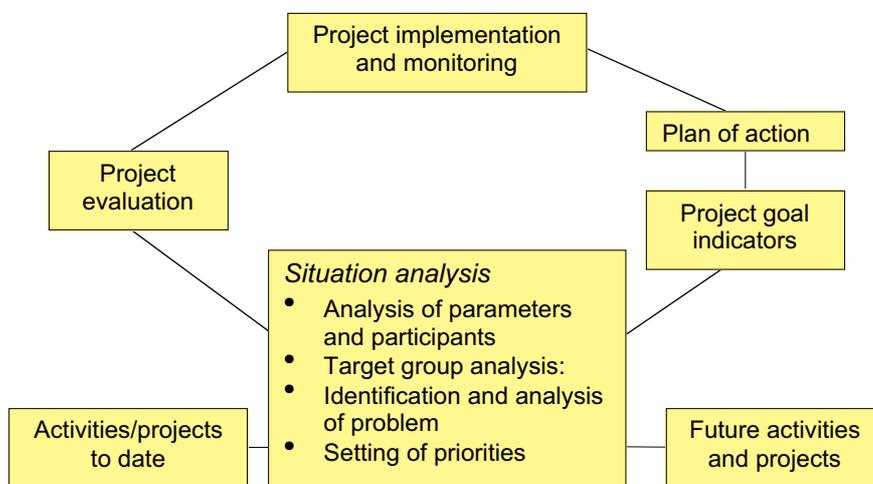
The situation analysis can comprise the following individual analyses:

- Analysis of parameters;
- Analysis of participants;
- Gender-specific target group analysis of young people
(Characterisation of the target group and the context: Knowledge, Attitude, Practice [KAP] of youth in relation to SRH; situation of adolescent health).

To obtain the most comprehensive picture of the SRH of young people, all partial analyses should be carried out. The **analysis of parameters** defines the legal, sector-political conditions and problems, which is rounded off by taking stock of all existing and potential actors, previous interventions and extensions of the programme. A **social differentiation** (demographic data, socio-cultural context) and inquiries into the health situation of young people and their health-related behaviour is presented from a scientific standpoint. This identifies and analyses the problems and life worlds of the target group.

The **target group analysis** collects differentiated information concerning the youth's living situation and room for manoeuvre; it ascertains their points of view, perceptions and interests, needs and opportunities to act in relation to future interventions (emic perspective), in order to, amongst other things, examine the risks and impact of a project idea/strategy (Forster & Osterhaus 1996). In order to use the results of the studies, priorities for future interventions are set based on completed data. A situation analysis does not replace participatory planning and implementation or decentralised decision-making processes at the target group level, but may support the participation of those involved in the project, in that they are involved both in the preparation of the study and in the evaluation of the results.

The situation analysis in the project cycle



(CIFRA 1999: 20; adapted by the author)

The Stages of a Situation Analysis

Various methods and approaches are appropriate to situation analyses and can be employed, flexibly and independently of one another, according to the need and available resources. Situation analyses in the area of adolescent SRH generally use a procedure that combines both quantitative and qualitative methods from the health and social sciences. Individual methods that involve youth in research work will not be looked at closely here (see Rollin and others in this publication). The methods chosen should be time-efficient for the participants.

Collection and analysis of available data and secondary literature

- Medical statistics;
- Data from state records (health, education, population sectors);
- National or regional health surveys and household polls;
- Existing study results and reports relevant to young people.

An inventory is necessary in order to gain an overview of the issue and to verify the validity of one's own statement of the problem, via the available data. It should be undertaken with great care since it may reduce costs, the likelihood of mistakes being made during one's own implemented study and the chances of superfluous surveys being undertaken. The availability, quality and geographical classification of the existing data must be assessed. Only when missing data and lack of quality are established, should the next step follow.

Own, new data surveys with quantitative methods

- Epidemiological surveys;
- KAP studies of young people;
- Standardised, structured interviews concerning the young people's living situation and their priorities and potential.

Quantitative methods are recommended when one would like answers to the following questions: 'How much...?', 'To what extent...?', 'What is the magnitude/nutritive value...?', 'What is the difference between two sizes...?'. They ascertain the extent and frequency of and discover relationships between variables and examine their significance.

Own, new collected data using qualitative methods

- Structured individual and group interviews with young people and other key players;
- Narrative interviews;
- Informal conversations;
- Participatory Rapid Appraisal (PRA);
- Focus group discussions;
- Participant observation.

The qualitative methods are suitable for 'Who/Which/When/Where/How...?' questions (CIFRA 1999, WHO 1993).

Participants in a Situation Analysis

Team Line-up

At the outset all persons and institutions should be identified who will participate in the survey or will implement the results. If a situation analysis is decided for, the counterparts should clarify their goals and expectations of the investigation. The team responsible for the investigation should comprise 2 to 5 people - preferably mixed gender, from various disciplines (e.g. health, social sciences, economics) with experience of various methodology. This team instructs interviewers for the investigation, such as peers, facilitators and doctors. The effectiveness of a situation analysis improves greatly when collaborators from partner organisations (as far as these are already identified) are integrated into the investigation team.

Target Group Youth

Young people are the first and most important source of information for the situation analysis and should be involved in the survey and planning of the project activities, so that there is a higher guarantee of the long-term relevance, acceptance and effectiveness of the programme (Mensch *et al* 1994).

Participants in the Investigation

The participants in a **qualitative analysis** of the target group should preferably be representative of their age group and social context in that they cover various criteria such as gender ratio, differing social and ethnic milieu, trainees, youth working in both the formal and informal sectors, unemployed youth and those in particular risk and crisis situations (such as street children, teenage prostitutes, refugees and orphans). They should also be drawn from a variety of places of investigation such as urban/rural areas, private and public schools, youth centres and other leisure facilities. Care should be taken not to distort the findings by e.g. concentrating on easily accessible places. The number of interviewees can be adjusted during the implementation of the study according to the complexity of the attitudes and behaviour and should comprise 20 to 60 young people.

The rule in the choice of participants in a **quantitative analysis** is: the greater the sample, the more representative. Thus the more conclusions can be drawn concerning young people as a whole (see also Görden in this volume). The planned study should comply with World Health Organisation (WHO) ethical standards.

Themes and Question Checklists

The following checklists offer a content structure for the situation analysis. The strategic orientation of the given measure dictates to what extent and with what intensity the questions within the parameters of the situation analysis are to be treated. The goal here is to offer a general overview, even though in the project context the complete lists may not be of importance.

Analysis of parameters	
Legislation and guidelines	<ul style="list-style-type: none"> • Marriageable age, allocation of contraception to adolescents, abortion, access for pregnant girls to school, female genital mutilation (FGM), sexual violence. • How is youth defined by current legislation?
Youth-related sector policies (education, youth, family and sport, social affairs)	<ul style="list-style-type: none"> • What status does the topic of youth have within the country? • Which youth policies and programmes are developed and implemented? • How are youth rights defined, specifically the sexual and reproductive rights? • Are girls/boys banned from school in the case of pregnancy/paternity? • How are young people politically and administratively represented?
Sector policies: health	<ul style="list-style-type: none"> • Do specific adolescent health programmes/policies exist? • Is contraception offered to adolescents? • Has the state adopted cost-sharing for contraceptives? Is there a special price regulation for the sale to young people? • In which programmes are condoms offered to adolescents? • Which approaches and services are developed and implemented specifically for adolescent health? • General health data: mortality/morbidity data, STD, HIV/AIDS rates etc.
Cultural and socio-economic background	<ul style="list-style-type: none"> • Poverty-related data, economic development in the region/country, traditional gender roles, meaning of sexuality in the cultural context. • How is youth perceived in the 'traditional' context?

Institutional analysis: Associated and existing programmes	
State institutions/Politicians	<ul style="list-style-type: none"> • Which institutions/organisations work in the area of youth? (Health, education, training, leisure activities, drug and violence prevention, income-generating activities, etc.) With which institutions could a co-operation take place? What is their main emphasis, approach and attitude to young people? • Are the sexuality and its varied expressions of unmarried adolescents accepted as a natural manifestation of life? What roles are assigned to female/male adolescents? • Which formal/non-formal education programmes exist to date? Improved curricula, family-education programmes? Which age group? Which type of school? What percentage of the young people is reached? • Who are the providers and facilitators of the programmes? How many are there? How and by whom are they trained? How is the quality and content of the programmes offered? • Do further relevant projects exist, such as sensitisation campaigns in the media, life-skills training, drug and violence prevention programmes...)? • Which of the participants have been involved in the programme so far (parents, teachers, health services...)? What are the main emphases of the promotion (age group, sub-groups)? • What were the successes and failures to date?
International donors	
Non-governmental organisations	
Confessional sector, social services	
Self-help organisations	
Media	
Religious authorities	
School authorities	
Teachers and other educators	
Public health services and personnel	
Private services in the health Sector	
Peers, facilitators	
Youth (see target group analysis)	

(GTZ 1997, GTZ 1998, Kotowski-Ziss 1997)

Characterisation of the target group and the context (gender-specific differentiation)	
Socio-demographic data	<ul style="list-style-type: none"> • Proportion of youth in the population as a whole, age structure, distribution of sexes, size of the target group? • Proportion of married adolescents (by age and gender)?
Level of education	<ul style="list-style-type: none"> • Enrolment rate, literacy rates?
Socio-economic data	<ul style="list-style-type: none"> • Financial dependence on parents or partner, own income due to informal work, other takings (allowances, pocket money). • Overview of young people's occupation: profession, employment (formal and informal sector). • Prostitution as a means of making money, as a survival strategy. • Expenditure for contraception/health treatment. • Expenditure for the use of commercial sex.
Sub-groups, special risk groups	<ul style="list-style-type: none"> • Which sub-groups exist, which should be approached? • Schoolchildren, particular ethnic groups, child household heads; trainees; child workers in the formal and informal sectors; unemployed youth, schoolchildren; youth in particular risk and crisis situations e.g. street children, young prostitutes, refugees, orphans, girl groups, boy groups?
Socio-cultural context	<ul style="list-style-type: none"> • Common understanding of adolescence and youth? • Influence of culture, religion, taboos, tradition, value system? • Does a gender preference exist in the culture? • Gender roles, what course does socialisation take? • Roles and responsibilities by age cohort? • How is (sexual) violence perceived and evaluated? (As an expression of manliness?) • Who are committing the acts of violence? • Role expectations of youth: expected/socially accepted behaviour in relation to own and the opposite sex, role models?
Problems and their perception	<ul style="list-style-type: none"> • What are young people's main problems, which could the project address? • Their goals, needs, priorities, worries, fears, preferences and potential in relation to the planned measures?
Potential and resources	<ul style="list-style-type: none"> • What potential and resources exist? What support do the young people perceive themselves as needing? • What organisational forms have young people developed in order to handle their problems themselves (groups, level of organisation)? • From which organisation do the young people get support; how do they claim it?

Knowledge, Attitude, Practice (KAP)	
Knowledge	<ul style="list-style-type: none"> • Sexuality, contraception, HIV/AIDS and sexually transmitted diseases, (sexual) violence?
Practice	<ul style="list-style-type: none"> • First sexual intercourse, age, voluntary or forced, type of sexual intercourse? • Number of sexual partners? • Current partner (age, profession)? • Sexual intercourse in the previous month? • Use of contraceptives and condoms? • Sickness and handling of sexually transmitted diseases (STDs)? • Experience of pregnancy and abortion? • Circumcision, FGM (if practiced)? • Practiced or suffered from (sexual) violence, and demand for help?
Attitude	<ul style="list-style-type: none"> • Sexuality before marriage? • HIV and own perception of risk? • Modern contraceptive methods? • Circumcision and FGM (if practiced)? • Pregnancy before marriage? • Relationship between man and wife, (sexual) violence?
Sources of information	<ul style="list-style-type: none"> • Where and how do young people get their information (friends, family, media, school etc.)?
Communication between female and male adolescents	<ul style="list-style-type: none"> • Ability to communicate, decision-making capacity and ability: who makes the decisions between boys and girls about sex, contraception, or termination of a pregnancy?
Communication between adolescents and parents	<ul style="list-style-type: none"> • How is the communication with the parents? Is sex talked about? Are parents involved in relationship matters?
Leisure-time behaviour	<ul style="list-style-type: none"> • Does this concept exist? If so, how is leisure-time spent? • Are there youth centres, leisure activities, who uses them (according to social positioning and gender)?

Adolescent health situation	
Health situation: morbidity and mortality indicators	<ul style="list-style-type: none"> • Frequent illnesses and their causes? • Age-related rates of fertility in married and unmarried adolescents? • Frequent causes of death for adolescents (nutritional situation, violence, drugs, suicide, illnesses etc.)? • Risk behaviour: drugs and alcohol consumption, unprotected sexual intercourse?
Prevalence/incidence	<ul style="list-style-type: none"> • Use of (modern) contraception among married and unmarried adolescents? • STDs (alternative: number of youth seeking services which treat STDs, syphilis, prevalence in pregnant girls)? • HIV/AIDS (usually information concerning HIV/AIDS can be found in the data from antenatal check-ups)? • Use of condoms (ever used/used during first sexual intercourse/regular use)? • Circumcision and FGM? • (Sexual) violence inside and outside the family and its consequences (termination of pregnancy, expulsion from school, depression, adoption of high-risk behaviours)?
Supply position (Public health resources)	<ul style="list-style-type: none"> • What access do adolescents have to advice and services? • What services exist (sexual advice, offers of contraception and condoms, treatment of STDs, advice on drugs, advice to victims of violence, etc.)? • What are the sources of information for young people (brochures, radio programmes, TV, soap operas, posters)? • What is the availability and quality of information material? • Which are the youth's preferred sources of information? • Offer and use of medical, advisory and legal help for victims of violence? • What do the services look like (personnel, professional groups, furniture)? Do youth use public health centres? • Are there youth-friendly services? For whom (in school/out-of-school)? Where? • Are contraceptives, medical treatment, advice and medicine financially and geographically available for adolescents? • What is offered through the private sector and how much is this used? • Do other sectors offer advice (e.g. advice before marriage concerning family, running a household)?

Evaluation of the Results of the Study and Selection for Implementation

The analysis occurs on three levels:

1. Description of the most important questions and test variables,
2. Study of the relation between main variables, to find out possible causes and contexts.
3. Identification of newly raised and unanswered questions or questions which were not initially taken into consideration.

The evaluation of the study-team's results should be presented in a workshop to the participants (*i.e.* team, representatives or interviewees), the decision makers (partner organisations, ministries) and the institutions which will want to work with the results of the study. The participants and interested parties will be given the study report.

During the presentation of the results the lines of conclusions play an important role, so that facts become future activities. The participants identify together what the young people and other persons concerned wish to/can change.

Lessons Learned

Projects are most successful and lasting when young people are not handled as a homogeneous mass, and the data evaluation from the situation analysis is carried out in as much detail as possible, since youth *per se* does not exist (Fischer *et al* 2000).

Projects often suffer from a missing or insufficient situation analysis, which entails that the project goal is too vaguely or unrealistically defined and the needs and potential of the target group youth are not taken into enough consideration (Augustin 1996, Forster & Osterhans 1996).

The point of a situation analysis is realised when on the one hand participation or 'ownership' of the young people is guaranteed, and on the other hand those responsible for the programme are willing to use results for the project conception, or improvements to existing programmes, and translate results into activities (WHO 1997).

Situation analysis in basic health project Mahajanga, Madagaskar, 1998	
Main themes	<ul style="list-style-type: none"> • KAP study of SRH • 'Localisation of youth': the living situation and leisure time behaviour of girls and boys • Communication behaviour between adolescents, and between adolescents and their parents. • Attitude and perception of the participants (parents, teachers, authorities)
Study team	<ul style="list-style-type: none"> • 1 partner expert, responsible for youth (female doctor), 1 field-staff member (ethnologist, public health) • 2 local experts (female doctors), 1 consultant (statistician) • Interviewer: from a pool of trained peers, disseminators, doctors
Method	<ul style="list-style-type: none"> • Structured, individual interviews and focus group discussions with boys and girls in school, working youth, parents, local authorities
Some results	<ul style="list-style-type: none"> • Adolescents do not see love, sexuality and questions of health as high priority • Sport is the main leisure activity, youth centres are rarely used • Among youth enrolled in school, decisions concerning sex, contraception, pregnancy and abortion are made by the boys; among working youth, decisions are made equally by both young men and women. • Sex and love are talked about with their parents but 50% of the young people feel their parents do not understand them. • Adolescents prefer to use health workers as advisers concerning sexuality and contraception, with teachers/pedagogical personnel in second place.
Implementation	<ul style="list-style-type: none"> • Training teachers and health workers in advising youth • School-based information events concerning sexuality, reproduction and contraception, health. • Providing a reproductive health service for youth within schools which complements the existing public services.

(Randriamialisoa & Girrbach 1998)

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1.2 Methods for Baseline Data Collection

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Introduction

Since young people are a heterogeneous group in terms of age, sex, education, socio-cultural environment, economic conditions, etc., assessing their actual behaviour and needs is imperative for designing potentially successful projects for and with them. Effective and, where possible, standardised tools are needed in order to analyse problems and collect baseline data. Based on research in Burkina Faso, Guinea and Tanzania, this paper explores select methods of ascertaining the knowledge, information needs, attitudes and behaviour of young people on sexual and reproductive health (SRH) issues. We found that the results were useful for designing youth programmes and, moreover, that confronting teachers, parents, local authorities and decision-makers with local findings had a tremendous influence on their willingness for action. Finally, the data provides a baseline for further evaluation.

This paper starts with a brief introduction to methodological issues which can assist the reader in choosing an appropriate method or a combination of different methods. In the second part, the planning and deployment of three simple methods, which have proven useful for working with adolescents in primary and secondary schools, are described in detail, namely:

1. Collecting anonymous questions (quantitative and qualitative)
2. Self-administered questionnaire (quantitative)
3. Paper Slip Method (quantitative and qualitative)

These methods may also be adapted to different settings (e.g. youth centres, vocational training centres etc.) and other age groups.

Methodological Options in the Field of Sexual and Reproductive Health

Choosing appropriate methods for studying sexual behaviour requires looking at various methods, their documented strengths and limitations, and their ethical acceptability. We suggest that both qualitative and quantitative approaches are needed for behavioural research. The aim of qualitative research into sexual behaviour is to gain insights into the personal and social context of sexual activity. Quantitative research provides data on how many people show defined knowledge, attitudes and behaviour, but it does not answer questions about what they do and why they do it.

Quantitative Methods

In research on sexual behaviour the scope of methods to be used is limited by the very nature of the behaviour under study. Self-reported behaviour is the most commonly used method, usually by way of formal surveys with closed or open questions. One strength of this method is

its high degree of standardisation and comparability of data. Its key problem is that of validity: are people able or willing to tell the truth if interviewed on intimate aspects of their life? Moreover, the specificity of the cultural and personal context lived by different social groups is ignored, and the same question may mean different things to people of different cultures. Experience with Demographic and Health Surveys (DHS) has shown that the non-response rate due to discomfort is usually low. Methodological studies evaluating the validity of self-reporting on sexual behaviour have shown that it largely depends on the specific behaviour assessed and might be different for different questions in the same survey according to the social desirability of the answer (Mac Laws *et al* 1990, Dare & Cleland 1994).

Other factors which might influence the validity of the findings include gender, appropriateness of the language used to explain the research objective and procedure, appropriateness of the terminology used in the questionnaire, and the relevance of the topic to the target group. Different procedures have been developed to enhance the likeliness that participants will give a true account:

1. **Anonymity:** omitting data on individual characteristics, or using self-administering questionnaires which avoid face to face communication with an interviewer;
2. **Discretion:** no other people present;
3. **Special wording** of questions so that the behaviour asked for appears as common and normal;
4. Designing the questionnaire in a way that sensitive items are embedded in a **non-threatening context** or, on the contrary, embedded in a context of more threatening items, so called throwaway questions.

Qualitative Methods

Qualitative methods are characterised by an open procedure, trying to determine what exists, which allows people to voice their opinions, perceptions, values and experiences as they see fit. Qualitative methods potentially provide a comprehensive picture of a setting and its complex dynamics. In addition to the classic methods - observation, interview and document analysis - there have recently evolved so-called projective techniques such as role play analysis, commenting on posters, or body mapping. In essence they try to provoke respondents into giving a meaning and an interpretation to stimuli presented to them or produced by them (Maier *et al* 1994).

A wide range of qualitative research methods has been used to study sexual and reproductive behaviour. The most favoured methods are semi-structured individual interviews, focus group discussions (Krueger 1990) and observation in meeting places like bars, clubs, discos or in health services. The Adolescent Health Programme of the WHO has developed the narrative research method to study the sexual behaviour of young people. This method combines the development of relevant questions through role plays with a questionnaire (WHO 1993).

Sampling: In qualitative studies, sampling is usually intentional; people with specific characteristics, behaviour or experiences are chosen rather than taken from a random cross-section of the population.

Representation refers to whether the people participating in the research are representative of the culture, the community, or a specific subgroup. 'The most useful generalisations from qualitative studies are analytic, not sample-to-population' (Miles & Huberman 1994:28).

The **validity** in qualitative research stems from a lengthy and continuous process of data collection using a systematic and repeated shift from the outside (etic) to the inside (emic) perspective. Different procedures are described to verify the data such as face or communicative validation (presenting data and analysis in a feedback process to the informants) or triangulation (using a combination of methods).

Ethical Considerations Regarding Research on Sexual Behaviour

The study of sexual behaviour implies eliciting information about an intimate sphere of human life, and the interference of the researcher might easily violate the individual's right to respect and discretion. The more overt the research the more likely it is to get socially desirable accounts. The more covert the more likely to detect people's genuine feelings. The growing need for research in the field of sexuality has created awareness of the necessity to define ethical principles applicable in sexual behaviour research.

Principles governing research with human subjects in other fields are equally applicable to research into sexual behaviour:

Risk versus benefit: Sexual behaviour research has to be especially vigilant about the question of whether the risk to the individual might be outweighed by the benefit to the community. No survey should be organised without linkage to a service for the communities under study.

No harm: Research should not jeopardise the psychological well-being of an individual. This is especially important when doing research with minors. There should be a critical analysis concerning the level of understanding and experience of the children or adolescents addressed.

Confidentiality: Interviews should be conducted in a private context or the questionnaire should be self-administered to guarantee respect and privacy if individual behaviour or experiences are asked for. Confidentiality refers also to the facilitators and the researchers charged with data analysis. Handling of sensitive data is an important issue. Procedures of confidentiality should be made explicit to the interviewees/participants.

Autonomy: The individual's right to consent or to withdraw must be respected. Consent implies that the individuals understand what is being asked of them and their right to withdraw at any

stage of the research process. Autonomy in research with minors might include the autonomy of parents to give informed consent or to refuse participation. In developing countries especially, the question of incentives for participation has to be critically studied. For poor people material incentives may resemble coercion because they have no real choice to refuse.

Ownership of information: The organisation of feedback sessions as part of the research process is a way to respect the participants' right to obtain information on the outcome of the study.

Three Cost-effective and “User-friendly” Methods

The three methods described below have proven cost-effective, useful and user-friendly with adolescents in schools. They can also be used with youths outside school, however, some changes in design and procedure may be required.

Collection of Anonymous Questions

The collection of anonymous questions may reveal information on young people's language, priorities and information needs with regard to sex, reproduction, contraception, sexually transmitted diseases (STDs), and violence. This can be useful for developing Information, Education, Communication (IEC) measures, creating awareness in teachers and other educators about young people's ideas, or for developing curricula.

Sampling: A stratified cluster sampling procedure is recommended. One or more classes of each grade should be selected at random from a list of all classes in a given area. All pupils present on the day of the study are included. The investigation is not announced in advance.

Course of data collection: A sheet with a short introductory text is distributed inviting pupils to write down all their questions on sex, reproduction and STDs. Students are asked to indicate their sex and age. It is of utmost importance to explain the anonymity of the process. Teachers are asked to leave the classroom and one hour should be allocated for writing down questions. The completed forms are collected in a ballot box.

Coding and analysis: All of the questions are entered into a data-bank software programme (e.g. Access for Windows) and categorised according to the content of the question. The programme allows easy grouping of similar statements and a qualitative as well as a quantitative analysis.

An example from Guinea

In a study undertaken in Guinea in 1995, about five hundred pupils from grade 6 to 13 (aged 12 to 19 years) were invited to write down their questions on SRH. On average each individual wrote 7.3 questions:

The questions fell broadly into three categories:

- General questions on the existence of sex and love, and on the differences between male and female bodies;
- Biomedical questions on conception, pregnancy and contraception, and sexually transmitted diseases including AIDS;
- Questions on sexual life e.g. on sexual intercourse, on normality and abnormality, based on own experience or on hearsay.

The questions showed age and gender specific differences for some issues: Girls were more interested in getting information on pregnancy, contraception, virginity and menstruation than boys. The boys showed a stronger interest in learning about HIV-transmission, AIDS-prevention, sexual performance and the possible negative consequences of sexual intercourse. Younger pupils tend to be more interested in questions about bodily functions, while older ones are more likely to ask about emotional aspects and values.

Self-Administered Questionnaire

A quantitative survey is the method of choice if you are interested in measuring change over time: a survey at the beginning of a programme provides a baseline and the same survey is repeated after intervention. Schooling youth represent a convenient study population: easily accessible, easy to sample, and able to handle self-administered questionnaires. They can be engaged in planning and evaluating programmes for enrolled adolescents and also for out-of-school youth. In the latter case they might play the role of an indicator population. However, we should bear in mind that pupils might be an elite group or be highly gender imbalanced if overall or female enrolment rates are low. Above all, self-administered questionnaires are not appropriate when working with illiterate target groups. The following key recommendations might help in conducting a survey:

10 Steps to conducting a survey**Step 1: Design a questionnaire**

It is self-evident that the questions asked in a survey depend on your research objectives. Design a few simple questions in a youth-friendly terminology that can be answered in 20 to 40 minutes on knowledge, attitudes and behaviour, and some demographic information (see Annex 1 in this paper).

Core variables on behaviour¹ serve to measure behavioural changes over time. These refer to

- Onset of sexual activity
- Type and number of partners
- Frequency of intercourse
- Use of means of protection (condoms, contraceptives, regularity of use, current behaviour)

It is not easy to formulate **questions on knowledge**, which are useful to measure change. Multiple choice questions are most helpful when there isn't one single correct answer, e.g. 'Tick all correct methods of avoiding pregnancy'.

'Agree/disagree' statements are an easy way to **measure attitudes**, whereas filter questions (e.g. 'Have you ever had sexual intercourse? If yes..., If no ...') separate a group, and are often unknown to respondents. However, to formulate them in a culturally sensitive manner requires familiarity with young people's attitudes in a given setting. Qualitative research prior to the survey (focus group discussions, in-depth individual interviews, analysis of published research) is important for formulating appropriate statements. We do not recommend measuring attitudes by a scale (1-5) because the concept is not always easy to explain, especially to younger pupils.

There should only be a few **demographic variables** because it complicates cross tabulations at analysis, and can compromise anonymity. We recommend that demographic variables be asked at the end of the questionnaire after the other questions have been answered.

All questions should have the option 'don't know' or an option for refusal ('don't have', 'didn't experience' etc.). The students are not given a choice about their participation but they are given the opportunity of denial or non-response (matter of research ethics).

Step 2: Test the instrument

Test a draft questionnaire with pupils of different grades and sex. We have had good experiences of testing with small homogenous groups of 10 pupils (e.g. 10 males from grade 6) in which they complete the questionnaire and then discuss how they understood the questions or how the questions could be made clearer.

Step 3: Training facilitators

Train at least four facilitators (two male, two female) about how to arrange the setting, how to explain the objective and the procedure, how to protect anonymity, and how to read out each question and to explain it in the local language if necessary. A training of two to three days is sufficient.

Step 4: Sample classes and establish a schedule

Large numbers: As age and sex are key variables, a breakdown by age and sex might be useful. If cross-tabulations with other variables like religion or ethnic group are intended a quite

¹ Adapted from the indicators developed by WHO for measuring young people's sexual behaviour.

large sample size is needed. Two to four thousand students can easily be surveyed in a short period. In Tanzania 300-500 students filled in the questionnaire per school per day.

Random cluster sampling: The different school grades provide the strata for sampling.² Normally lists with all classes of all schools are available from the regional or district school administration. A defined number of classes from each grade are randomly selected based on the desired sample size. If there is a huge gender imbalance (fewer girls than boys enrolled) additional classes are selected for 'girls only'-questionnaires.

No announcement prior to survey: The students should get no prior information about the survey (to avoid self-selection). The teachers should only be given general information, e.g., that part of their teaching time will be needed for a health survey.

No search for missing cases: All individuals present on the day of the survey participate. No efforts are made to track down missing individuals another day.

One day per school: All surveys in one school should be organised on the same day. This minimises the spread of information among pupils and teachers.

At the end of the selection process a list for each school can be established which indicates the selected classes:

- E.g. Primary School xy
- Class 5 c, 6 a, 7d, boys and girls
- Class 5a, 6 c, girls only

Then schedule this selection for five class hours.

Step 5: Inform the head masters

Contact the head masters of the schools in the sample some days in advance, requesting the participation of the classes selected for the survey, and explaining that the study is about health issues. Explain in detail how the day in their respective schools will be organised. Consider whether the head masters and teachers should get to know the questionnaire only at the end of the data collection process to avoid school personnel briefing the pupils beforehand. Ideally, they will prepare two classrooms so that girls and boys can be separated and that each student has adequate space for self-administration.

Step 6: Prepare the material

Data collection in different classes of a school takes thorough preparation of the material required. We recommend filling in the code for the school on the questionnaire form in advance. Two sets – one for boys, one for girls – are always needed at the same time.

² Here, it has to be noted that in many African countries the age difference within one grade can be up to seven years in one class.

Material needed:

- Sufficient questionnaires (with the code for the school)
- Poster size questionnaires and flipchart holder (two sets)
- Scotch tape
- Pair of Scissors
- Ballot box (two)
- Ball pens (enough for all students)
- Plastic bags or files in which to collect the questionnaires of each group
- Big felt pens for labelling the different piles

Step 7: Conduct the surveys in schools

On the day of the survey the male facilitators work with the boys and the female facilitators with the girls. Teachers should be asked to leave the room. The research supervisor should circulate to make sure that the groups are not disturbed and do not lack any material.

Introductory speech: A simple introductory speech which arouses the pupils' interest is of utmost importance. This speech should explain the objective of the research and emphasise the anonymity of the procedure with the absence of names and use of the ballot box. The pupils should understand the importance of filling in all of the questions to the best of their ability and there is nothing to be gained by lying or cheating. They should be encouraged to fill in their responses discretely so that their neighbours cannot see them.

Visualisation and filling in: The facilitator reads out the questions one by one from a questionnaire enlarged to poster size so that if anyone does not understand a question it can be read again or translated into a local language. It is also possible to ask for discrete individual help. Then, all pupils answer the respective question. After having gone through all of the questions, pupils are asked to check for completeness and to put their questionnaires in a ballot box. The whole procedure takes 20-45 minutes for each group.

Thanks and incentive: At the end students are thanked for their collaboration and - if affordable by the programme - the pen could be given as a reward.

Step 8: Data entry and data clearance

For data entry we recommend using a simple programme which is commonly used in the country/region (e.g. Epi info). Invest some time in defining precisely which values you want entered (e.g. a student older than 25 should be excluded). This reduces considerably the time needed for data clearance. Double data entry (each questionnaire is entered twice by different persons) is the best procedure, although more costly, because it allows easy checking for errors in data entry. We have good experiences in paying assistants per questionnaire entered.

Step 9: Data analysis and report writing

Two steps are recommended. In a first step, the frequencies of particular answers should be ordered according to sex and age of the participants. Discussion of this (vast amount of) data

will elicit key findings for further cross-tabulation. Limited statistical analysis should be done in a second step, though by no means with all variables, hoping to find statistically significant differences.

Step 10: Presentation of results

It is important to present your findings to the teachers and head masters of the schools involved and to discuss with them further steps. It is also very useful to present findings to a selection of pupils and to invite them for interpretation of data (communicative validation or face validation).

The Paper Slip Method

The Paper Slip Method (PSM) can be classified as a participatory rapid appraisal method (see Rollin in this publication), which combines quantitative and qualitative instruments. It can be used in various stages of the programme design and implementation where maximum participation of the target group is desired and feasible, such as monitoring and evaluation. It can easily be combined with a questionnaire to get immediate feedback on the frequency of selected questions. In fact, the research setting is similar to that described for a survey: Two to three facilitators conduct the PSM with groups of girls and boys separately. They will have prepared questions beforehand, which they present on a flipchart. They ask a simple question, and the participants write the answer on a slip of paper. The slips are collected, counted and the frequencies are displayed in front of the group. Subsequently, the group comments and discusses the results - the main strength of the method. In this way quantitative data can be interpreted and validated in a qualitative cross-check.

Materials needed:

- A set of questions for boys and girls
- A small container (basket, bucket, box etc.) for collecting paper slips
- A container for destroyed paper slips
- Pair of scissors
- Marker pens
- Flip chart paper
- Paper slips
- A pen for each pupil

Steps to use PSM

Step 1: Breaking the ice

Before starting, facilitators should make the group feel at ease by various methods, like singing, moving about, joking etc.

Step 2: Introduction

The facilitators introduce themselves, then explain the procedure of questioning and a final discussion, and what the study findings will be used for.

Step 3: Asking the question and writing answers

One paper slip is distributed to each participant. The facilitator reads out aloud the question written on a flipchart. A very simple response format in symbols or numbers is given for each question, for instance a number (e.g. for age), a tick for 'yes', a cross for 'no', a zero for 'not yet', or 'don't know'. The facilitator invites the participants to write their answer on their paper slips without consulting with their neighbours. It is recommended to start with a very simple question to introduce the method, such as 'How old are you?'

Step 4: Data presentation and discussion

The slips are collected in a container and counted in front of the class. The frequencies are written on the flipchart. Then, the facilitator encourages and guides comments, such as 'Do you think this answer gives a true picture? How do you explain this outcome?' Another facilitator takes notes during the discussion. After each question is evaluated, the facilitators destroy the paper slips (by cutting them in small pieces) demonstrating the confidentiality. Step four is repeated for all select questions. At the end, an open discussion can be organised if time allows.

Information generated through the PSM is transferred to a summary sheet for each group, separately for boys and girls. When selecting a programme for data analysis, it should be kept in mind that the unit of analysis is the group not the individual. This means that no cross-tabulations or filters are applicable, for example to compare answers of sexually active and non-active individuals. The main use anyhow is the qualitative data generated in the discussions forming part of the PSM.

Outlook

The main lessons learnt from our experiences in Burkina Faso, Guinea and Tanzania using the methods discussed above, namely the collection of anonymous questions, survey, and PSM, were:

- Confronting teachers, parents, local authorities and decision-makers with local findings tends to have a positive influence on their willingness to act and become involved.
- The findings provide an excellent starting point for designing youth programmes.
- These methods allow young people some involvement in project design and implementation.

The data provides a baseline for further evaluation. The survey could be repeated after two to three years. By then, the cohorts of young people asked in the first survey have already left school or do not fit in the study design anymore. New cohorts, e.g. again grade 6 of primary school, should be surveyed to measure programme impact.

An example from Tanzania

We used the PSM method in combination with a Knowledge, Attitude, Practice (KAP) survey on Sexual and Reproductive Health with pupils in 48 primary schools in Lindi Region, Tanzania, in November 1999.* 1600 pupils filled in the self-administered questionnaires and a sub-sample of about 500 pupils (from 8 schools) participated in the PSM.

The KAP questionnaire contained 32 questions, 10 of which were used for the PSM (Questions Nr. 1, 4, 6, 8, 11, 12, 13, 15, 18, 24 of the questionnaire in Annex 2 in this paper), including the core questions of this paper on sexual behaviour. Regarding frequency distributions we achieved similar results in the two surveys, a result which is only logical assuming that the answers given are valid or the same bias appears in both cases.

The PSM proved to be a useful method for validating and interpreting quantitative data with the respondents. Discussing the answers in a group helped to explain findings that were otherwise difficult to understand, e.g. a large age-range for male initiation. To some the initiation (kishuaheli *jando*) means the traditional circumcision ritual conducted in the bush, in which boys are circumcised but also given information about sex and sexual practices. To others it refers to a medical procedure, involving cutting off the penis foreskin at a modern health care facility, without any instructional services. Traditionally *jando* used to be carried out at the onset of puberty (age of spermathe), however nowadays parents often send children to the bush prior to enrolment in primary schools to avoid conflicts with the school system. The cutting of the foreskin is then done later during school holidays.

In another question, researchers explored why boys do not use condoms. The class in unison responded that existing condoms are too big for their penises. In short, the PSM added flesh to the bones provided by the KAP survey.

* The idea to use this method was taken from Shah (1999)

Annex 1: List of Variables to Consider for the Questionnaire Design:

Knowledge of

- Reproduction
- Contraception
- HIV/AIDS/STDs

Practice

- First sexual intercourse, according to age, voluntary or forced, type (vaginal, anal, oral)
- Number of sexual partners to date
- Current partner (age, profession)
- Sex last month
- Use of contraceptives
- Condom use
- Experience and treatment of STDs
- Experience with pregnancy/abortion
- Female genital mutilation (where applicable) or initiation

Attitude towards

- Premarital sex
- Own susceptibility to HIV infection
- Modern contraception
- Female genital mutilation (where applicable)
- Premarital pregnancies
- Gender relations

Annex 2: Example of a Questionnaire used in Tanzania³

Questionnaire for students in primary schools

Number of Questionnaire	○○○○
Code of the school	○○○
Day of the survey	○○○○○○
Code of facilitator	○○

1. How old are you?

/_/_/ years

2. What is your religion?

Catholic

Protestant

Islamic

Other _____

3. What is your ethnic group?

Wayao

Wamwera

Wangido

Wamakonde

Wamachinga

Wamatumbi

Wamakua

Other _____

4. Girls: How old were you when you had your first menstruation?

Boys: How old were you when you had wet dreams for the first time?

/_/_/ years

not yet

5. How old were you when you participated in the initiation rites?

/_/_/ years

not yet

6. Is it possible for a girl to get pregnant the first time she has sexual intercourse?

yes

no

do not know

³ In the survey there was a separate form for boys and girls. The final questionnaire was in Swahili and the layout was more user-friendly for primary school pupils.

7. What could a girl do to avoid getting pregnant?

- Not have sex
- Jump up and down several times after sex
- Have the man use a condom
- Have the man withdraw before ejaculation
- Wash intimate parts immediately after sex
- Take the pill
- Drink very strong tea without sugar after sex
- Have anal sex
- Choose safe days for having sex
- Do not know

8. What could a boy do to avoid impregnating a girl?

- Not have sex
- Use a condom
- Withdraw the penis before ejaculation
- Wash intimate parts immediately after sex
- Make sure that the girl takes the pill
- Respect the girl's safe days for having sex
- Have anal sex
- Do not know

9. How old were you when you had sex for the first time?

- / / years
- not yet

10. When you had sex for the first time was it...

- By force?
- Willingly?

11. How often have you had sex in the last month?

- / / times
- none

12. How many boys/men or girls/women have you had sex with in your life?

- / / boys/men or girls/women
- none

13. Do you currently have a lover?

- Yes
- No

14. How old is your lover?

/_/_/ years

don't have one

15. What is your lover's profession (activity)?

Apprentice

Apprentice

Driver, Housemaid

Teacher

Bar staff

Small trader

Big Businessperson

Policeman/Military

Farmer

Office worker

Doctor/nurse

Craftsman

No profession

Other _____

Do not have a lover

16. Did you and your lover use a condom when you last had sex?

Yes

No

Never had sex

17. How can you catch the AIDS virus?

Drink from the same bottle as an infected person

Have sex with an infected person

Shake hands with an infected person

Wash in the same river as an infected person

Deep kiss an infected person

Mosquito bites

Do not know

18. Can you be infected with AIDS by a healthy looking person?

Yes

No

Don't know

19. What can you do to protect yourself from getting AIDS?

- Use condoms
- Don't have sex with older men/women or bar staff
- Have sex with only one partner
- Avoid meeting people with AIDS

20. Whom do you live with?

- Mother and father
- Mother only
- Father only
- With relatives
- Other _____

Now we would like to get your opinion. Do you agree or disagree with the following statements

		agree	disagree	don't know
21	Nowadays it is not possible for girls to remain a virgin till marriage			
22	Boys put girls under pressure to have sex			
23	The pill is not for girls, only for adult women			
24	Condoms are not good for youth because it encourages them to have sex			
25	Girls have sex only because they want gifts or money			
26	Girls should be expelled from school if they get pregnant			
27	If a boy gets a girl pregnant he should be expelled from school			
28	Girls should avoid spending time with boys after classes			
29	It is normal for boys to have sex before marriage			
30	People with AIDS should not be allowed to eat together with others (kula pamoja, sahani moja)			
31	It is not possible to talk to parents about sex, love and disease			
32	Condoms should be given to young people to help them avoid pregnancy and disease			

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1.3 Participatory Rapid Appraisal in Project Planning

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Introduction

Children are capable, resourceful people whose individual histories, feelings and opinions must be respected. It follows that projects must be considered always as working with children rather than for them, encouraging and facilitating the fullest possible participation (Johnson et al 1998: 4).

The immense customary obligations and socio-economic duties that many young people bear across the world do not necessarily correspond with their participation in decision-making processes, despite the fact that the latter constitutes their basic human right. In development co-operation, adolescents' views have often been ignored, and this exclusion can compromise their own quality of life, as well as the development ideas springing from more inclusive approaches. Hence, recent development efforts are increasingly interested in incorporating young people's abilities and strengths into decision-making processes.

No integrated discourse on youth participation exists, nor are there established methods for ensuring that young people participate fully and freely. This paper provides suggestions and examples of how adolescents can be assisted and empowered to express their opinions and describe their life worlds using Participatory Rapid Appraisal (PRA, formerly the abbreviation for Participatory Rural Appraisal). Part one of this paper introduces the concept of PRA, part two describes PRA procedures used with young people in planning a non-formal education project in Uganda, and in part three, four PRA tools are discussed.

Convention on the Rights of the Child, Article 12: The child's right to express an opinion, and to have that opinion taken into account, in any matter or procedure affecting the child.

Participatory Rapid Appraisal

The kind of participation in which adolescents initiate project options and take decisions together with adults requires appropriate, open-minded approaches and sufficient time. In societies characterised by hierarchical socialisation and education, it is a long and challenging process to empower adolescents to be critical, dynamic and self-reflective participants, and for adults to recognise the value of young people's contributions. Among the many participatory approaches, PRA lends itself particularly well to expressing, enhancing and analysing the wide variety of adolescents' thoughts, feelings, and creative

PRA is 'a family of approaches and methods to enable rural people to share, enhance, and analyse their knowledge of life and conditions, to plan and to act[...] to monitor and to evaluate' (Chambers 1997: 104).

abilities because of the flexible and fun methods it employs, such as drawing, model-building and drama. PRA methods involve primarily the construction of visual representations by the target group of their life situations, which is then fed into project planning or other stages of the project cycle, with the aim of facilitating peoples' participation and empowerment.

Advantages of PRA with young people include:

- High relevance of the research results to project activities;
- Increased enthusiasm, confidence and skills of youth due to extra attention and responsibility;
- Change in attitude beyond the research setting for youth to claim their rights more actively;
- Strengthened community relations, also drawing together people who usually do not co-operate.

However, bear in mind that PRA tools are not always effective in analysing social relations or power structures in the community, two spheres of knowledge which are a prerequisite for the organisation of successful PRA-based work. The linguistically, socially or otherwise dominant ones in a community can influence 'consensus' and consequently research results. For example, adolescents may face practical, social and methodological impediments in PRA processes *vis-à-vis* adults. Their participation may also be hampered by power relations among themselves due to gender, age, heavy workloads, disability, poverty, low literacy, remote homes, or lack of confidence.

The Project Context

In Uganda, where HIV/AIDS takes a heavy toll, particularly among 20 to 40 year-olds, and where today half of the population is under 15 years, it is apparent that incorporating the views of adolescents in the planning phases of projects lays the basis for sustainable forms of development. Against this background, GTZ supports the Ugandan Government in implementing two youth-specific projects, which employ participatory approaches with adolescents. The project *Basic Education in Urban Poverty Areas* (BEUPA) serves as an example throughout this paper. BEUPA provides life skills-oriented, non-formal education for out-of-school children in certain poor areas of the capital, Kampala. Its target group is teenagers between 12 and 18 years of age.

The target group has been involved in the development and implementation of project activities from the outset. Initially, they took part in PRA in the project-planning phase – involved as both facilitators and participants – together with adult community members. This exercise represented one step in an ongoing participatory process, in which the adolescents continue to be actively involved. This paper abstracts from the experiences of the PRA with young people in the initial planning. The tools, however, can be adapted for use at other stages of project implementation.

The Process

Whether or not to use PRA in the planning stages is not an easy decision. It means commitment to a long process of social analysis and transformation. PRA has to go hand in hand with other steps, like developing of youth-conscious thinking among adults, collecting and disseminating youth-specific information, building in youth-focused research, and restructuring existing measures to enable their participation. Both the 'project team', and the target group must be comfortable with the PRA process, and parents must give consent for their offspring's participation. Hence, it is necessary to include the wider community in the process when embarking on a programme involving adolescents' participation.

Identifying Training Organisations

The first step in undertaking PRA in the project-planning phase is to identify an organisation that can train PRA facilitators, then clarify with them the needs and objectives of the partnership, and outline a binding agreement. Both parties can then work together to choose target communities for

Selecting an organisation to conduct PRA training

The organisations should

- Have a history of youth-centred activities;
- Be a community-oriented organisation;
- Be registered or recognised by local government;
- Have a shared vision with the project objectives;
- Be willing to abide by the working conditions and contract.

the PRA workshops, and consult regularly with local officials on the PRA activities to secure their backing. Subsequently, the project team, partners, the training organisation staff and community officials should be sensitised regarding children's rights and responsibilities, and the importance of adolescents' participation. (Sensitisation could for instance involve other development projects, community meetings, or theatre for development.) Finally, the roles, motivations, contributions, etc. of all parties involved in the PRA process should be specified, and outlined in a proposal and schedule for the PRA framework.

Training Facilitators

The training of facilitators remains largely the responsibility of the partner organisation. In a pre-training meeting with the latter the logistical arrangements should be confirmed, such as transport, venue, meals, daily allowance for facilitators, etc., as well as the roles of the trainers. Also any training material should be checked to ensure that it is appropriate for the facilitation of adolescents' participation. The most difficult task is to identify suitable facilitators from the target communities, and to make contact with official departments relevant to the project focus, like health, education, agriculture, gender, and/or youth. Local officials or youth representatives can be useful in this enterprise. The team of facilitators should be a representative crosscut of gender, age, and socio-economic background. Lastly, it is important to supervise and document the PRA training of facilitators.

Choosing facilitators

- Facilitators should be self-critical, friendly, flexible, open, and sensitive.
- Facilitators should form a mixed group.
- Female facilitators stereotypically find it easier to approach youngsters, but men professionally trained to interact with them are just as suitable, e.g. teachers, paediatricians or puppeteers.
- Adult facilitation may increase the self-esteem of adolescents, but at the same time, the latter may feel more compelled to say what they think they are expected to say.
- Young facilitators may disperse barriers to youth participation, but their relative lack of power in the community makes them more exploitable and vulnerable.

Mobilising the Community

The project team and the facilitators must take the initiative in mobilising the community. It is challenging yet essential to identify those members of the community who are likely to remain excluded from participatory approaches, such as out-of-school children, older girls, the handicapped, and very poor people, and to affirmatively



Young dancers and drummers attract attention for PRA activities

mobilise them for the PRA workshops. Local officials, teachers, nurses, religious leaders, artists and the like are particularly suitable to help spread the message of the PRA among young people. BEUPA worked together with a group of young local amateur dancers and drummers whose performances attracted the attention particularly of young community members, who could then be made aware of the project. Before the first PRA workshop and at the beginning of each session, the facilitators walked through the community to address individuals in the streets, bars, workshops, or houses.

Setting the stage

- Seek tips on working with young people from experienced agencies in the country;
- Inform officials (e.g. the Secretary of Children in Uganda) about their responsibilities;
- Undertake youth advocacy prior to PRA to increase acceptance of young people's participation;
- Mobilise adolescents informally via religious groups, education officials, employers, and clubs;
- Select a time that suits most young people, if necessary meet at two different times every day;
- Make sure the meeting place is friendly, free of harmful objects, animals or people;
- Take a conscious decision whether the PRA should take place away from or near adults.

Running Workshops with Young People

At the beginning of the PRA session, adults and adolescents have to be sensitised to issues of youth participation and the role of PRA in the planning phases. The objectives, processes and end-use of the workshop must be explained, in order to avoid raising expectations.¹ In doing the actual PRA activities for planning, a youth-focus must be maintained at all times. Someone from the project should record the power relations and dynamics that shape how information is produced, and try to enable less visible individuals to participate fully. At the end, in a final community meeting, participants are given an opportunity for feedback, and the organisers may even consider holding a small celebration in recognition of the time and effort the participants have invested. The facilitators should compile and analyse the information and impressions gathered during the workshop, and make processes and results available to the project team for further planning activities. Facilitators should be awarded a training certificate. The project team should continue to appear in the community until the project implementation starts in order to ensure continued participation and ownership.

Working with young people

- Be sensitive and open, stimulate creativeness and diverse opinions, listen, and encourage questions;
- Develop trust through work in single-sex groups, discussions in pairs, games and songs;
- Involve male and female facilitators;
- Take notes of the verbal and non-verbal interactions during the whole PRA process, and of the power relations observed;
- Recognise the extent to which your own personal and institutional culture influences the capacity of adolescents to participate;
- Identify how your attitudes, behaviour and methods affect your representations of the young participants.

Planning BEUPA

BEUPA commissioned the *Community Development Research Network* (CDRN) to conduct the PRA. CDRN trained some 35 facilitators, with an equal number of male and female adults and adolescents from a diverse background. Training and implementation went hand-in-hand. For two weeks, the facilitators were trained in PRA methods in the morning, and went to one select pilot community in the afternoon to apply the various techniques and begin the research. After a break of several weeks, the facilitators reconvened to conduct PRA with adolescents and adults in two other communities. The aim of the PRA was to research information for the planning of project activities. A welcome side-effect was the community's sensitisation to educational issues.

¹ It was revealed throughout the PRA process that the research may foster misunderstandings and high expectations. For example, one child said in the PRA for BEUPA, pointing at the resource map on the ground, 'Here is some space for [the project] to build the school', and an old man approached the facilitators with a photo of his nephew, a school-drop-out, asking the project for financial support with school fees.

During each PRA session, one facilitator took notes on the process, interactions, observations, and outcomes. Information drawn on the ground was copied on paper. Following each day of PRA research, the facilitators discussed their notes and conclusions back in the training centre. Maps, tables, etc. transcribed on large sheets of paper were shown to the participants the following day and one copy left with them. The facilitators made plans for the next day, taking on board any need for alteration regarding tools, time, mobilisation, etc.

The young facilitators were very enthusiastic. In contrast, it was difficult to mobilise adolescent participants, who tended to have other priorities, for the PRA exercises. Older women and young children were available and eager to take part. The number of adult participants was more or less consistent at forty over the course of the two-week workshop, so was the number of adolescents and children – with many more women and young children than men and adolescents. Unfortunately, no adjustments were made regarding mobilisation strategies or workshop setting to achieve a more even balance of participants. Opinions on the ideal group size for PRA vary. A group of 20 to 30 adolescents with two facilitators seems viable, allowing for diverse viewpoints yet group cohesion. However, it may turn out problematic to keep the number of young people down without actively excluding some. PRA tends to be exciting and attract more curious participants every day. If the group is too large divide them for particular exercises by age, gender, or school/drop-outs/out-of-school. If that is not an option, ensure that voices come from a good cross section of the participants.

The Tools

PRA should be seen as part of a participatory learning approach, whereby the whole process, rather than each tool, has to be participatory. The tools described below constitute part of a wider range of techniques, which could be used in the planning phase. It's important to check the tools carefully to ensure that they are appropriate for the particular research setting, and possibly adapt them to the local environment, participants' age, level of concentration, and so forth. It's equally important to ensure that the PRA exercises are fun and interesting at any given time. If enthusiasm wanes, participants could have a rest, sing songs, or play a game.

Methods to complement PRA with youth

- Participant observation of the adolescents' work and play;
- Discussion or informal talks with individuals and groups;
- Classroom-based exercises such as drawing or writing about a particular aspect of life;
- Playing and singing with the children;
- Interviews or PRA with adults, including teachers, parents, officials working on youth-related topics, etc.;
- Quantitative research about adolescent health, nutrition, education, workload, etc.

The four tools described in some depth below are examples that proved particularly suitable for work with adolescents. Other PRA tools can also be adapted, but such a discussion would be beyond the scope of this paper; please refer to PRA manuals for adults (e.g. Pretty *et al* 1995; Schönhuth *et al* 1994).

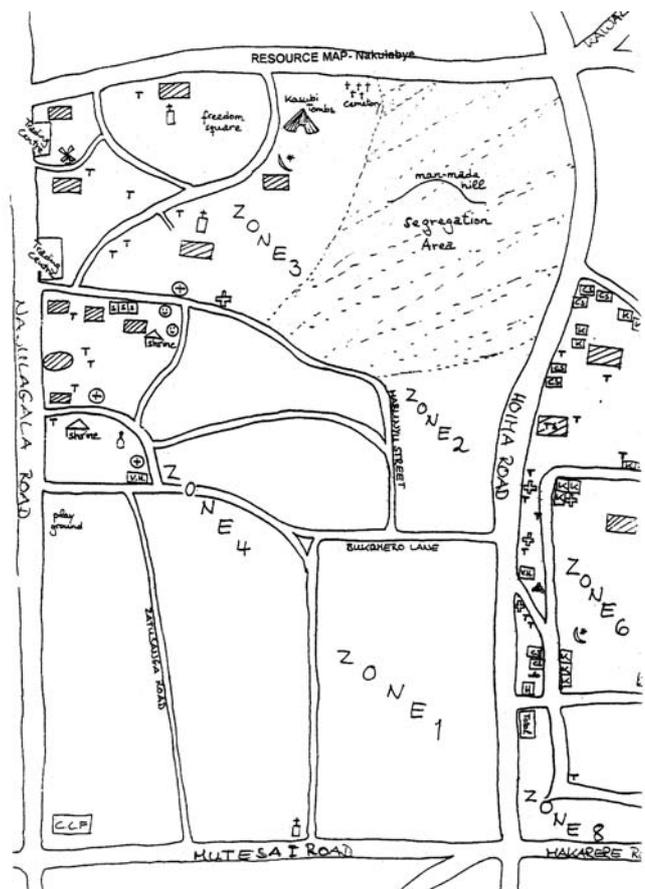
Resource Map

Purpose: Mapping provides a means of expressing spatially the relationships of adolescents to their living environment and social world. Some of the problems in their lives relate directly to the spatial properties elicited in resource and social maps, such as prohibitive transportation distances between home and school, or the detrimental physical environment of a health centre. This tool demonstrates to the adolescents that everyone has different ideas of where they live depending on who they are and what information they have.



Mapping exercise

Process: Two female facilitators of the BEUPA project encouraged the adolescents to draw in the sand the boundaries and roads of the zone in which the research is being conducted and to think about where their homes, as well as major landmarks, resources, smaller streets, etc. were situated. One teenage boy picked up a thick stick and drew a long line representing one of the border roads. With advice from some peers, he continued to draw all of the boundaries. Others joined in to draw smaller streets in the community. Then, the boys and girls collected stones, sticks, plastic pieces, and leaves to mark the location of different resources such as water taps, schools, charcoal stalls, private houses or bars. The facilitators intervened by eliciting some resources obviously missing from the map: e.g. 'Do you have a market in your zone?' They concluded with an open discussion of the whole process, asking 'What did you learn?' 'Did you like the exercise?' 'What was difficult?'



Transcript of resource map

Transect Walk

Purpose: The walk offers a chance to look at the vegetation and livestock, settlement, economic activities, administrative and social centres, including health facilities in order to find out more about the socio-economic and physical features of the community the adolescents inhabit. It is interesting to compare such observations with the findings revealed by the resource/social map activity, and also to practice another PRA tool, which adolescents tend to enjoy. This tool shows young people the importance of going to different places in person, and talking about things of local importance.

Process: The BEUPA facilitators divided the adolescents into several (random) groups, and let them decide which part of their zone they would each cover in their walk. The groups had time to plan their walk, and the facilitators talked with the participants about what they would primarily be looking for *en route*. The groups set off to walk through their community and meet again at an agreed time. The youngsters were very willing, almost proud, to lead the facilitators through their zone. They knew their community very well: who's who and who owns what. With such an activity it is primarily the facilitators, but also the participants, who learn about the socio-economic and physical environment as they walk past saw mills, elevated toilets, rubbish tips, schools, hospitals, and churches, families eating *matoke*, the staple food in Kampala, and so forth. The transect walk also allows an opportunity for the adolescents to chat informally amongst themselves and with the facilitators, thus strengthening group rapport. Afterwards the groups present their findings to the others and join in a group discussion.

Daily Calendar and Gender Analysis

Purpose: Find out what adolescents do and where they do it. What is their daily calendar? How do young people contribute to the community welfare? When are the out-of-school children free for potential project interventions? Who engages in which productive, domestic or community activities – women, men, boys or girls? Who has access to and who controls which activities or resources? The many differences between the activities of boys and girls, worse-off and better-off, young and old, Muslims and Christians, in-school and out-of-school children, etc. are revealed, and the discussion tends to foster greater self-awareness in comparison to others as well.

Process: In casual conversations, the facilitators asked the adolescents 'When do you get up?' 'What do you do at 6 a.m.?' 'What happens next?' etc. and recorded the answers in a long 'time line', which they draw on the ground. Activities varied considerably, especially by gender and whether the participants go to school or work, rendering generalisation difficult. However, the results were useful for planning BEUPA, helping to determine, for instance, that out-of-school working adolescents would be free for non-formal education in the late afternoon.

Transcript of daily calendar

Boys:

6 a.m.	8 a.m.	10 a.m.	12 noon	2 p.m.	4 p.m.	6 p.m.	8 p.m.	10 p.m.	12 night
to village with pick-up	fetch water for home			eat lunch and rest		Eat		sleep	
pray	buy food in market			play football, visit video-hall		personal hygiene		watch tv	
personal hygiene	sell food or water			sell or buy food		play, video, rest, gamble...		eat	
house-work (make juice)	house-work (wash clothes)			brick laying or pottery		look for girls			
	brick laying			wash clothes					

Girls:

6 a.m.	8 a.m.	10 a.m.	12 noon	2 p.m.	4 p.m.	6 p.m.	8 p.m.	10 p.m.	12 night
personal hygiene	buy or sell in market/shops		prepare food	house-work (wash-up)	wash clothes, etc.	go to video hall	watch TV, listen to radio, play		
house work (clean, cook)	prepare food		eat	prepare supper	bath siblings	wash dishes	sleep		
buy food	personal hygiene		wash dishes or clothes	wave mals	buy and prepare food	fetch water	visit friends		
pray			play, visit video hall	visit video hall	visit video hall	Rest	pray		

For the subsequent gender analysis, one facilitator drew a table in the dust, and the adolescents name activities like sweeping the house or selling fruit, which are entered in the first column of the list. The top row indicated the potential 'type' of person performing the task, *i.e.* man, woman, girl or boy. When asked for one particular task, the participants shouted out 'girls!!!' or 'boys!!!' to identify who fulfils it, and jumped around excitedly while doing this exercise. There was great disagreement between the girls and the boys, who both claimed to do more of each activity respectively.

Transcript of gender analysis

Activity	Performer	Man	women	boy	Girl
dig		- (4)	5 (6)	- (1)	3 (3)
build		5	-	3	-
fetch water		5	2	5	4
wash clothes		1 (-)	6 (6)	3 (3)	4 (6)
clean house		1 (2)	6 (6)	2 (4)	4 (6)
prepare food		- (1)	6 (6)	- (3)	4 (4)
buy food at market		4	6	1	3
sell charcoal or sell milk		4	6	-	-
knit table cloth		-	6	-3	
carpentry		4	-	6	-
dry-cleaning		5	-	4	-
tailor		4	5	-	-
sell second-hand clothes		4	6	-	-
clear wells		6	2	1	1
attend funerals		6	2	1	1
attend religious ceremonies		(1)	(3)	(5)	(4)
attend women's groups		4	6	-	-
child-rearing		- (1)	6 (4)	4 (1)	4 (6)
visit hair saloon		2	6	-	2
drum (at tombs)		6	1	4	3
animal rearing		4	3	6	-
wash dishes		- (-)	6 (4)	2 (2)	4 (6)
wash cars		4	-	6	-
mechanics		4	-	6	-
attend LC meetings		4	6	3	1
clean trenches		- (2)	6 (5)	4 (5)	3 (5)

The numbers within a row indicate the adults' opinion on who engages in a particular activity and in which quantity compared to the other potential performers in a family. E.g. women wash dishes a lot, girls do so to a lesser extent, and boys still less, while men do not wash up at all. The figures in brackets are those agreed on in the separate gender analysis with children.

Focus Group Discussion

Purpose: Discuss with the adolescents the factors that determine, for example, whether or not adolescents attend schools or health facilities. Such discussions allow the participants to learn more about those who do not or cannot attend school or a health centre and some of the reasons why. It's also an opportunity to discuss what skills or resources young people possess, as well as their visions of the future and what they perceive as possible opportunities to improve their living, health and/or educational standards. Finally the adolescents talked about what results they would like to see come out of the project. In the BEUPA case, the boys agree that they wanted to be taught mechanical work, driving and carpentry in addition to literacy and numeracy, while the girls wanted to learn tailoring, computing and nursing.

Transcripts of focus group discussion on reasons for adolescents out of school

Parents' background:

- many are single-parents
- family size ranges from two to 15 members, sharing one to three rooms
- most houses are semi-permanent or permanent
- most are engaged in petty business
- especially women have a positive attitude towards education
- some prefer the provision of formal education and others of vocational training by BEUPA to their children

View:

- child is undisciplined and withdraws due to parental or teacher pressure
- teacher harasses child
- girl gets pregnant early
- child is a (semi-)orphan and receives no financial support from parent(s)
- parents cannot spare money for schooling, especially when single-parent
- parents fail to sensitise their children on educational issues
- due to peer pressure, child does not want to go to school
- chronic diseases or disability prevent child from regular attendance and continuous performance
- family moves home often/migrates

Children's background:

- many stay with one parent only or with other relative
- family size ranges from 4 to 12
- most live permanently in the area

View:

- parents have low income
- child learns slowly and is made to leave by teacher or parent
- non-biological child or orphan has problems in finding a sponsor
- child has to contribute to family income through petty business
- parents have no chance to discuss their problems with school administration
- girl prefers marriage to education
- step-parents mistreat child who then runs away
- child refuses to go to school
- pupil fears punishment for not doing homework
- long illness interrupts school attendance

Local council's view:

- parents have low income
- child has no biological parents and no sponsor
- child is a slow learner
- girl gets pregnant at early age
- due to delay of government salaries, parents fail to pay school fees in time
- most schools are private and local council has no impact on decisions regarding education

Process: The facilitators divided the adolescents into several groups of five to seven, and invited them to select one key informant. Most groups nominated a more dominant individual, generally male and relatively old (and the facilitators failed to redress the balance). The remaining members of each group were then asked to interview their key informant about a particular topic. Two groups worked on the individual reasons, family conditions and institutional situations that determine the attendance, drop-out or non-enrolment of children at school; two on adolescents' visions of their educational future; and two on what the BEUPA project could

contribute to the educational situation in their community. In most groups, the interview style quickly turned into a lively and fruitful group discussion. The task was quite challenging and the older adolescents proved to be much better at it than the younger ones. The three facilitators drifted from one group to another, and mediated or stimulated the discussion when necessary. (It is preferable to have one facilitator for each group, or at least one for each topic discussed, so that notes can be taken of the process and findings.) After approximately 30 to 40 minutes, the facilitators asked each group to present their findings to the others. In conclusion, the facilitators asked the young people what they enjoyed and experienced as problematic in the exercise. Most participants enjoyed it.

Conclusion

BEUPA, the partner organisations, and the community all had some positive experiences regarding PRA with young people. For the project team, research with adolescents as opposed to adults seemed all the more relevant for planning project activities for that target group. For instance, adults identified different priorities for the curriculum than the young people did. Observing the strengths of youths in the PRA exercises, adults became more convinced of the adolescents' abilities, and accepted the latter's opinions in the PRA context and possibly beyond. Generally, the PRA helped earn the trust of the community towards the project team and its activities. Moreover, training and working with facilitators who come from the respective target communities offers a strategic entry-point to the community in the long run.

Outlook for reproductive health

PRA is a useful instrument at the stages of planning, implementation, and/or evaluation in the project cycle. The methods used in PRA exercises bear particular relevance to adolescent reproductive health interventions, because they give young people the opportunity to discuss and analyse their sexual behaviour, its impact on their lives as well as resources and priority needs in their surroundings. In the process, trust to adult mediators with regard to sensitive topics is built up as well as a wealth of background information usually hidden behind statistical data on teenage pregnancies and STIs.

In the GTZ-supported project TESAIRA in Paraguay, young people were trained as facilitators in a one year course that covered self-consciousness, gender relations, sexual and reproductive health, incl. HIV/AIDS, participation, and participatory research and tools. The training – besides being a first-time experience for many - improved the participants' self-esteem and sense of solidarity. However, participatory planning was only the *first step* in a process: Supported by TESAIRA the adolescents are also implementing the priorities which they previously identified using participatory research. In one region they set out to improve communication on sexuality between youth and their parents, in another region, they develop IEC material on HIV/AIDS and teenage pregnancy.

The NGO CDRN, which supervised the training of facilitators and implemented the PRA, as well as the wider community, were positively surprised about the enthusiasm and know-how of the young participants in the PRA, and learnt to appreciate their voices. CDRN realised that active strategies and different research methods have to be used to counterbalance the tendency towards power inequality along generational lines. For most adolescents, the PRA was fun and

represented a change to their daily routine. The most novel experience for them appeared to be the (temporary) suspension of age hierarchies, and the sense that their opinions were valuable. The feelings of empowerment and ownership that were established will almost certainly be useful for the implementation of further project activities. In the PRA process, the young people learnt about themselves and about their peers of the opposite sex or different ages. They were also sensitised about educational issues and the project goals.

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1.4 Action Research Training

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Introduction

Action research is a process in which people explore their own field of work and develop appropriate solutions for the problems identified jointly with all concerned. It can be applied to help identify factors which determine the behaviour of adolescents regarding sexuality and reproduction, and initiate action suitable to meet related needs and rights.

When in a given work or project context expected objectives are not achieved, often either the objectives or activities are revised somewhat at random and without knowing the true causes. This might result both in unsatisfactory working conditions and service provisions. In contrast, action research is a methodology which facilitates analysis of specific obstacles encountered. Understanding of their root-causes informs actions taken subsequently to solve the problems.

The research is undertaken by those actors who encounter the obstacles in their work, for instance health and social workers who provide SRH services to adolescents. This way the identification of the initial problem(s) and the development of possible solutions are undertaken locally, and together with all those directly concerned. Thereby, action research offers an opportunity to improve services, activities and everyday situations 'from within', and with relatively small financial input. It is crucial to the success of action research that the target group - in our case young people - are not only questioned on their knowledge, attitudes and practices - that is in establishing the problem - but should also participate actively in finding appropriate and acceptable solutions.

The combination of research, action and reflection which constitutes action research initiates a process of ongoing change. At the same time, it serves as a means of quality assurance for the services offered to the target group. The aim is to strengthen the critical and constructive thinking skills of social and health services staff, with a view to improving service provision and achieving project objectives.

International Course for Action Research Training

An action research training programme has been elaborated and taught for 10 years at the Cours Internationale de Formation en Recherche-Action (CIFRA – International Course for Action Research Training) based in Ouagadougou, Burkina Faso. CIFRA offers a range of courses, adapted for the management and planning system in the health and social services sector of West African countries. It offers an annual supra-regional course, decentralised courses in various countries of the region, as well as short courses on specific topics, in the

French and English language. So far, two courses on action research in the context of the sexual and reproductive health (SRH) of young people have been conducted. Training is aimed at health personnel, social workers and staff of non-governmental organisations (NGOs) and youth programmes who wish to improve services for their young clientele. The courses offered by CIFRA consist of three parts: a basic course, a practical study at the participants' work-place, and an evaluation seminar.

After an introduction to the SRH situation of adolescents in the region, the instruments and methodology of action research are explained. During the training, a concrete problem in every participant's daily work is analysed and an effective and profitable strategy to solve it is developed. Every individual strategy is then put into action in the participants' own working environment, with the support of the CIFRA team and course participants network. The following sections describe the stages of the action research training. Each stage is illustrated by one continuous example.

Stages in Action Research Training

Identifying the research problem

The most important problems in the everyday work of the course participants can be identified through a situation analysis, Knowledge, Attitude, Practice (KAP) study, and reflection. Based on this, in the context of action research, each participant draws up a list of existing problems ranked by urgency for the situation of the target population. It is helpful to pick one problem as a research problem for which there is currently not enough information available for a practical solution. In identifying the research problem, it is useful to look at some key information (e.g. the percentage of adolescents using a SRH service) and then consider the possible causes and implications of this initial situation together with representatives of the target group. In addition, a list of past and possible future activities can be compiled. In the course of this analysis, it should become clear what information is missing to tackle and solve the problem in the existing working context.

The reasons why adolescents in the district do not make much use of the information centre and the SRH services are not known.

Definition of a practical aim

When formulating the practical aim, care should be taken, that this covers action that directly contributes to solving the identified problem. The practical aim and the relevant action should also be within the area of responsibility and influence of the health service involved and the people responsible for the action research.

To identify the reasons for modest use by adolescents of the information centre and SRH services, with the aim of pursuing strategies that promote more frequent use of the centre.

Formulation of the research question

The research question orients the entire cognitive process. It must be directed at the research problem and the practical aim. This requires narrowing down the research problem, which can be done with the help of specific questions, which might be aimed at:

- The level of knowledge and awareness of adolescents with respect to the topic;
- Their habits and practices with respect to the topic;

- Perception by adolescents of the existing services;
- Their expectations of their social environment and the services in this context.

Which factors prevent adolescents from using the services? Specifically:

1. How many of the adolescents know about the centre, about sexually transmitted diseases (STD), HIV/AIDS, and family planning?
2. What do adolescents think about the centre's services, and what improvements would they like to see?

Choice of techniques and data collection instruments

Based on the research question, techniques and instruments are chosen for collecting the data required. Action research primarily uses the tools of empirical qualitative social research. The choice of method should reflect not only the research question but also the perception of the local personnel, and the financial resources available.

The following participatory methods can be used for situation analysis:

- Participant and non-participant observation
- Written survey
- Individual oral survey, e.g. through semi-structured interviews
- Focus group discussions

It should be borne in mind that questions and topics regarding the SRH of adolescents, often relate to very personal aspects of their lives which must be approached with discretion and sensitivity to gender. The choice of method should also include practical considerations, e.g. how many interviewers are involved, how should they be trained, when and where should the surveys be carried out, and with which groups and individuals, etc. In choosing interviewees, situations for discussions and questions, the risk of oversights or thoughtlessness by the action researcher distorting the findings should be considered. Gender aspects also need to be taken into account when determining group composition. Most issues are discussed and dealt with differently in male, female or mixed groups. Differences in age or geographical, social or ethnic origin should also be reflected.

Semi-structured individual interviews, focus group discussions.

Data collection

In this stage, data is collected in the working environment of the action researcher and among the identified target group(s). The data provide a basis for answering the research question at a later stage. To obtain usable data, the action researchers must comply strictly with the rules stated above. At the same time, they must be open to unexpected data, the value of which may not emerge until later, and which should therefore be well documented. This may require modifying the research question, the instruments, or the sample. This is a very demanding activity, for which expert backstopping ought to be available.

Target group: 10-24-year-olds, male and female, school and out-of-school.
Breakdown of a city district into 5 survey zones, interview of 357 youths (155 girls, 202 boys), at random in workshops, schools, houses, streets.
Interviewers: 2 health workers and 3 students trained for 3 days.

Data analysis

The unprocessed raw data from data collection must be reviewed for plausibility and consistency. This requires taking into consideration how, when and in what environment the data was collected. Sometimes the framework conditions can have a substantial influence on data volume and quality. If different techniques were used in data collection, data are first analysed separately and compared and combined only later.

With computer based data processing (*epi info*) for individual interviews, manually for focus group discussions.

Answering the research question

In this phase, the results of the data analysis are summarised and used to derive the answers to the research question. It is very important to document also unexpected information, and to look for possible explanations. Analysing the data should result in increased knowledge, which can be used to improve the existing services.

The services are too far away, have long waiting times, are not discrete, provide unfriendly service.
Answer to specific questions: 1. x% (few) of the adolescents are aware of the youth centre and its advisory services, but do not use them.
2. young people's wishes: Improving the above factors, longer opening hours and better qualified staff.

Practical conclusions

The conclusions are derived from the answer to the research question and related to the objective of the action research.

Many of the adolescents (particularly out-of-school youths) had inaccurate ideas about the centre and services, those who needed services; were deterred by negative attitudes of receptionists or lack of privacy.

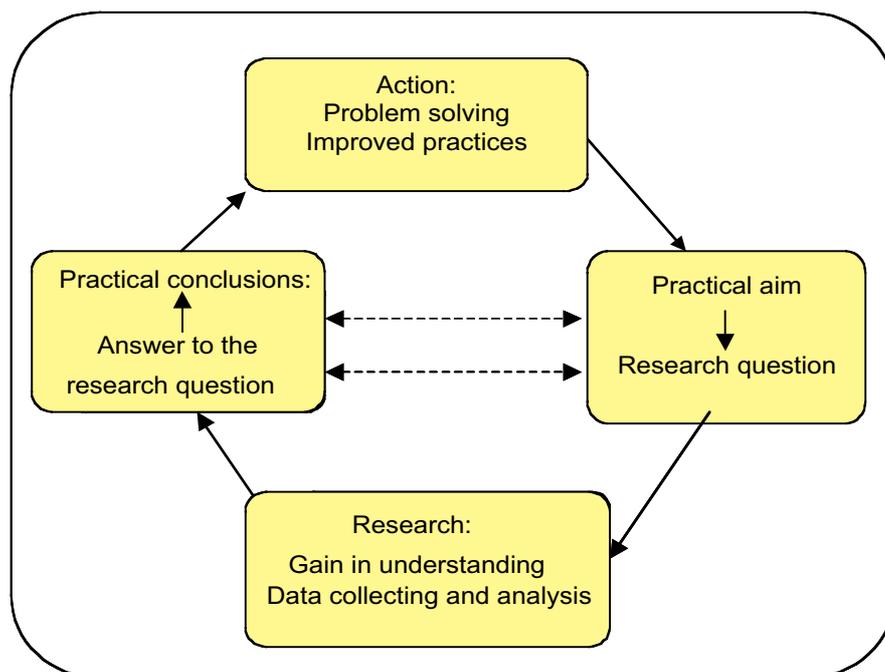
Planned actions

Action research is distinguished by its operational orientation. Therefore, a realistic activity plan is drawn up. It is important that the possible level of action and respective responsibilities are already considered when formulating the practical conclusions.

Planned actions:

- Organise discussions in the city district to make the centre and its activities known;
- Put up signposts;
- Produce and distribute flyers about the services, location and logo;
- Co-operate with the city district theatre group;
- Contact development committee and health services management to evaluate activities carried out;
- Upgrade staff for reception, reproductive health and counselling.

All stages described are interrelated. The choice of techniques, and data analysis are internal phases, which have a decisive impact on the success of action research. The other phases are external and relate directly to practical activities aimed at the target groups of the social and health services.



An example from Togo

In Togo, employees of the Association Togolaise pour le Bien-Etre Familial asked themselves why only 10 percent of young women between 15 to 25 years visited youth centres and took advantage of the SRH services. The problems of unplanned pregnancy, illegal abortion and HIV/AIDS were particularly worrying in Sokodé. In 214 individual and group interviews, data was collected on what the young women knew about the centre. They were also asked about their opinions and practices in the field of SRH and their assessment of the health centre. The action researchers had assumed that the young women involved might lack information on the centre and on SRH. They had also assumed that parents' disapproval of the centre and staff's lack of discretion when dealing with adolescents were the main reasons for low attendance. However, the results of the interviews showed that it was primarily the irregular and awkward opening hours of the centre which made it difficult for young women to visit. They also complained of the inadequate facilities of the centre, lack of leisure facilities, high price of contraception, and the lack of discretion of the staff. Based on these statements, changes were made which improved the operation of the centre and the number of visits (Thandikou 2000: 21-14).

Outlook: Action Research in Practice

Action research aims at identifying the possibilities for change and directly implementing the results obtained. The actors' need for understanding of a problem should motivate research and improvement in the actions taken. Discussion and dissemination of the research findings should be an essential part of the research process. Action research needs open-minded people, who are willing to take responsibility for their own actions and who are willing to work for change.

When working with adolescents in the field of SRH, special sensitivity is required not only in applying the techniques described, but also when implementing new measures. Action research focuses on analysing people's own situation, and at the same time it makes use of other research findings and available data. CIFRA's training programme mainly covers the research part of action research and links the problem analysis with action for improvement. However, to effect sustainable improvement – *i.e.* better services for the adolescents – supportive superiors, co-operative colleagues and constant reflection are needed.

An example from Burkina Faso

In Burkina Faso, according to the 1998 Demographic and Health Survey 72 percent of women and girls are suffering from female genital mutilation (FGM). Some of the consequences are physical injury and psychological damage, social conflicts and lifelong pain for the women. The action researchers were not aware of the attitude of young people towards this practice. They assumed that the reasons for the continuation of FGM were a lack of mobilisation of young people in the struggle against this practice and strong socio-cultural traditions. In individual and group interviews, 481 young people were asked about their knowledge, and attitudes to this issue. A clear majority of respondents stated that they knew of the practice, the consequences and the law on FGM. They clearly supported enforcement of the law and the struggle against FGM. Only a small minority thinks that the practice combats prostitution, that the law unreasonably limits the freedom of men and/or that genital mutilation is not a major problem. Together with the young people, ideas were developed for combating the harmful traditional practice. These included seminars, discussions, including opinion leaders in the struggle against FGM, organising radio broadcasts, evening information events and recreational activities such as theatre and soccer games (Tamboura 2000: 61-64).

An important factor in action research is ensuring that the research results are disseminated and used.

Within the CIFRA programme

- Decision-makers and local actors are informed and involved throughout the action research process;
- Research findings are documented and published.

Action research provides techniques for empirical social research which can be used in a range of sectors, e.g. health, youth work, capacity building, organisational development, education, agriculture and small scale business promotion. Action research can also help to increase the actors' everyday working efficiency and job satisfaction.

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1.5 Indicators for Monitoring and Evaluation

Cordula Schümer, Team Member, Promotion of Reproductive Health, GTZ

Introduction

Whether a project is useful or successful can only be established in relation to defined objectives and measured according to set indicators. However, one obviously should not spend all one's time measuring and counting on Monitoring and Evaluation (M&E): What do we really want to know about a project, what does the donor need to know, and what information do health workers or other actors want to work with? As the monitoring of programme progress and the evaluation of project success is based on the repeated measurement of indicators, it is worth spending some time on discussing and defining useful indicators – and not just live with the ones put in the project planning framework – once a project has started.

Proposed minimum list of indicators for adolescent reproductive health

- Age-specific fertility
- Abortion complications
- Condom use (last sex, first sex, ever use)
- Contraceptive use (by method, by source)
- Service use (e.g. sex education, counselling, contraception, treatment of sexually transmitted diseases (STDs), antenatal care, delivery, abortion)
- Knowledge (e.g. on reproduction, contraception, protection, HIV, STD – age/sex disaggregated)
- Policies (right to access services, ban of female genital mutilation (FGM), sex education in schools)

These indicators were selected as an intersection of what is desirable, measurable, feasible, important, interesting and customary. Other – more specific – indicators might be selected depending on project objectives, strategies, priorities and size.

Outcomes: What has Changed for Adolescents?

The purpose of a project is a situation change for the target group: In what way has their sexual and reproductive health (SRH) improved or changed compared to the situation before the intervention? This means that we would want to know how outcomes have changed after the intervention, such as fertility level, the incidence of STD, abortion complications, maternal mortality and gender/sexual violence, the prevalence of HIV, FGM, or other reproductive ill health, or the prevalence of sexual abstinence.

It is relatively easy for countries, districts and health projects to monitor important data on adolescent SRH by disaggregating routinely collected data by age. While the short list of indicators for reproductive health proposed by the WHO does not include indicators on adolescent SRH, the most important information would become available if these indicators were disaggregated by sex and age:

- Age-specific fertility rate
- Adolescent use of contraception
- Prevalence of FGM among adolescents (where practiced)
- Maternal mortality for adolescents
- Prevalence of syphilis in pregnant adolescents attending antenatal care
- Complications of unsafe abortions among adolescents

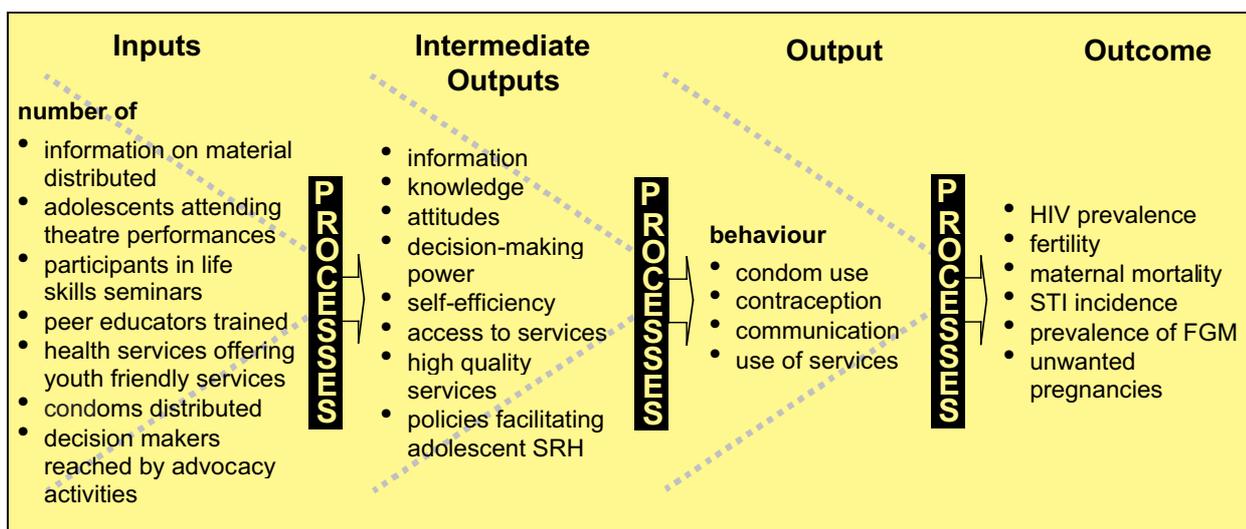
Always disaggregate all data and statistics by age and sex!

Many countries collect data for most of these outcomes on a national, regional and district level. Where this data is not collected, projects should consider supporting the development, implementation and strengthening of data collection strategies.

As much as we would like to know the incidence of STD and HIV prevalence in adolescents – important indicators for reproductive health – the WHO stresses that measuring these 'present major ethical problems in the data collection methods and follow-up' and 'extreme caution is urged, both with regard to operational aspects and to issues of interpretation' (WHO 1997b).

Should and Can Projects use Outcome Indicators?

It has become common to disregard the measurement of outcome indicators: According to the ZOPP logic [Zielorientierte Projektplanung/Objectives Oriented Project Planning], outcome indicators usually measure project goals,¹ i.e. goals that reach beyond the direct objective of the project. It tends to be difficult to determine to what extent the project contributes to reaching these goals.



¹ The Evaluation Project defined 'Inputs' as human and financial resources, physical facilities, equipment, and operational policies that enable services to be delivered, 'Processes' as activities that are carried out to achieve the objectives of the programme, 'Output' as the result of programme efforts at the programme level, 'Impact' as anticipated result of the programme process and long-term output that is subject to influences of non-programme factors (Adapted from: Bertrand *et al* 1994).

It might be worthwhile considering outcome indicators for adolescent SRH: Some of youth-specific outcome indicators are relatively easy and cheap to obtain. They use data that is – or should be – routinely collected in the health sector anyway and they can be measured at district level. At programme or project level they only make sense if the project covers a specific delimited population, for example a health district. A youth centre, for example, cannot measure contraceptive use or fertility rate in the adolescent population, as it is difficult to establish the size of the population the centre serves: clients might come from outside the project area, and many other factors such as the availability of other sources of contraceptives in the area, affect contraceptive use.

Projects are often small and they are usually not the only actor in a sector or area. The question is, how to estimate or ascertain how much the project contributed to changes in outcome levels. In many cases it will be impossible to prove how the activities of a single project influenced outcome indicators such as maternal mortality or adolescent fertility rates. Project managers have different options: They might

- assume that the project contributed to a trend that has been shown,
- base interventions on strategies that have been scientifically proven to be effective, or
- invest in closely monitoring innovative strategies (this often requires more resources than the intervention itself and cannot be achieved with routine data collection only!)

Very small scale projects probably need to acknowledge that either they would need to spend more resources on measuring the project's impact than on the project's activities, or that measuring the project's impact is not feasible.

What else?

Some of the above mentioned prevalence data do in themselves not necessarily provide information on how effective an intervention is: even though, for example, HIV-prevalence is increasing in a project area, the incidence of HIV infections might be slowed by project activities. Rather than registering an actual increase of an event, data might also reflect the increased use of health services (e.g. for abortions) or improved reporting (e.g. regarding maternal mortality or syphilis incidence). To complete the picture, behavioural data is needed:

Outputs: Adolescent Behaviour

Outputs which complement outcome data and for which we can be reasonably certain that they lead to, or facilitate, the desired change in outcomes, are indicators measuring behaviour, such as sexual behaviour, the use of protection, and the use of services.² These outputs can be measured at the level of the target group and at (health) service level.

² Condom use, for example, reduces the risk of acquiring STD and thereby will very probably reduce the incidences of STD, HIV and unwanted pregnancies. Use of STD-services should lead to a reduction of the prevalence of STD.

Typical indicators are:

- Proportion of adolescents who used condoms during their first/most recent sexual intercourse;
- Proportion of adolescents who ever used condoms;
- Proportion of adolescents who use condoms with a steady partner/with casual partners;
- Proportion of adolescents who ever used/currently use contraception (by method);
- Proportion of adolescents who have attended sex education modules in school;
- Proportion or number of adolescents who used counselling, contraception, antenatal care, delivery or pregnancy termination services;
- Number of adolescents who were treated for STD.

Intermediate Outputs: Debatable Indicators

Outputs that can be directly influenced by project activities, and which are often chosen as indicators, concern:

- Knowledge, attitudes and self-efficacy of adolescents;
- Access to, and quality of, services;
- Policies.

Project planning often assumes that improved services and improved knowledge lead to the desired outcomes or project goals. Unfortunately, evidence of a direct link between these facilitating factors and actual behaviour or improvement in health status has been rather inconclusive to date.

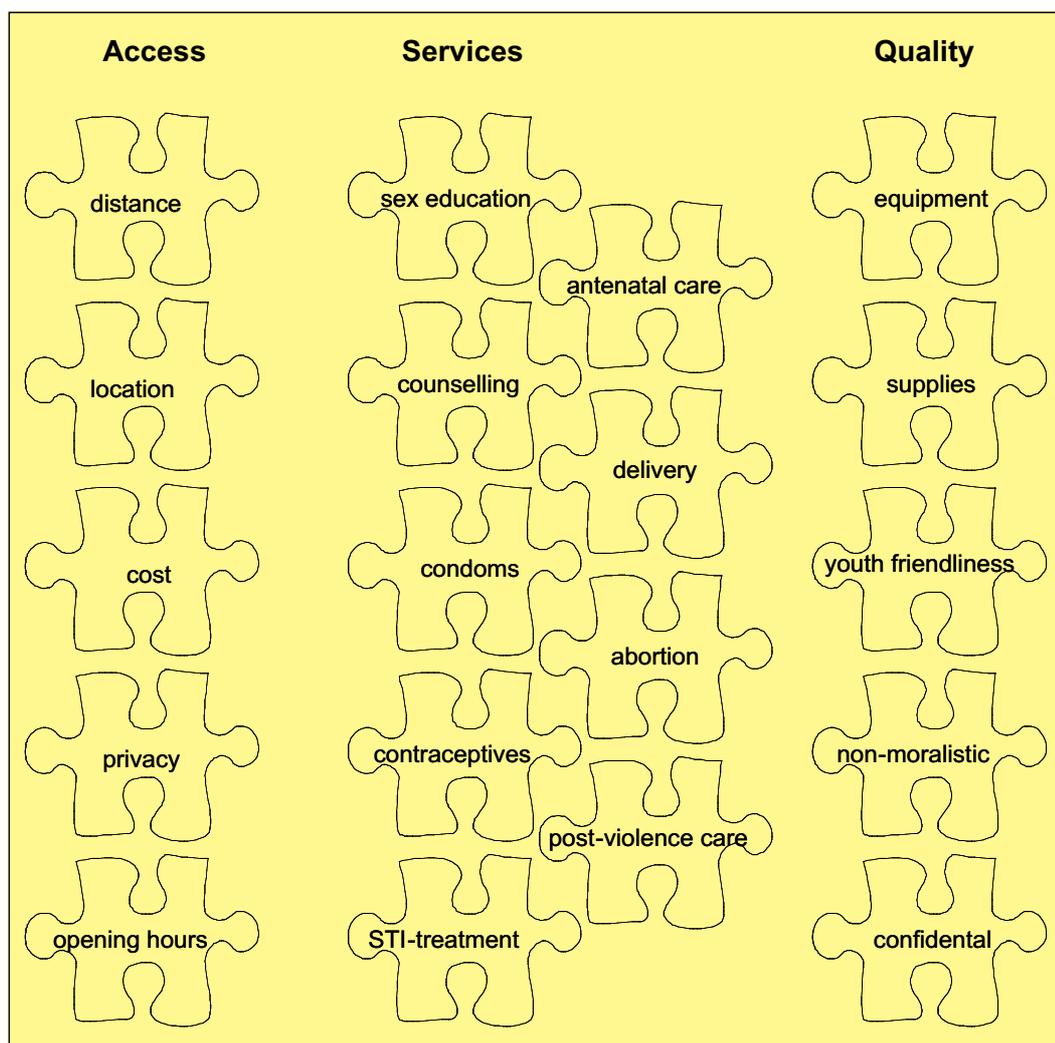
Projects usually lack resources to conduct research into these linkages. They can assume that a causal link exists and/or plan their strategies based on existing evidence. They can also choose strategies that have proven effective. Projects can compare intermediate output indicators to changes in the above-described outcomes to check whether they correlate. If outputs and outcomes do not correlate, try finding the reasons for this.

As the list of possible indicators for intermediate outputs is endless, it is worth deliberating the indicators most suitable for the project activities (e.g. Stewart & Eckert 1995). Surprisingly, data for many of the indicators is not as easily obtainable, and evaluating projects on the basis of inconclusive, unrepresentative or biased Knowledge, Attitude, Practice (KAP) studies or service quality surveys is very unsatisfactory.

Accessibility and Quality of Services

Access to quality services is essential for many aspects of SRH, and projects often feel directly 'responsible' for facilitating it. Indicators should be chosen accordingly, for example by selecting a combination of the factors regarding accessibility and quality of services.³

³ For ideas on the definition of quality see Bruce (1990) and Miller *et al* (1998), for a definition of 'youth-friendly' see Focus on Young Adults (1999 and n.d.).



Projects then have to decide whether they want to measure the proportion of adolescents having access to a certain type of service, or the proportion or number of centres offering a certain type of service. As the latter usually proves to be far easier, it is reasonable to choose it and to match it with data on service use by adolescents (see Outputs above), which is relatively easy to obtain.

Knowledge and Attitudes

KAP surveys on SRH abound in most countries (see G6rgen in this publication). They measure adolescents' knowledge on reproduction, contraception, STD/HIV and prevention. Most studies also include questions on adolescents' perception of risk, intention to use condoms or contraceptives and attitudes towards some aspects of communication or gender roles. KAP questionnaires can get mechanical and might suffer from 'courtesy bias'. Questionnaires need to be adapted to the local youth culture and can be inventive: In addition to the usual questions on knowledge, surveys might ask questions regarding social norms, for example whether youth

think it appropriate for a girl to carry condoms, to suggest condom use, whether they think it is hard to convince a partner to use a condom or whether they carry a condom right now.

Policies

Some projects select indicators to measure the existence of an environment that is conducive to delivering adolescent SRH services: These policies can include banning FGM, abolishing age restrictions on access to contraceptives or establishing adolescents' rights to information and services (Focus on Young Adults 2000). Steps towards a policy change – e.g. availability of data for decision makers or awareness-raising events involving policy-makers – can be monitored.

Input Indicators: Bean Counting?

The most boring – but most common – indicators are the ones counting inputs, e.g. the number of leaflets produced, the number of persons trained, the number of active peer educators. Most often, they track whether project activities have taken place according to the plan of operations, but can usually not say whether the project is successful in meeting its objectives.

Having trained a certain number of health workers in adolescent counselling, or teachers in sex education, does not necessarily mean that they provide adequate counselling or teaching, that adolescents use the service offered or behave according to what they have been told. 1000 leaflets printed or distributed does not mean that they have been read and understood, or that they changed the readers attitudes or behaviour. This kind of indicator is appropriate to tick off a 'to-do' list as part of monitoring operational plans but is not helpful for project evaluation. Some input indicators can be made more meaningful by bearing in mind the objective of an activity, for example by replacing 'Number of trained peer educators' by 'Number of peer educators who are competent to provide counselling', where 'competent' needs to be defined and measured.

New Process Indicators

Sometimes inputs are described as process indicators, but processes are more complex than organising training or Information, Education, Communication (IEC) sessions. Technical co-operation is about empowering people to make choices. Active participation in knowledge generation and participation in the design of projects and services as well as participation in life skills training contribute to this empowerment. The sustainability of programmes depends on a sense of ownership of the project or of the strategies and services developed in a programme on the part of the community and the major players or stakeholders in the process. This is especially important for programmes for adolescents.

Accordingly, indicators reflecting the active involvement and participation of adolescents as well as indicators measuring co-operation and co-ordination between stakeholders need to be developed. Indicators could be formulated to measure the degree or quality of adolescent's participation in project activities and in the development of programme strategies. Projects could also monitor co-ordination processes between stakeholders or communities in developing initiatives concerning adolescent SRH. A number of other combinations are conceivable, and indicators have to be developed according to a project's strategy and environment.



Challenging but not Impossible to Measure

Important factors in young women's lives are sexual violence, abortion and – in some regions - FGM. Studies in different countries have shown that up to one third of first sexual experiences for adolescent girls were involuntary, while very little data exist on sexual or gender violence for most regions.

Data on **sexual violence** collected in health services usually gives very little indication on the actual prevalence of violence: the more prepared and professional the service is in asking about violence and caring for victims, the more cases it will discover or attract. It is rare that baseline data on sexual violence is obtainable and sometimes it is not probable that projects can make a measurable difference to the prevalence of sexual violence in the projects' lifetime. In those cases it will be sensible to select an output indicator on policy development regarding sexual violence, such as the existence of data, the wide distribution of data, the development of policies or discussions on the issue at policy level or in the community.

Even though the prevalence of violence might not be selected as an indicator, projects should include questions on sexual violence in all surveys on sexual health, for example whether the first/last sexual intercourse had been voluntary or more generally on experience of abuse and coercive sex. In most situations, qualitative data is needed on prevalent forms of violence, perception of violence, attitudes towards it, and ability of services to adequately respond to it, before routine questions on sexual violence can be included in service statistics.

FGM is usually measured by asking women whether they have been circumcised, what they think of the practice and whether they intend to circumcise their daughters. The WHO proposes to estimate prevalence of FGM by measuring the percentage of women interviewed in a community survey, reporting to have undergone FGM themselves. Screening in health services might be unacceptable and ethically difficult, especially if confidentiality cannot be guaranteed or health staff are involved in the procedure.

There also is no standard or reliable way of measuring **abortions**. Surveys can ask whether a pregnancy was wanted, or whether adolescents have experienced pregnancies and abortions. Hospital records or health service based studies can show incidence of abortion-related complications admitted to hospitals, or – in countries where the procedure is legal – the number of abortions performed. Collecting and disseminating data on abortion is important for awareness raising and policy making. As indicators for monitoring and evaluation, age-specific fertility rates and contraceptive use might be more realistic for projects that do not specifically emphasise activities regarding unwanted pregnancies or abortion.

Another option is to estimate the proportion of births to adolescents that are wanted. As not all teenage pregnancies are unwanted this additional indicator can provide important information on adolescent knowledge, access to contraceptives, self-efficacy and gender relations, especially if it can be combined with information on communication with partners and sexual violence.

Selecting Indicators: Additional Considerations

- Is the indicator useful for feedback? Advocacy? Evaluation? Policy making or strategy development?
- Does the indicator reflect project priorities or test a new approach?
- How measurable is the indicator? How good is the data? What input is required to obtain good quality data?
- Is the indicator ethical (WHO 1997; see also Görger in this publication)
- Is the indicator scientifically robust?⁴
- Can we assume that an input/output will contribute to a desired behaviour or outcome? Is this link verifiable?
- Do all persons involved in the collection and analysis of the data understand what the data is used for and is it useful to them? Can and is feedback always given?
- Is the indicator necessary?
- Is the number of indicators selected manageable?

Where does the Data come from?

Projects have a tendency to produce all 'their' data themselves. Unless the project needs input or process data related directly to the functioning of the project, it might be easier, cheaper and more sustainable to rely on data that is

- Routinely collected in the health or other sectors;
- Collected in larger studies in regular intervals, such as Demographic and Health Surveys (DHS), or other national or regional studies.

⁴

- Valid - an indicator must actually measure the issue or factor it is supposed to measure.
- Reliable - the indicator must give the same value if its measurement was repeated in the same way on the same population and at almost the same time.
- Sensitive - the indicator must be able to reveal important changes in the factor of interest.
- Specific - the indicator must only reflect changes in the issue or factor under consideration.
- Representative - the indicator must adequately encompass all the issues or population groups it is expected to cover. (WHO 1997)

Demographic and Health Surveys usually contain more regional data than what can be seen in the printed DHS reports. If DHS are regularly conducted in a country and the project area roughly represents or encompasses a region, the project can access the original DHS data for more detailed regional and age-specific information.⁵

General population data, however, has to be treated with caution: whereas it can be assumed that the vast majority of adults are sexually active and married, this is generally not the case for adolescents. This means that the events concerning this age group that are reported in the collected data concern a smaller group than the total adolescent population: contraception, STD/HIV, condom use and abortion all occur in the sexually active part of the adolescent population. Also, large differences might exist for unmarried and married adolescents, depending on how common sexual activity before marriage and/or teenage marriage are in a population. Some surveys include only married respondents, which would in most cases not give a representative picture of the adolescent population.

If routine data, as well as surveys organised in the country or project region, do not collect data for the indicators chosen by the project, one could explore the possibility of **adding questions to such surveys**. For regular monitoring, **introducing the indicator into routine data collection** can be considered. Very often it is easy to introduce age and sex disaggregation of data collection into service data and surveys, without significantly increasing the workload of staff or the cost of studies.

Repeated **studies in the project region**, funded by the project itself, might be needed for data for which no routine statistics exist, such as – in many cases – gender violence, sexual violence or abortion. In such cases it might be worthwhile to **pool resources** and study themes with other organisations or institutions in the health or education sector. The most inefficient and least sustainable ways of collecting data for project indicators are asking already overworked **health personnel** to collect a new list of information, which might not fit into routine data collection forms and need an additional form, as well as data collection by **project personnel**.

Sources

- Routine (service) data
- Large (regular) studies
- Surveys funded by projects
- Insertion of questions into routine surveys
- Pooled studies

When planning to collect data through surveys, it has to be taken into account that surveys need to be repeated if the information is to be useful to monitor changes over time. Once a new project has a plan of operation and starts implementing activities, one ought to seriously discuss and decide upon the choice of indicators and to make sure baseline data is available. There is not much point in trying to measure change after some years if there is no data on the situation before the start of the project. Baseline data does not necessarily have to be collected by the project itself: Most projects don't start in a vacuum or at point zero and surveys or statistics containing 'your' data might already exist for the project region.

⁵ DHS data can be obtained through the national institution involved in the survey or from www.measuredhs.com. Some caution is necessary as combined age and sex-stratified information for only one region might not be representative, as for example the number of girls age 15-19 interviewed in a specific region might be very small.

Where does the Data go to?

While one destination for project data is to get translated and sucked into the black hole of donor bureaucracy, there should always be more reasons to collect data: All persons involved in data collection for project indicators should understand the indicator and find it useful for their own work. Accordingly, a process of giving feedback on all data collected and analysed should be institutionalised. The WHO urges not to select indicators 'generated through data collection methods which do not require efforts from institutional levels that have no use for them'.

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II Approaches

2.1 Alternative Youth Policies

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Introduction

In this paper, we interpret a policy as the broadest set of priorities defined by the state with respect to approaches, strategies and programmes, and in relation to a system of norms and institutions that guide, justify, rationalise and communicate the actions undertaken, in order to solve given social and political problems, as for example adolescent sexual and reproductive health (SRH). Public policies may also be viewed as governance tools for society. Such policies should be endowed with special characteristics:

Have high degree of social legitimacy: it must be the result of public discussion and conciliation processes, in which a broad range of specific interests participate;

Be legal: it must not contravene any national norms, and have a 'mandatory' character committing political institutions to guaranteeing that such agreements are in the general interest of the citizenry;

Commit public expenditure: it must be carried out as an investment of the state, which channels public spending according to the guidelines designed for the policy.

Promote citizen control and government accountability in order to facilitate broad social consensus and institutional development.

Parallel to other state social policies that are also bound to influence how young people live - such as education or health policies - youth policies consist of public actions undertaken in favour of young men and women; they seek to generate and maintain conditions under which young people can maximise their potential and participate in society in as varied and self-reliant a way as possible. Until now, however, youth policies have attempted to insert young people into society by improving the mechanisms that ensure their transition to adulthood. Generally, both in content and support structures, they have been highly fused with educational policies regarding spare time, work or citizenship. These types of policies tend to imply that obstacles to insertion lie in the young themselves, as if society as a whole were waiting for them with open arms.

Our position is virtually the opposite: Youth policies should promote and assert the affirmation of the condition of youth in society, fostering greater equality in the access of the young to public goods and services, backing youth organisations and those committed to fighting for their rights, increasing the control of resources by young men and women, raising awareness among public opinion about the discrimination affecting young people as a social group and, in short,

facilitating not only young people's transition to adulthood but also their political legitimacy as social actors having interests, needs and proposals of their own.

The Role of Government Bodies

Ideally, policy guidelines originate at the highest level possible, and the municipal level is responsible for their operationalisation via the design and execution of plans and programmes, while subnational levels act as intermediaries between the two levels. In reality, however, the political difficulties arising from having low-intensity democracy and weak governance cannot be ignored.

The role of national youth entities:

- Abstain from executing youth programmes, or from co-ordinating programmes to be carried out by sectoral entities (those developed by Ministries of Planning and Development);
- Compile in-depth and systematic information about the reality experienced by young people, in co-operation with statistics and census divisions and research institutes;
- Co-operate in the evaluation and follow-up of sectoral youth programmes both at national and municipal levels, also helping to disseminate 'best practices';
- Develop training programmes and seminars on youth-related issues in association with higher education centres, bringing together specialists on the subject from various sectoral levels of intervention;
- Promote actions to raise public awareness, with emphasis on parents, schoolteachers and entrepreneurs, about discrimination against youth, as well as about positive actions that are being undertaken in society;
- Provide technical support to municipalities in the design and implementation of youth policies at the local level, and offer access to international co-operation networks;
- Place youth-related issues on the agenda of decision-makers at national and municipal levels, trying not to regard young people merely as part of the problem but as part of the solution;
- Create mechanisms of political dialogue for dealing with the situation of the most marginalised youth, linking up political parties, civil society organisations, youth organisations and international co-operation agencies.

The role of municipal bodies:

- Support education for adolescents, trying to mediate between out-of-school and enrolled youth, and between schools and parents, in order to make formal education more accessible and more highly valued;
- Ensure the presence of civil servants in places where young people are to be found, who must be accepted by the young as positive caring adults.
- Promote youth-related initiatives, avoiding undue interference and respecting the ways in which such initiatives are manifested (these may be informal, temporary, fluctuating, in conflict with adult authority, etc.);
- Make the interests of the young visible, including facilitating access of youngsters to various institutions, linking interests with attitudes and capacities, and giving advice during electoral processes, etc.
- Be catalyst for existing youth organisations, helping them out, raising awareness among adults, strengthening their participation in local bodies such as Development Councils, Community Boards, etc.

Institutional Difficulties for Effective Implementation

The number of support structures and state institutions working for youth promotion in Latin America has visibly multiplied, though substantial obstacles still impair the effective implementation of youth policies.

Sectoral programmes and unhealthy competition

Entities specialising in youth claim to take a holistic approach, whereas in practice they tend to carry out an aggregate of sectoral projects (employment promotion, drug prevention, sexual and reproductive health, etc.). As a result, efforts are duplicated, and at the same time, specialised youth offices are pushed to merely fill in the gaps left by sectoral bodies.

Striving for universality

The mass-scale programmes are not very varied, and ignore that young people are not a homogenous group. Programmes that do attempt to recognise specific youth groups, or themes tend to be generic and thus do not acknowledge the specific interests, potentials, difficulties and resistances of each group.

Centralisation and concentration of decisions

Commonly, public entities attempt to do everything themselves, hoarding all decisions regarding financing, design, co-ordination, execution and evaluation of the various programmes and projects. This keeps services offered inflexible, and results in a lack of co-ordination with other (public and private) bodies.

Instrumental relation with adolescents

The notion continues to prevail that poor youth should be beneficiaries of special services, state benefits or other types of assistance, perpetuating dependency and low levels of citizen participation. In addition, services often centre on more traditional social settings (family, school, and workplace), at the expense of less institutionalised ones (e.g. sports and recreational infrastructures, or the mass media), which instead are subject to policies characterised by social control and prevention approaches. In short, youth policies remain conservative in their form and content, corresponding to interests and logics that do not match those of adolescents.

Excessive 'partisanship' and low professional skills

Specialised youth divisions have to struggle for recognition within the state's organisation, but they usually are the first to be affected by budgetary cuts and adjustment measures. In fact, youth structures are often instrumentalised by the political parties in power. In addition, such entities rarely upgrade their technical staff's professional skills and provide them with continuity, making it difficult to produce the information and experience 'banks' needed to generate institutional learning. Hence, such bodies only achieve low levels of legitimacy even within the state, and can seldom exercise any authentic level of co-ordination of youth policies.

A Complementary Approach to Youth Policies

Solving the problems mentioned above is not easy and requires different strategies, techniques and policies by various agents. We propose that the consciousness of citizenship must be reinforced among non-integrated youngsters, so that these young people can more actively and creatively withstand the exclusion dynamics imposed on them. Only in this way can they construct alternatives – beginning with their own lives.

It is essential to create a space in which public actions to promote young people might be more relevant and cause greater impact, also helping specialised youth divisions to gain political and technical legitimacy *vis-à-vis* the state and society. In this sense, it is necessary to complement current actions geared towards integrating youth into society with affirmative actions that take into account the interests of young people and particularly the most disadvantaged. Such public actions would be geared towards preparing young people to become social actors capable of changing their own environment, by strengthening their capacity to:

- Define personal objectives and be socially responsible,
- Communicate and defend in public the legitimacy of their interests and needs, and
- Act with awareness that they are citizens; that is, making use of their rights.

Recommendations to Promote Youth Policies

The institutional development of youth policies in Latin America not only requires upgrading the state's public administration but also increasing the capacity of civil society organisations (CSOs) to negotiate, reach consensus and control the governance agreements needed to formulate and apply these policies. It is therefore necessary to place special emphasis on the following four aspects:

Institutional Capacity-building

Institutional capacity building cannot be separated from the framework of new models of public relations between the state and civil society. The state as guarantor of public interest *needs to increase the technical profile of its interventions* in the scenarios designed for reaching consensus, whereas CSOs, as sites for the promotion and representation of society's particular interests, *need to increase the political profile of their interventions*. We propose a radical reversal of the roles that governmental and non-governmental sectors have carried out up to now: On the one hand, the state has always been suspected of being too politically motivated and technically insufficiently prepared; and on the other hand, civil society has been represented by non-governmental organisations (NGOs) alone, their chief strength being essentially technical, basically concerned with project execution and not very willing to add to and mobilise the interests and demands of other sectors of society. Citizens themselves – the users of public services – should exert control from their own organisations.

Promotion of the Political Role of Youth Organisations

The key function of public youth policies is to facilitate the influence of young people in strategic decision-making.

Characteristics of youth organisations

- Enhance direct participation of the target groups in defining public policies;
- Mobilise and represent interests legitimately;
- Represent a site for the accumulation of experiences and learning about the 'real world' of youth;
- Focus on content rather than conditions (a group of friends meeting may be just as useful as a church-based youth organisation or the scout movement).

Checklist for youth policy development

- Identify who the current users of a given service are;
- Adapt access to adolescents who are little socially integrated or unstable;
- Be aware of gender and ethnic considerations;
- Go 'where young people are' (streets, schools, parks etc.) instead of places where they don't go;
- Gain youth's trust, observe and listen;
- Start from young people's own capacities, making their skills and talents visible also to themselves;
- Support young people to establish their own demands, also towards the municipality;
- Promote their evaluation skills to help them reflect and express their interests and needs critically;
- Provide youngsters with information on opportunities, benefits and services, which may allow them to make better use of possible solutions to their specific problems and questions, e.g. studies/work, health, sexuality;
- Promote collective actions by young people, stemming from the initial identification of their interests;
- Create opportunities for the expression of their common and/or complementary interests, as a basis for collective action and joint experiences.

Design and Operation of New Networks on Youth between the State and Civil Society

It is a challenge to set up new forms of governance that will include the growing number of NGOs forming part of civil society in a process that is beginning to generate the growing empowerment of citizens with respect to the state. With respect to youth policies, it is often suggested to develop actions carried out on the basis of broad conciliation and complementarity between the state and society. Promoting the participation of networks of CSOs offers comparative advantages over promoting their participation in isolation (see Kramer & Meyer in this publication):

- Networks have greater synergetic effects in their condition as organisations integrated into other organisations.
- Civil society being the site *par excellence* of 'particular mannerisms', network involvement counteracts the danger of the excessive dispersion of specific and closed interests.
- Acting within networks has pedagogical effects that contribute to forming social capital, such as the capacity to comply to self-imposed norms, the thematic undertaking of particular struggles, the conciliation of interests, working in teams, making collective decisions, learning the adequate formulation and negotiation of demands.
- While a shift, decentralisation and de-concentration of the state's functions take place (crucial points for a modern public youth policy), networks between NGOs and the state's non-central agencies will have the potential to increase the scope and quality of social services for young people.

The Impact on Public Opinion

The dominant public representation of the role of young people in society – while acknowledging their status as the *future* of society – underestimates their *current* value as youngsters. The young are very often perceived as creators of problems linked to anti-social behaviour, cultural marginalisation, political apathy, drug consumption, vagrancy and sexual promiscuity. This opinion is reinforced by mass media, where the subject of young people is usually handled in a superficial and sensationalised 'news-seeking' way. Such a limited vision of youth-related issues has not been duly confronted, because adequate and sufficient communication strategies have not been available in order to mobilise alternative 'symbolic capital' to oppose the dominant discourse in the circuits of youth-adult interrelation (mainly the family, the school and the labour market).

As a result, adults who are in closer contact with young people's daily lives, like parents and teachers, for example, but also politicians and entrepreneurs, tend to be insensitive to recognising and granting legitimacy to young people's points of view and personal experiences. They are therefore little prepared to undertake a frank, respectful and socially productive inter-generational dialogue.

In short, while the positive assessment of young people as social actors and alternative interpretations of youth-related issues continue being restricted to a more or less closed intellectual circle comprised of specialists and technocrats, the chances that their ideas can make any impact on how the subject of youth is positioned in society are bound to also be extremely limited. In other words, communication strategies need to be designed and applied, through the mass media, in order to contribute to making youth issues more socially relevant and to have an impact not only on young people themselves, or on the institutions specialising in the promotion of their rights, but also on the adults who share their lives with youngsters on a daily basis and are of strategic importance in their lives: Parents, teachers, entrepreneurs, politicians.

The Implications of Applying Youth Policies to Marginalised Young People

Focusing the actions promoted in youth policies on young men and women who are little socially integrated implies taking into account conditioning factors that are usually not considered by those who implement youth policies and threaten the success of any initiatives undertaken with this group. These marginalised young people, who are supposed to be supported, do not identify with what they are doing, be it spare time, family, school or work-related activities; they experience a big gap between their ambitions, which are necessarily vague and imprecise, and the experiences that marginalisation and social rejection thrust upon them. Their present appears as more of an obstacle than an opportunity for the future.

Many of these youngsters have never attended schools, have dropped out or been expelled, resulting in low literacy, low capacity to concentrate and pay attention, and little awareness of external norms and hierarchies. On the other hand, they have greater appreciation for learning by doing. They have their own conscious and unconscious ways of challenging authority and norms, and a higher probability of expressing and acting out their frustrations through non-verbal forms involving symbolic manifestations of an artistic nature. Moreover, there is a strong tendency among these young people to form groups, gangs, collectives, etc., for psychological reasons such as the need for 'protection from the world' and to acquire social recognition.

In an effort to support these marginalised youth, we must

- Identify and work at their meeting places, which they feel that they 'own', and where they feel safe;
- Design activities that take into account the particular nature of their adolescent transformations (development of cognitive stages, coexistence of adult traits such as forming their own families, commonalities with other young people by reason of their youth, etc.);
- Show that youth can be a state of opportunities and learning for life, rather than a set of limitations;
- Develop a low threshold for the young to your institution, as well as for staff to these young people;
- Display a non-interfering attitude, maintaining a balance between proximity, stimulus and availability, while always remaining in the background.

More than among other young people, the difficulties, setbacks and limitations of non-integrated youths are greatly determined by adults, who often view them and experience them as social problems. Hence, potential efforts to promote marginalised youth, complementary activities for adults who are in close contact with the young people are necessary: (a) try to gain the support of parents and pedagogical personnel so that they become active in reducing the tensions between themselves and their children or students/clients, and (b) de-stigmatise young people from the popular sectors in society, making visible their positive sides, as well as the discrimination and exclusion that they endure.

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2.2 Inter-sectoral Youth Promotion

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Introduction

Several minds think better than one (voice from the commission).

Youth promotion is about letting young people have a go – letting them decide and shape the kind of world they want to live in. What is more, successful youth promotion does not limit itself to young people's needs, but also looks at their social environment. Inter-sectoral youth promotion thrives on the many different actors involved.

The following paper summarises experience with inter-sectoral youth promotion gained by a municipal commission with participants from the state and non-governmental sector and also from the target group itself within the scope of the project Promoting Women's Integral Health (PROSIM) in Nicaragua. First, a brief description is given of the concept on which intervention in systemic health promotion is based, *i.e.* the *settings* approach on the one hand as well as comprehensive youth health promotion measures on the other, whereby the starting point is the young people's potential (and not their problems). The emergence of the Inter-sectoral Youth Promotion Commission in Managua is then outlined on the basis of its objectives, principles, structure, strategies and fields of activity. Finally, the impacts, successes and problems encountered are discussed and lessons learnt drawn for future prospects.

The socio-cultural context will only be mentioned in passing here: Nicaragua is, on the one hand, characterised by Catholic-conservative traditions with *machismo* and authoritarian tendencies. On the other hand, the social revolution in the 70s and 80s has softened many formerly unbending structures and, in spite of certain developments to the contrary in recent times, is still making its influence felt, for example, as regards the following factors which are of interest to us:

- A marked willingness for voluntary community and citizen participation;
- A relatively strong women's movement – also in regional terms – which has put the theme of gender-specific violence against women, children and young people on the social agenda;
- A relative openness to sexuality-related themes, even though key social institutions, such as the Ministry of Education and Ministry for Family Affairs traditionally take a more conservative approach.

Theoretical and Conceptual Background

Health is more than the mere absence of disease and infirmity (WHO)

Systemic health promotion – based on the understanding that health is a product of social processes and relationships – centres on people and their potential and responsibility for leading a healthy way of life. It takes account of people's social environment, *i.e.* the conditions determining their scope for action and the social factors determining their health status. This approach is to be seen as a reaction to the limited success of traditional Information, Education, Communication (IEC) activities which generally relate to an isolated problem such as smoking, alcohol or nutrition and which, since geared to the individual, fail to take the respective living conditions into consideration.

Systemic interventions have most impact when they initiate processes of change in organisations and/or social systems. Health as a variable of social and political action should be promoted at different levels; from the development of personal competencies and skills, the restructuring of health services and support for health-related community activities through to the promotion of a general health-oriented policy (WHO 1998).

Against this background, the creation of health-promoting *setting* plays a very important role. A setting is a social system that contains all of the relevant influences from the surrounding environment. Normally, it can be identified on the basis of its physical borders, people's defined roles within it and its organisational structure (Spelleken 1999). Desired changes in behaviour cannot be generated through the provision of information alone, but necessitate a change in values, a process which, in turn, has to be set in motion by a suitably conducive environment. To change social systems, it is necessary to adapt communication structures, in particular those decisions and rules that give individuals a greater chance of exerting an influence, participating or making a choice and which create scope for behavioural alternatives. These interventions give rise to an innovation system in or between organisations (Grossmann & Scala 1996). A typical starting point here can be a target group, *i.e.* in this case young people, in its specific setting, or a theme such as the prevention of risk-taking behaviour like addiction, violence, unprotected sex, or even the expansion of options for a disadvantaged group, e.g. young girls, by strengthening their self-confidence and giving them new opportunities for education, employment and leisure-time activities. In the example presented here, the youth's setting is a poor district in Nicaragua's capital Managua.

The PROSIM Project Approach

The organ mainly responsible for executing the PROSIM project is the Ministry of Health, represented by the General Directorate for Health Services. The contacts at national level include the Directorate for Integrated Health Services for Women, Children and Youth and, at the local level, the health districts Managua, León and Chinandega. In the project area itself, some 13 urban and 14 rural health centres are being supported. One of the four project results

relates to the inter-sectoral co-ordination of various institutions operating in the field of sexual and reproductive health. An example of this is the Inter-sectoral Commission for the Comprehensive Promotion of Youth Health in Urban District VI, Managua, which integrates those responsible for the youth programme in the health district and the three health centres in the urban district concerned.

The PROSIM project came about as a result of the 1994 International Conference on Population and Development in Cairo and is designed to help implement the action programme agreed on here on the basis of the new concept for sexual and reproductive health (SRH). This concept comprises, amongst other things, a holistic approach to people and takes account of gender- and generation-specific aspects while acknowledging sexual and reproductive rights as unalienable human rights, irrespective of age, gender, ethnic and cultural origin or social status etc. Working on this premise, the project has accorded great importance not only to women and their partners, but to the target group youth, both as users of traditional, public health-care services and as a target group and independent co-designers of broad-scale, inter-sectoral health-promotion strategies aimed at primary prevention.



The project approach aims to generate settings conducive to good health and youth-friendly services. It also aims to create development opportunities for young people and to empower them to pursue a health-conscious lifestyle based on and shaped by their own initiative. Youth-oriented strategies include introducing comprehensive promotion strategies on a policy level and offering targeted services for young people in public health services, as well as inter-sectoral promotion of youth health. The latter entails

- Co-ordinated, mutually complementary activities with actors in other sectors, for example, co-operation with the Ministry of Education and non-governmental organisations (NGOs) on social projects;
- Equal participation of youth in the planning and implementation of activities;
- Involvement of the young people's families and parents.

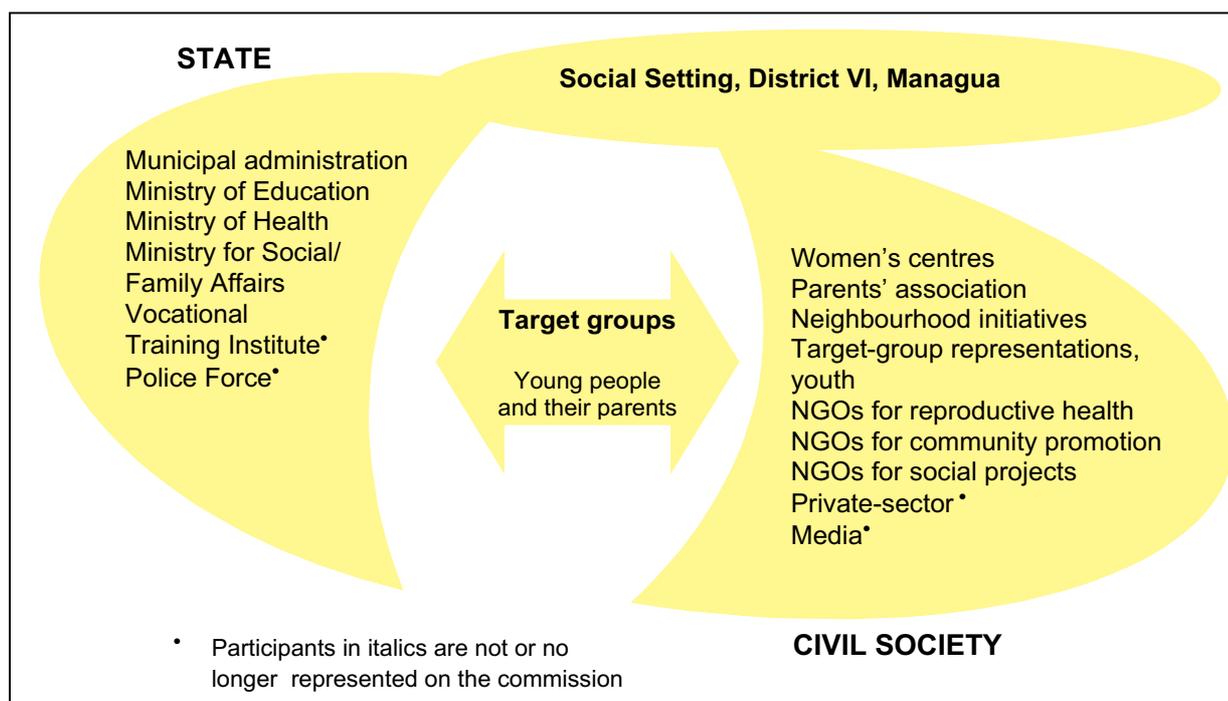
Activities by the Inter-sectoral Commission consist of:

- Workshops and upgrading courses on various themes;
- Annual sporting tournaments and other leisure-time activities (see also Kreiß & Loewen in this publication);
- Access to grants for vocational training;
- Organisation of sales exhibitions with products handcrafted by young people
- Public Relations work and advocacy for youth rights as well as an active youth policy that offers young people opportunities for participation and development;
- Awareness-raising campaigns and rallies on (inter-)national days of remembrance.

In this context, one particular strategy that is widely acknowledged as important, but which has not been adequately pursued to date, focuses on local media inputs to destigmatise youth and their reputation as violent and criminal in the hope of painting a more realistic picture of their situation and needs. Last but not least, public relations work promotes exchanges of experience, since it passes on the experience gained by the actors involved to other interested parties inspiring them to do the same.

Experience gained by the Inter-sectoral Commission for the Promotion of Youth Health

The Inter-sectoral Commission for the Comprehensive Promotion of Youth Health in Urban District VI, Managua now comprises some 19 institutions, organisations and associations. Representing the state are the Ministry for Family Affairs and Ministry of Education as well as the municipal administration through their operational units at district level. Civil society is represented by several NGOs, a parents’ association and by young people themselves. It would be expedient if the Vocational Training Institute, the police force, private-sector and the media were to participate too.



In a purely governmental inter-institutional commission in the same urban district, set up by the Nicaraguan government as part of its action programme to prevent youth violence, active participants include the police force – which was previously involved in the Inter-sectoral Commission – along with the vocational training and agricultural extension institutes. Merging the two structures would be one way of getting all the actors together around one table, while at the same time actually reducing the amount of time they spend at meetings. However, this can only evolve as a result of the gradual process of gaining the acceptance of decision-makers, which has been underway for a while now.

Networking Stages and Approach

Already prior to the foundation of the commission in 1997, the organisations in this urban district had realised there was a need to co-ordinate activities and so joined forces to implement bilaterally organised activities. Following on from an exchange of experience relating to a 1997 Knowledge, Attitude, Practice (KAP) study conducted as part of the PROSIM project and targeting precisely this group of young people, it was possible to bring together more and more youth-relevant institutions and actors in the inter-sectoral youth promotion commission. In 1999, a representative of the target group itself joined, lending a whole new dimension to participation. Since the commission was established in response to a specific event, the actors involved were sufficiently motivated to co-operate with each other in the start-up phase and indeed to maintain further co-operation on a sustainable basis. Various other commissions in different urban districts or on different themes that were set up without a concrete, clearly defined mandate have not demonstrated the same kind of continuity.

A meeting is held at the beginning of each year to plan activities for the 12 months ahead. Here, the participants define the commission's objectives for the year in question, which implicitly reflect the institutional objectives, and agree on activities suitable for achieving these aims. Also, the project-funded budget is planned on the basis of cost estimates. The individual participants from the respective institutions assume responsibility for the implementation of certain activities. For example, an NGO provides the premises and moderator for a workshop while PROSIM meets subsistence expenses. In other words, the respective institution opens up its activities for others and finances them from its regular budget. The planned budget deals only with the total amount PROSIM will provide to finance activities; no price is put on the inputs and services by the respective actors. This is because the annual plan would otherwise take on too much of an institutional character, with the result that inputs by young people and their parents, as well as grass-root initiatives without their own budget, would be underrated. Such activities include, for example, accompanying the sports team on bus journeys to the sports fields or putting up decorations for celebrations. The German contribution also consists of technical advice and – should it involve consultancy, moderation inputs for the planning session, a workshop or logistical support – is not priced either. The activities that have already been implemented and those that are scheduled for implementation are discussed in the plenary meetings held each month. The co-ordination committee evaluates the annual plan and presents the results at the end of each year.¹

¹ Compliance with the plan is expressed as a percentage based on the number of activities implemented according to plan.

Principles of Co-operation

You don't have to think the same to be able to work together (Commission).

The commission is not a legal entity and does not have an official institutional framework. It is purely thanks to the will and interest of the individuals represented in the commission that joint preventive youth work is still ongoing. The experience gained by the commission has shown that, given the various basic lines of conflict (state/civil society, youth/adults, laypersons/professionals), joint principles have to be upheld when working in a network. These principles, which came about as a result of changes in attitude during the course of co-operation, were compiled on the basis of a participant survey (CIS 2000).

Agreement on a joint objective: A basic prerequisite for co-operation is the pursuit of joint interests for which a joint objective or vision is formulated as a binding and unifying element that generates a sense of identity.

Consensus: Co-ordination processes can split a group and so it is important that each actor has the chance to articulate his or her proposals and that resolutions are the result of a discussion process, not a majority decision. This method facilitates acceptance of decisions and promotes identification with jointly executed work.

Voluntary participation: This kind of consensus-finding process has to be voluntary. The actors must decide for themselves what components of the activities they can perform and which themes match their organisation's profile. If, for example, an organisation avoids the themes of sexual education and family planning, it can deal with other themes such as values, communication, non-violent action etc.

Mutual respect for differences: It is important for joint success that the actors accept each others' differences and avoid distrust, competitiveness and resentment. The same applies to the relationship between adults or experts and young people which has to be based on mutual respect, tolerance and equality.

Permanent communication: Communication is particularly important, if there are great differences between the actors. Since local restrictions in terms of telecommunications and transport make the co-ordination process more difficult, it is all the more important to agree on specific work procedures that occur in the course of routine work, such as regular meetings, joint planning and evaluation as well as documentation of the work done etc.

Impacts on People, Organisations, State and Civil Society

People

Yet another key factor for the success of the commission revolves around the personality and commitment of the individuals representing the respective organisations. For the commission to contribute to *human capacity building*, it must fulfil a basic prerequisite, namely, it must identify with youth work and accept youth as an equal partner. The commission offers a forum in which the actors concerned can establish new working relations and friendships, gain confidence in each other and find acknowledgement for their work. The exchange of experience broadens the actors' respective horizons and promotes openness for new developments. Experiences gained in inter-sectoral co-ordination breaks down prejudices, rouses team spirit and solidarity and promotes self-initiative and self-organisation. As such, this process also contributes to *leadership-building*.

The ongoing consultancy and upgrading provided by the project help raise the participants' level of professionalism; they learn about planning instruments and increase their specialist know-how, develop skills in the field of communication and constructive dialogue, conflict management and problem-solving, consensus-finding and decision-making.

Organisations

Aspects of organisational development include the greater professionalism of all parties involved (state, NGOs, target group) and the realisation of (common) long-term interests. The networking of interests, resources and social forces strengthens the institutions and enhances the organisations' competence to act as intermediaries. Over time, the commission has built its managerial capacities thanks to joint annual planning, co-ordination, monitoring and evaluation activities.

This unique combination of organisations with their varying fields of specialisation facilitates the formation of the multi-disciplinary teams necessary to handle the theme of youth health promotion in all its complexity.

State and Civil Society

The commission takes on the function of a conveyor belt and helps pass young people's interests onto state executing structures and boosts the process of democratisation: Civil society is able to influence youth policy, and state services become more efficient, because they are closer to the citizens and are co-ordinated with other non-governmental actors. In other words, state services become more target-group oriented and the chain of impact between planning and implementation is shorter.

When faced with conservative and authoritarian governments which treat civil society with reservation, if not with disdain, which invokes a correspondingly negative reaction from NGOs, this coming together and process of democratisation are of great significance. A great many NGOs and grass-roots organisations belong to opposing groups. Thus, in order to succeed in the given political landscape, inter-sectoral co-ordination requires an external moderator who, as a neutral party, can channel conflicts and help develop long-term conflict management mechanisms.

Youth

Young people have been organised in their own district commission since 1999. Youth representatives are elected at the annual general meeting. Additionally, the young people also elect a youth-group council (*junta directiva*) in each organisation which represents young people in 'their' organisation (e.g. health centre, NGO, etc). Forming their own organisational structures

helps young people to pursue their own political interests and strengthens their independence. Youth representatives, be they girl or boy, participate on an equal footing in the commission, contribute initiatives developed by the youth groups and assume responsibility for the implementation of the annual plan. In this way, young people learn how to recognise and



articulate their objectives and desires. They see that they are taken seriously and that they can achieve something. This process of *empowerment* initiates mutual understanding between adults and young people and leads to the realisation of youth rights.

Limitations and Challenges for the Future

Structural problems

A great many of the problems encountered by young people are of a structural nature. Most young people would like to apply their newly acquired knowledge, but come up against difficulties in their particular setting which do not allow for any changes in behaviour: Broken families, violence in the home or parents' opposition. This is why more and more activities are being implemented together with parents, with a view to promoting communication with and an understanding of young people and their needs.

One task still to be dealt with is that of finding out what happens to those young people the commission is not able to reach and pinpointing the reasons why they could not be reached. In

most cases, these groups consist of young people who are being denied any chances of development. However, a great deal more can be achieved with very little input amongst those youth groups that are easy to contact. Thus, this approach is a good start facilitating the generation of structures that can be expanded in future to groups that are more difficult to access, as shown by the recent accession of an NGO which is dedicated to street children.

Decision-making authority

Sometimes the commission is unable to implement its activities because they are not in keeping with the work schedules of individual organisations. This limitation is the result of an organisational and planning deficit that can be eliminated with other planning procedures (e.g. appropriate planning rhythm) and upgrading. Differences in decision-making authority can hinder co-operation, if no binding agreements can be made *ad hoc*, but first have to be approved by superiors. Although this obstacle has not yet had a detrimental effect on the dedication and enthusiasm of the actors involved, it could, in the long term, lead to frustration and cause some people to give up their work in the commission. This shows just how important it is to win over the decision-makers' and management level's approval for the commission's activities, so as to ensure that the commission's work is acknowledged and regarded as meaningful.

Institutional vulnerability

As already stated, the commission is not a legal entity and it is purely the will and commitment of the individuals working on the commission that keep it going. Institutionalisation (and its own financial budget) could help ensure the commission's longer-term existence. For example, it would be expedient to integrate it into the municipal administration. However, co-operation with government structures depends greatly on the political situation. Conflicts can arise between state and local governments. Also, the high level of staff fluctuation following elections damages the continuity of work inputs. And, on top of this, state employees are bound by institutional obligations preventing them from openly expressing their opinion.

Matters of basic issues awaiting discussion

Some members feel there is a need to discuss taboo themes that weigh heavily in ideological terms and on which there is no consensus (sexuality, sexual advisory services, abortion etc). However, this risks putting certain members under pressure, leading to their resignation or exclusion. For this reason, ongoing gradual learning processes would seem to be the more suitable option for eventually reaching a consensus on tricky issues. For example, having young people involved in the commission was by no means an obvious matter. Indeed, there was a great deal of resistance which has only been overcome in the course of joint activities. This learning process is being supported by joint training and upgrading on such themes as gender, participation of youth and children, sexual advice etc. Shared experience and group learning promote co-operation and generate a joint basis for further work.

Sustainability

Although no companies could be found to co-finance the annual sporting events in the urban district, the task of finding sponsors will stay on the agenda, the aim being to promote sustainability. This year, the project will halve its financial inputs and concentrate more on promoting the commission's fund-raising activities. In other countries in which the state and NGOs are better equipped, it might be conceivable to introduce a membership fee, depending on the financial status of the organisations taking part.

Summary

When it comes to promoting such a complex and multi-faceted problem as the health situation of impoverished youth in Nicaragua, systemic youth promotion is a very suitable approach. No individual organisation, but only a group of several organisations from different sectors can manage to support young people in this way. Individual measures complement each other and enable activities to be implemented on a much larger scale than would be the case were an organisation to act on its own. Forces are united and resources harnessed more efficiently, as many different standpoints, approaches and sectors are dovetailed and integrated thanks to co-ordination. Voluntary participation keeping with particular preferences and qualifications produces a potential of motivation and creativity. This can increase the impact of measures on the target group. The networking of several actors facilitates exchanges of experience between organisations and offers young people a forum for active participation. Apart from health promotion in a wider sense this results in competence gains, in promotion of citizenship and strengthening of local democracy.

The scope of replication of these measures is an issue for technical co-operation. How much time, effort and money will have to be invested just for replication in another area of the city? Without doubt, the major factor determining the repeatability of these measures is the exchange of experience between actors in other districts. Furthermore, a committed and, at least at local level, influential institution will have to take on responsibility for expanding the commission's activities. Under the premise that political exploitation can be avoided, involvement of leading institutions such as the city government and/or the Ministry of Health in the Commission would be highly desirable in the dissemination of the experience.

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2.3 Youth Organisations: Co-operation – Support – Setting Up

Babette Loewen, Consultant, with focus on youth

Introduction

The perception of young people in development processes has changed in recent years: They are no longer seen merely as passive recipients of interventions and assistance, but increasingly as social actors in their own right. Youth participation and peer group education have become almost mandatory for sexual and reproductive health (SRH) measures. The results are convincing in terms of representing the interests of young people, and gearing activities to the actual needs of young people and to their lifeworlds. Co-operation with groups organised by young people themselves also plays an important part here, although their potential is still often underestimated. Practical examples show various arguments in favour of co-operation with structures organised by young people.

Advantages of co-operating with youth organisations

- Youth organisations and their members are direct mediators for SRH.
- They have better access to the target group than 'adult organisations'.
- The viewpoint of the young people can be incorporated in project work as genuine participation (perhaps new joint projects).
- Youth members of the organisations receive individual promotion. Their contribution and inputs are spotlighted and rewarded, and access to knowledge and information enhanced.
- At group level, behaviour patterns and characteristics are supported, which encourage healthy and responsible living, tangibly reducing high-risk behaviour and addiction.

In this context, it is important not only to see youth groups as organised leisure activities, but to take into account their autonomous form and degree of organisation, which is extremely high in some cases. In some countries very active associations exist, in which young people look at political or health-relevant topics, motivated by their own interest, such as groups at neighbourhood level, or political or artistic youth organisations, or again networks of youth groups. Since these organisational models cannot be found in all countries, it might be appropriate to co-operate with more institutionalised forms of youth representation, such as school representatives, youth parliaments or trade union youth movements.

The first part of this paper looks at co-operation with existing youth organisations. If there are no youth organisations in the project environment with which to co-operate, the project can encourage or support the setting up of a new youth group, which might later become a suitable co-operation partner. This option will be explored in the second part.

Co-operation with Youth Organisations

Co-operation with youth organisations can have a major impact on the situation of the target group youth, also with regard to SRH. The young people know their way around the 'youth world'. They know where young people meet, what their concerns and anxieties are, how to talk to them and what might put them off. When organising events, when producing materials, when getting to know youth cultures or identifying facilitators, young people and their organisations are important partners. The work within an organisation has provided some young people with a point of entry into health promotion work, or has raised their awareness for this topic, and perhaps raised their interest in further training on this topic or in multiplier training. Generally, a large number of young people with leadership abilities and high organisational potential can be found in youth groups. Activities to date and youth projects offer a platform for co-operation (drama, neighbourhood meetings and music performances, carnivals, political meetings and forums, parent or child work, etc.).

As a rule, youth organisations have specific structures, which differ from those of 'adult organisations'. In concrete co-operation, the special features of youth organisations should be taken into account in planning.

Special features of youth organisations

- Youth organisations rarely have any financial resources worth mentioning. Possible contributions to co-operation can thus take the form of planning, organisation and implementation work, and of course, of the access they offer to the target group. Often they have no infrastructure (telephone, fax or computer), and correspondence must be routed via the private addresses of representatives.
- Work in youth organisations is generally voluntary. The young people are often still undergoing training or work parallel to their work in the organisation. This has an impact firstly on the amount of time available for their work in the group, and also on the continuity of work, since time-consuming voluntary work must often be sacrificed for gainful employment, and the work in the group passed on to 'new' young people. The working rhythm too is shaped by the voluntary nature of the commitment; work tends to be done outside conventional office hours: In the evenings, at weekends and in the holidays.
- Because of these 'unattractive' conditions, many youth organisations rely on the inputs of a few, active individuals. Often a handful of individuals are very committed and the others help sporadically, at best. The group may not, then, have the manpower it needs for time-consuming projects.
- The genuine grassroots youth organisations might be difficult to contact, since they are not sufficiently well known.

If these characteristics are respected, and if the project is prepared to accept them, and to learn from the young people and their situation, a youth organisation can become an important partner for SRH measures. It gives the project a direct contact to the world in which young

people live, e.g. to a neighbourhood youth group or the representative council of a school or university. As regards participation, they offer the advantage that the young people already have a 'political culture' and that they can contribute their experience and arguments, in order to become involved and achieve their goals more effectively. The concrete proposals of young people can also be realised through co-operation, which is crucial over and above the principle of participation.

For the youth organisation, too, co-operation brings advantages; it can establish contacts to various other organisations, and build up relations that might be important; their ideas and approaches can be incorporated into the work of other players. Alongside these aspects, youth organisations, which rarely have a lobby in society or in the world of politics, can do with a bit of publicity so that what they do is seen, and so that youth-specific organisational forms are taken seriously.

Supporting Youth Organisations

Alongside the concrete co-operation with youth organisations, specific strengthening of youth structures through capacity building and empowerment can be important for SRH measures for young people. The work of non-governmental organisations (NGOs) is already supported in many fields, in order to strengthen grassroots work and build capacities. This also applies to youth organisations, although their position is initially somewhat different for the reasons listed above. The main aim here must be to strengthen the activities of the young people and the young people themselves in their capacity as social actors. The promotion of a youth organisation also impacts on the individual plans of the protagonists for the future. Work in the group promotes access to knowledge and boosts social participation. This helps achieve more equal opportunities for young people who might be disadvantaged as a result of their social or educational background. Seminars, supervision and co-operation with other organisations offer young people the chance to think again about their work, to obtain further training and to find new impetus. In practice, many projects have discovered time and time again that the commitment within youth organisations has an impact on the occupation of choice of the young people involved, and, in fact, on the occupation they subsequently choose. Proper promotion work should support this, and boost the chances of these young people to obtain access to further education.



Members of a youth organisation co-ordinate their work Ecuador 2001, B. Loewen

At the outset of co-operation it is important to build a basis of trust, and to get used to working together. On the basis of concrete work, various processes can develop.

Strengthening youth organisations

- Further training and consultancy services for project planning;
- Further training and consultancy services on specific subjects (SRH, AIDS, networking, etc.);
- Consultancy services to realise specific activities;
- Evaluation of measures already implemented.

The focus is always on the youth-specific characteristics and structures; consultancy services must thus be offered at times when the young people are available. The services should focus more on organising concrete planned activities than on complicated and longer-term planning methods, etc.

An example from Columbia

Co-operation can take the form of regular collaboration in networks, which are open to youth organisations. The GTZ-assisted youth network PAISAJOVEN in Columbia, which aims to strengthen youth work, collaborates with NGOs managed by adults, but also with youth organisations (including the representative of a network of youth organisations).

Members of the network must work with young people and must appoint a representative; the membership fees levied on other organisations are much reduced for youth organisations, or dispensed with entirely.

Within the scope of the networking, young people take part in various working groups and activities (e.g. working group on local youth policy, or video documentation of the situation of young people). The project guarantees the participatory representation of the interests of young people in network activities in this way. In many contexts, the knowledge of the young people and the access they offer to other young people can be put to good effect. The youth organisations can increase their lobby through their work in the network, and can work to have themselves and their approaches accepted. In various activities they can expect to receive technical consultancy services and perhaps also financial promotion from the network, as can the other member organisations.

During the initial project phase, the youth organisations that became members were categorised as 'neighbourhood organisations'. Thanks to the efforts of the youth organisations themselves, a special category 'youth organisations' was introduced, in order to make it quite clear who they represent.

The services available from the network include organisational consultancy services (for project management) and various further training courses on specific topics. The young people make the most of training and information on facilitation, gender, teamwork, planning and monitoring projects. Their organisations benefit from this, build capacities in relevant topics and can apply their new knowledge and methods directly in practice, and pass them on to other young people.

An example from Burkina Faso

The GTZ-supported sector project Promotion of Initiatives to End Female Genital Mutilation (FGM) is working in Burkina Faso with the youth organisation APJAD (Association pour la Promotion de la Jeunesse Africaine et le Développement), which is conducting a campaign against FGM. The young people got together on their own initiative at university, and initially worked primarily on HIV/AIDS, only touching on the issue of FGM. A study performed on behalf of the sector project identified a group of committed individuals and made contact with them.

As part of their current work within the scope of the campaign to eradicate the harmful traditional practice, the youth organisation invites young people in villages to attend meetings. They offer a wide range of activities, addressing girls and boys of various age groups, school pupils and out-of-school youth. Plays are performed to introduce the audience to the topic, didactic materials are produced to raise the awareness of young people, films shown, discussions offered and dances held at which information is available. The group also trains facilitators and sensitises traditional and religious leaders. APJAD pursues a peer educator approach, with young people passing on new knowledge to their peers. In this way, the organisation can better tackle the typical problems of youth.

The work of the youth organisation is financially supported by the project, and consultancy services are provided; an on-site co-ordinator provides backstopping, advises on organisational development and networks with other actors.

Setting up New Youth Organisations

The peer group has a special role for youth. Alternative forms of socialisation are explored here, which are important for the development of their own identity and for their own definitions of values. The youth organisation offers a framework for similar interests and encourages solidarity, respect and understanding. Group experience, identification and meaningful activities help foster the SRH of young people. Groups that encourage high-risk behaviour are an exception to this rule.

When promoting SRH, it is important to support the formation and further development of independent youth groups for these reasons. The groups can also become important partners in the process of multiplication, if they focus on concrete topics pertaining to youth health.

The health sector is often 'unattractive' for young people, since on the one hand, services are not youth-friendly, and on the other hand, they prefer to get involved in music or sports, or meet up with friends. For the project, this means that there might not be any youth organisations that deal specifically with topics relevant for SRH. In this case, the project can consider whether it should encourage or support the establishment of groups of this sort. If so, it is important not to make health issues the sole motivation, but to underline the chance of doing something for oneself and for other youth, making new friends, learning to learn, taking part in cultural and sporting activities, and the chance to determine the agenda of the group. Depending on the group dynamics, the group might of course prefer to focus on some topic that is more removed from the health sector, but even this can be seen as promoting health, since self-confidence, a meaning in life and positive group processes themselves foster a healthy way of living.

The aim is not to develop a youth group which can only take part in activities offered by the project or work for the project, but to encourage the foundation of a group that works independently, develops ideas, and finds its own means of expression. Even if a youth group is externally founded, there can be participation and representation of the group's own interests, if work is geared firstly to enabling the young people to participate and then to providing a framework for possible participation.

The following ideas can form the foundations for setting up youth groups:

- **Objective of youth groups:** Is a group to be set up to represent young people, to play the part of a 'youth project partner', in order to advise the project, in order to give young people space to develop their own projects? Are facilitators to be selected from the group? What are the expectations placed in this group? These considerations form the basis for the motivation of young people and their further work, but also help clarify the motivation and role of the project.
- **Target group:** Which young people are to take part in the group? This question helps establish contacts with potential participants. Depending on the choice of target group, schools, certain neighbourhoods, rural areas or universities are places to look for interested young people. Experience of work with youth groups indicates that there is a lot of dormant potential that can develop within the framework of work within a group. In order to motivate the young people, information events can be organised, young facilitators can present their work, posters and flyers can be used to publicise the group, or again contact can be established via the church or a neighbourhood organisation. Existing youth groups can also be approached directly 'at the street corner'. In principle, the form of address must be appropriate for the group in question, *i.e.* if you are looking for out-of-school youth, do it during school hours and remember that they may not be able to read, etc..
- **Gender aspect:** If girls are to be addressed, places typical for girls must be visited. In most cultures, girls are limited to the house and home, while boys can be found in more public areas; girls are less likely to be allowed to set up (mixed-sex) youth groups. Girl-specific services and information events for parents can help facilitate access for girls.
- **Participation:** When planning the first meetings and activities, the young people should be involved straight away. The group should discuss expectations, and decide what the goal of their work should be and which activities they would like to see. It is important not to expect too much of the young people at this stage, for few have experience of being listened to or involved in decision-making. Games and discussions help overcome inhibitions and encourage trust in the group. They also help the group come together and each member find his or her own role. Excursions and meetings with other groups can underpin this at a later stage.

- **Supervising the group:** As regards the role of a supervisor for a group of this sort, it is vital that it be clear from the outset that the group should take over the co-ordination work itself as soon as possible. The external co-ordinator withdraws gradually and is only available as an advisor. The young people must realise that they are not working *for* anybody and do not need to meet the expectations of others, but that they work for their group and make their own decisions.
- **Space for young people:** In general, young people have no space to themselves. At home they share rooms with parents and siblings, at school they are controlled so that they often make public places their own; the meeting place in the park or at the street corner offers them their own space. When setting up a youth group, one important motivation is therefore to have a place of their own, which encourages responsibility and identification with the group.

An example from Ecuador

The GTZ-assisted project RIAS (Red Inter-sectorial de Adolescencia y Sexualidad) in Ecuador, on adolescent SRH, has set up a youth organisation in co-operation with a local NGO. The young people were offered seminars on self-awareness and awareness of their own bodies at school. After the seminars, the young people were invited to get together as a group, and to perhaps look at similar topics; all in all more than 50 young people could be recruited in this way in a first stage. The seminars were intentionally kept low-key, so as not only to motivate those young people who already work as facilitators or are part of councils of some sort, but above all to attract young people with no prior knowledge or experience in the field of SRH or in work as facilitators. In the first year, the young people worked mainly on group-building, but also on topics such as youth identity, participation, sexuality, gender and HIV/AIDS.

Over time, new members have joined, through contacts in the district some out-of-school youth are now also involved in the group. Others have not returned for various reasons (starting work, girls have not been allowed to attend, other interests). The group is now stable with about 30 members, who focus partly on acrobatics (fire-eating, juggling, stilt-walking, etc.) and who have been trained especially as youth facilitators. The project offered the relevant training, and continues to advise and support them. The topic of the group is SRH, but group life and friendship are also major reasons for motivation and participation.

The group-building process has been completed, the co-ordinators, who initially worked intensively with the group, have withdrawn, and only provide support on request. The group is an independent member of the RIAS network, with the task of representing youth and co-ordinating work with other youth organisations. Alone, or with other actors, the group holds festivals, seminars, information events with district health centres, etc. on youth participation and SRH. The other network members try to respect the youth-specific structures and to set events and meetings for afternoons and week-ends.

The group has a small office and its own group room, which it decorates and maintains itself. In the start-up phase the project provided infrastructure (telephone, fax, computer, e-mail). At present, the group is working on a concept for a small business or offer of services in order to finance its group activities independently.

Conclusion

Co-operation with youth organisations is an important component of SRH measures and can help them achieve their objectives. The following experience should be incorporated in project work:

- The project should establish whether or not there is a general willingness to accept the specific characteristics of youth groups. This will mean, for instance, that initially the project will need to go and look for youth organisations, that it will have to take into account the limited time available to young people, and that there might well be a high turn-over of representatives, etc.
- Co-operation with a youth organisation is expedient if there is an overlap in terms of subject matter or if the strengthening of a youth organisation *per se* is seen as a health-promoting measure for participants.
- The financing of youth activities is an important form of support for the project, and can help achieve the objectives of the project. Nevertheless, care should be taken not to finance everything (although the sums involved are often small) so that the young people do not become dependent on the project, and lose independence rather than gaining it. In the long term, (financial) independence from the project is important for the group.
- In the start-up phase of a youth organisation, one or more people will need to support the group. These people should have some pedagogical knowledge of group-building (encouraging group processes, building trust, etc.). The pedagogical concept should clearly indicate at what point these persons should begin to withdraw.
- Co-operation with other organisations always takes time, so that efforts to work together with youth organisations must be taken seriously, and not just run alongside everything else.
- The young people must be respected as actors and experts in their field, for otherwise there is no point in launching co-operation. That means accepting different opinions, learning from one another and not instrumentalising young people for the project.
- Sustainability of youth organisations, however, can only be achieved when new young members are continuously attracted to compensate for (time) constraints and 'natural' turnover of young people (see also Blankhart in this publication).

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2.4 School-based Sexuality Education

Gabi Gahn, Consultant

Introduction

Concerns about adolescents' sexuality have emerged in the light of decreasing opportunities for realistic preparation for sexual life in the family context. Traditional education through initiation ceremonies, grandparents as role models, oral traditions and folklore, ancestral sanctions, etc. have declined in relevance. The erosion of traditional control over 'appropriate' sexual behaviour has been attributed to socio-economic and demographic changes, including urbanisation, greater mobility, stimuli in the media, and more interpersonal openness. In addition, as an increasing number of adolescents is subject to sexually transmitted diseases (STDs) and HIV/AIDS, unplanned pregnancies and unsafe abortion, the need for inculcation on sexual and reproductive health (SRH) for adolescents acquires a new urgency.

Sexuality is important for general health. However, adolescents are not only embarking on risky sexual relationships out of ill-informed choice, but also by force, e.g. prostitution, sugar daddies, protection in turn for sexual favours in street gangs, etc. Currently, neither parents nor the education system appear competent to address this issue, and youth instead turn to peers, the media, or popular role models, who do not confer the relevant information or morale for a healthy sexuality of adolescents either. It is hence of vital importance to adapt those institutions directly involved in the upbringing of children and youth, primarily the family and school, to the needs of adolescent SRH. This paper is concerned with sexuality education at school as a strategy to address adolescent SRH. This focus is at the detriment of the large number of out-of-school children and youth.

- Helpful as school-based sexuality education is, it does not reach all adolescents, and needs to be supplemented by community-based non-formal educational programmes.

What is Sexuality Education?

Sexuality education emphasises a broad approach to sexuality, focusing on the whole person and presenting sexuality as a positive part of life. It covers all aspects of becoming and being a sexual, gendered person and includes biological, psychological, social, economic, and cultural perspectives. It explores values and develops social skills with the goal of promoting SRH (Irvin 2000). Because attitudes towards sex are usually adopted prior to adolescence, and to pre-empt risky sexual activity, sexuality education should begin to intervene at an early age.

To be effective sexuality education should be a gradual process, with appropriate information and skills conveyed at different ages. Initially, the facts of life should be disseminated as an integral part of other subjects, including biology and social sciences. Progressively, sexuality education should adapt to the learners' changing interests and capacities. It must also be

complemented by counselling and other services. It requires a non-judgemental approach based on trust between the educator and the young person in order to discuss the meaning, pleasures and risks of sexuality in the youth's own terms. Although such a relationship is difficult to establish for a variety of reasons (age hierarchy, taboo to talk about sex, institutional impediments, etc.), educators must be trained and motivated to build a positive environment and empower youth to understand their sexuality, resolve conflicts and take their own decisions.

If it exists at all, sexuality education at school at present tends to be part of family life education, and is mostly only introduced at the end of primary school or in secondary school. Family life education generally concentrates on responsible parenthood within marriage, reproductive physiology and to a lesser extent on STDs, usually with a moralising connotation. It rarely offers information about sexuality and gender relations, or reproductive health services.

- Effective sexuality education teaches practical skills such as sexual negotiation, decision-making and life planning, in addition to providing basic information on gender, human reproduction, contraception, STDs and HIV/AIDS, and counselling services.

Objectives of sexuality education as concerns children

- Understanding human relationships;
- Acquiring acceptable attitudes and values towards sexuality;
- Enriching the conceptualisation of family life issues;
- Understanding the spiritual aspects, to ensure self-discipline;
- Knowing about primary and secondary sexual characteristics and how they function;
- Understanding the processes and consequences of sexual activity, of pregnancy, contraception and abortion, and of STDs and HIV/AIDS;
- Providing knowledge of relevant available health services;
- Identifying the potential impact of sexual activity on their personal development, and interpersonal relations.

Curriculum Development

In almost every country, the implementation of sexuality education in and outside schools has faced legal, cultural and religious barriers as well as opposition from parents, teachers, health care providers and government officials, who often find it difficult to agree on the need for and nature of sexuality education. At issue are the subjects to be covered, the age groups taught, teacher training, and the method of instruction. At the basis of such considerations should be a needs-assessment of the target group youth (see Girrback in this publication). In country's where there is no provision for such education, the Ministry of Education together with the Ministry of Health should be at the forefront of devising school-based sexuality programmes, to spearhead necessary policy adjustments. Co-ordination with the Ministry of Education as legally responsible for syllabuses and curricula is necessary also because of the increasing number of educational and social issues competing for limited school time. Clearly stated policies and an appropriate curriculum are essential for successful classroom approaches.

Bodies to develop the sexuality education curriculum can be curriculum centres, educational institutes, or ministerial departments. In any case, curriculum developers should be competent in planning, needs assessment, curriculum development techniques, participatory and didactic educational methods, and evaluation, as well as have sound background and understanding of the complex issues involved in communicating about sexuality. School-based sexuality education should be developed within the context of the traditions, beliefs, values, and behavioural and educational norms of the society. It must address the needs and concerns of young people themselves as well as those of communities and teachers (UNAIDS/WHO/UNESCO 1999).

- Without changing the overall school curriculum, modules can be pre-tested in selected schools by inserting them into existing subject areas.
- Sexuality education can be taught either as part of an established subject e.g. health education or social studies, or as a separate subject, or as a cross-curricular issue, or as an extra-curricular activity.

AIDS as a topic in primary education in Guinea

The GTZ-supported projects Promotion of Basic Education in Labé and Rural Health, together with the regional health authorities, the National Institute for Pedagogical Research and Implementation (INRAP), and various NGOs, developed a concept for the integration of HIV/AIDS as a topic in primary education. The aim is to effectively prevent the spread of the virus by addressing young people before they become sexually active, which is as early as 12 years of age. A trial curriculum will be launched in six primary schools in Labé and Faranah in the academic year 2000/2001:

- In class, HIV/AIDS will be addressed from year one onwards in various subjects, and wherever the topic of discussion allows reference.
- In the wider school context, peer education and distribution of condoms will take place, complemented by work with parents, and out-of-school youth.

Both school-based and community-wide activities will be initiated by teachers. It is particularly important to change methods of instruction, in order to foster an open dialogue between teachers and pupils, and to provide mother-tongue education. Accordingly, teachers will undergo special (in-service) training, imparting among others skills for self-initiative, creative and participatory teaching methods, and the development of their own ideas. Currently, an initial 18 teachers are being trained.

Contact: Prof. Thomas Ott, Promotion de l'Education de Base dans la Region Administrative de Labé

Teacher Training

Teachers tend to be no better equipped to provide sexuality education than parents, and may give inadequate or incorrect information. This is not only a question of lack of training. Teachers have also been raised in traditions, beliefs, values and taboos similar to the parents and students. Their behavioural patterns often do not differ from their students as for instance the level of HIV infections among teachers indicates. Moreover, due to authoritative education systems, and the concomitant nature of student-teacher relationships, as well as large classroom sizes, students will be reluctant to confide and discuss sexual issues with teachers and *vice versa*. The quality and impact of sexuality education crucially hinges upon the educator's capacity and style. Numerous guides and materials are available to assist individual

teachers or institutions to develop training sessions, including teaching guides, workbooks, educational games, audio-visual tapes etc.

- Sufficient time and resources must be allocated for training, practice, supervision, and refresher courses for a large number of teachers, as well as curriculum and material development.
- Counsellors should support teachers in or outside the school, who can adequately help pupils with personal difficulties regarding SRH.

Strategies for teaching

- Answer children's questions honestly at all levels;
- Encourage observations of insects, fish, etc. for incidental learning of reproductive processes;
- Use direct teaching for specific issues like menstruation;
- Co-operate with the (school) health club if existent;
- Encourage project work on specific issues to find out pupils' attitudes and suggestions (topics could be: mates who have dropped out because of pregnancies, abortion, STDs);
- Foster healthy relationships through interactive methodology, including role plays, discussions;
- Allow for peer discussions;
- Provide for (or refer to) individual counselling;
- Organise SRH weeks in schools;
- Use radio, posters and other material to disseminate information.

Pedagogical Approaches

Responsible behaviour is key to adolescent SRH, and to preventing teenage pregnancy, STDs and HIV/AIDS, sexual violence and substance abuse. In order to modify negative behaviours, information dissemination has to go hand in hand with the promotion of personal skills that influence behaviour, *i.e.* life skills, which help the individual translate acquired knowledge, attitudes and values into positive behaviour. Traditionally, teaching about sexuality in schools has taken a moralising, simplistic approach. To change the overall climate of formal education from a teacher-centred, authoritarian system to an open, enabling learning environment is a necessary though time-consuming process.

Life Skills

Life skills are personal skills that have a strong influence on behaviour, providing the link between underlying co-requisites such as knowledge, attitudes and values, and the desired positive health behaviour outcome. The list of life skills described by both WHO and UNICEF includes:

- Decision making
- Problem solving
- Creative thinking
- Critical thinking
- Effective communication
- Interpersonal relationships
- Self-awareness
- Self-esteem
- Empathy
- Coping

Age Appropriateness

Sexuality education programmes are sometimes simplistically designed for an apparently homogeneous group of adolescents with regard to biology, sexuality, age, power relations, family situation, socio-economic background, etc. Interventions must be appropriate to age, gender and developmental stage. It is useful to conduct a mini-participatory research or question-and-answer session to determine what issues are of interest at a particular age. For instance at early puberty, adolescents tend to be curious about sexuality, emotions and the physical changes experienced at puberty. Timely quality sexuality education can help prevent undesirable or risky behaviour patterns.

- Quantity and type of health-related information must be suitable for the age cohort addressed, and appropriate health services available.
- In recognition that attitudes and beliefs are formed early in life, sexuality education should start in primary school, before young people engage in sex, and before substantial proportions of young people drop out of school.
- 'Spiral curricula' reinforce newly acquired knowledge and attitudes at regular intervals, thereby enabling students to relate them to specific situations encountered at different ages.

Gender Considerations

It must be ensured that male and female adolescents are comfortable in discussion on sexual and reproductive issues with each other. Though some subjects may be better dealt with in single-sex classes, there are advantages in mixed sessions – beyond feasibility – especially when discussing gender relations. Mixed settings help adolescents to understand better each other's anxieties and attitudes and improve communication.

- Involve a combination of mixed and single-sex classes, depending on cultural appropriateness, and subject matter, yet allowing scope for exploring the other sex's views.

Participatory Learning

Evidence points to the fact that sexuality education, which tries to involve the adolescents in discussions and activities, are more effective than teacher-centred lectures. A workshop approach allows young people to explore their own attitudes and make discoveries for themselves, and it helps them to build self-esteem and gain confidence to make choices regarding sexual behaviour – including the confidence to delay a sexual relationship until they feel ready.

- Active, participatory learning methods are required to address the affective and behavioural domains of sexuality education.

- A useful approach is to bring trained outside (health) educators into the classroom, in order to alleviate concerns about confidentiality, and to utilise innovative, participatory and interactive educational techniques.

Peer Education

Given that adolescents tend to communicate better with their peers than with adults, peer education can be a useful supplement to a comprehensive school-based sexuality education – but should not substitute it. In the school context, peer educators can either work together with the teacher to promote SRH, or offer activities/services of their own to complement the teachers' role. There are clear limits to adolescent peer educators' ability to handle certain situations, for which they may need to refer their peers to trained adults, health and counselling services.

- Peer educators should be approachable inside the classroom and informally during breaks, sports activities, and in school-clubs, or they may set up a special room for counselling, information, and distribution of condoms (see Blankhart in this publication).
- Sports programmes are one opportunity for girls to develop self-esteem, master new skills, and formulate a sense of bodily integrity crucial to promoting their health and self-image (see Kreiß & Loewen in this publication).

Community Links

In many societies, community members may feel that sexuality education encourages young people to experiment prematurely – even though several studies have shown that it does not lead to increased sexual activity (UNAIDS 1997b, WHO 1993). However, typically there is a range of opinions in the community, some of which can be drawn upon for support. In order to change sexual behaviour sustainably, programmes need to adopt a participatory community development approach, which is often achieved through involvement and adaptation of strategies to local concerns. Through sensitisation of the community and, in particular, the elders, leaders, decision makers, women's and youth groups on the positive aspects of reproductive health one can find ways to develop community support.

Networking with groups and organisations, such as social services, youth-agricultural departments, women's groups, youth organisations and vocational training schools, may assist in programme design and implementation.

- Parent-teacher associations, adult education classes, formal meetings and presentations, religious groups' activities and community group meetings are appropriate settings for promoting collaboration between the school involved in sexuality education and the wider community.

Checklist how to proceed

- Take into account national guidelines because curricula, teacher training, and to a certain extent also in-service training, are decided upon at central government level.
- Co-operate with the Ministry of Education and of Health, to lobby for sexuality education to become part of the school curriculum for boys and girls preferably before they reach puberty, each and every year as they move from primary to high school.
- Advocate for clear, appropriate policy and curricula adjustments, and relevant pre- and in-service training of large numbers of primary and secondary school teachers.
- Promote sexuality education at school through one of the following:
 1. implementation of a separate course;
 2. infusion of topics into core subjects;
 3. utilisation of outside educators prepared to discuss sexual matters and help students gain access to community health services;
 4. introduction of sexuality education/reproductive health issues through existing HIV/AIDS prevention programmes.
- Assess and understand the concerns and needs of adolescents (differentiated by age and gender) prior to developing messages and activities which meet the needs of the different cohorts.
- Involve young people at all stages, *i.e.* design, implementation and evaluation of the sexuality education, to secure their acceptance and use of the programme. Girls' participation requires extra efforts according to their specific needs.
- Supplement the sexuality education with various pedagogical approaches, including peer educators, sports, community development, etc. aiming to impart information on adolescence, gender, human development, communication, participatory methodology, managing group processes, etc.
- Collaborate closely at all stages with teachers, parents, health personnel, community and religious leaders to get school-based sexuality education accepted.
- Mobilise multi-sectoral commitment and support, and build on existing networks e.g. youth or women's groups, churches, informal work sites. Consider forming multidisciplinary networks to broaden the school-based programme, and overcome the separation of formal and non-formal education.
- Offer or co-operate with community-based non-formal educational programmes in order to reach the out-of-school youth.

SRH projects should attempt to enhance strengths of school-based sexuality education, and confront its weakness.

Strengths of school-based sexuality education	Weaknesses of school-based sexuality education
<ul style="list-style-type: none"> • Chance to reach all young people in school 	<ul style="list-style-type: none"> • Does not reach those who do not attend school or drop out early. • Lack of active support, commitment and co-ordination from ministries of health and education and school officials may hinder progress • Inadequate mechanisms to supervise, monitor, and evaluate programmes
<ul style="list-style-type: none"> • Sexuality education can be included in the pre-service and in-service training of teachers 	<ul style="list-style-type: none"> • Young people have problems to talk about sensitive issues in front of their teachers • Sexuality educators must be carefully selected. Not everyone is suitable.
<ul style="list-style-type: none"> • Trained teachers can function as role models, resource people for accurate information, and effective instructors. 	<ul style="list-style-type: none"> • Lack of skilled personnel, training, and materials or transfer of teachers trained in sexuality education • Teachers feel embarrassed to discuss sensitive issues with students because they have been raised in traditions, taboos and beliefs similar to the parents.
<ul style="list-style-type: none"> • Sexuality education can be integrated in ongoing programmes or school clubs 	<ul style="list-style-type: none"> • Opposition from parents, school leaders, teachers, religious leaders.
<ul style="list-style-type: none"> • The school setting allows to provide youth with information and services with relatively few resources. 	<ul style="list-style-type: none"> • Heterogeneous target population: Young people are not stratified according to age and gender. The curriculum does not consider different interests; the same materials are used for girls and boys.
<ul style="list-style-type: none"> • Introduction of sexuality education/ reproductive health through existing HIV/AIDS-prevention programmes. 	<ul style="list-style-type: none"> • Many subjects compete for limited school time.
<ul style="list-style-type: none"> • Good AIDS education for adolescents does not lead to increased sexual activity, but on the contrary delays the age of first sexual intercourse. 	
<ul style="list-style-type: none"> • Teachers can have a substantial input in the activity of the community. 	
<ul style="list-style-type: none"> • School can reach the community; links with parents and community members can ensure that they receive consistent SRH messages. 	

<ul style="list-style-type: none"> • There are educational opportunities by overcoming the separation between the formal and non-formal school system. Both systems may inform and complement each other. 	
<ul style="list-style-type: none"> • Establishment of linkages with health system for youth services. 	
<ul style="list-style-type: none"> • Bringing outside educators into the classroom might alleviate pupils' concerns about confidentiality. 	<ul style="list-style-type: none"> • Outside educators who are only involved from time to time are unlikely to assure sustainability of activities.
<ul style="list-style-type: none"> • School provides options to train peer educators in sexuality education. 	<ul style="list-style-type: none"> • Peer educators are not willing or able to volunteer for a longer period of time. They also need training, motivation and continued support. • Peer educators/counsellors require intensive training and ongoing follow-up/supervision as well as back up by qualified adult educators.
<ul style="list-style-type: none"> • Integrating reproductive health education into sports promises to be a valuable strategy, especially for girls. 	

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2.5 Health Information Centre for Young People

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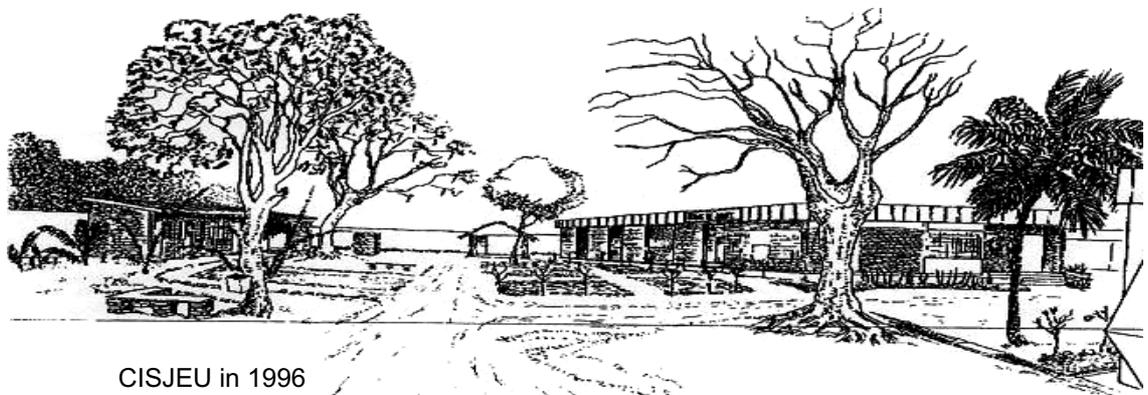
Introduction



Sexually transmitted diseases (STDs), HIV/AIDS, unwanted pregnancies and sexual violence among young people in sub-Saharan Africa have consequences, sometimes serious or even irreversible, for their development, which can go as far as compromising their role in tomorrow's society. With a view to enhancing health care for adolescents in the Central African Republic, specific activities were defined within the scope of the National Health Programme for Young People and Adolescents. The programme provides for structures to deal with young people, and for inter-sectoral co-operation, in particular with the non-profit private sector, namely non-governmental organisations (NGOs) and churches.

Against this background, the Health Information, Education and Communication Centre for Youth Sexual Health (CISJEU) was set up at Bangui in May 1994, jointly by the l'Eglise du Christ Roi church and the Youth Support Project for Responsible Sexuality (PAJERS), with GTZ assistance. The aim has been to help reduce the incidence of problems related to sexual and reproductive health (SRH) among young people in the 10 to 22 age group, and to help promote responsible sexual behaviour.

The mission of CISJEU was defined in terms of the expressed needs of young people, within the scope of discussions with them organised by PAJERS. The authenticity of these needs was confirmed by two complementary studies of young people in Bangui carried out by PAJERS: one Knowledge, Attitude, Practice (KAP) study of sexuality and health-seeking behaviour, and one evaluation of the rate of attendance of young people at health centres.



CISJEU in 1996

¹ The author would like to thank the many people who helped develop CISJEU, and the editor of this article, Gérard Foulon, Technical Counsellor at the Ministry of Health of the Central African Republic from 1996 to 2000.

CISJEU offers information, counselling and leisure activities. It provides primary care in the field of SRH and refers cases requiring more specialised attention to the relevant health-care structures. It is also the base for community and neighbourhood activities.

This article sets out the principles which led us to create and develop CISJEU. Two points seemed particularly important to us: How we selected the location, and how we gradually established the organisation and the current operations. The textboxes point out some weaknesses and strengths experienced in six years of work.

Establishment of CISJEU

The successful integration of the Centre in the urban environment, and its acceptance by young people depends largely on the choice of location, the opening hours and publicity activities.

The Choice of Location

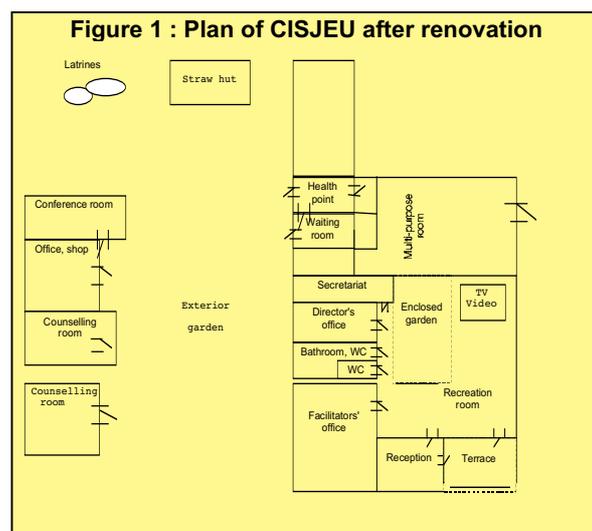
Criteria

The location must be :

- Easy to reach for as many young people as possible (*i.e.* in or close to the most densely populated parts of town) and close to a location already attended by young people (school, church, sports centre, etc.)
- Neutral (for instance, independent of all political parties) and suitable in architectural terms (building suited for current needs, with potential for extension and external use)
- Attractive for youth and acceptable to their parents (calm, safe, pleasant atmosphere)
- Financially viable (rent, water, electricity and caretaking). This aspect is important for sustainability.

Decision made

CISJEU was set up within the grounds of the Protestant Youth Centre, at the border of two densely populated neighbourhoods, close to four schools (with a total of some 9,000 pupils) and to a well-attended church. The Centre is non-denominational. The church, l'Eglise Christ Roi, agreed to provide the buildings rent-free for a limited period, in return for help with renovating the Protestant Youth Centre. After renovation, CISJEU had eight rooms, one recreation room, one conference room and one large straw hut, spread over three buildings in a vast garden (figure 1 and drawing on first page of this article). The recreation room also serves as a library. The Health Point and the counselling rooms are some way away, to ensure more privacy and anonymity.



Opening Hours

Criteria

The opening hours must take into account the fact that young people are not generally available in the mornings (when many of them work or are at school) and the need for them to be home before nightfall (for reasons of security). The staff must also have enough time to manage the Centre, prepare activities, write reports and conduct awareness work in the relevant districts of town.

Decision made

CISJEU is open all year round from Monday to Friday, but not at the weekend, when the staff has time off or is busy with awareness-raising outside the Centre. Activities take place every afternoon and three mornings a week. Initially, the first session of the afternoon (2.30 – 4.30pm) was reserved for young adolescents, and the following period (4.30 – 6.30pm) for the older age groups. For security reasons though, and because of a shortage of staff, only one session is now offered, with activities finishing at 5.30pm.

Advertising Boards and Publicity

Criteria

Everything possible had to be done to publicise the Centre from the outset, in order to attract as many visitors as possible. According to our statistics, 62 percent of young people found out about CISJEU from other young people, 26% from their parents and 10% from the media.

Decision made

The following means of publicity were used:

- A competition to choose the Centre's name and logo, with prizes awarded at CISJEU;
- Inauguration of the Centre in the presence of local authorities with huge media coverage;
- Special activities to celebrate CISJEU's first anniversary;
- Distribution of leaflets on CISJEU and pocket calendars;

Table 1: Programme for IEC activities at CISJEU - April 1999			
Educational Events			
Dates	Topics		Speakers
Wednesday 7 April	How does a boy's body work?		Jean – Vincent
Wednesday 14 April	The disadvantages of back-street abortions for young people		Dr. S. Gondje
Wednesday 21 April	Alcoholism and AIDS among youth		Kévin Bobella
Wednesday 28 April	Detecting HIV. What is it?		Dr. J. Sehounou
Film/Video Shows			
Dates	Title	Topics	Speakers
Thursday 1 April	Bonheur la vie	Puberty in boys and girls	Jean - Vincent
Thursday 8 April	Samadoom mon fils	Combating drug abuse in young people	Jean - Vincent
Thursday 15 April	Karaté kids	The deceit of adults	Jean - Vincent
Thursday 22 April	Tintin	Fidelity and courage among young people	Jean - Vincent
Thursday 29 April	TASO	How to take care of people living with HIV	Jean - Vincent
Talks/Discussions			
Dates	Topics		Speakers/ Leaders
Friday 2 April	How does a girl's body work?		Jean – Vincent
Friday 9 April	AIDS – a unique STD		Jean – Vincent
Friday 16 April	What can the Red Cross do for you? (Part 3)		Jean Nordmann
Friday 23 April	Do we need hope?		Frédéric Tolo
Friday 30 April	Young people's commitment to the community		Max Biampeng

- Creation and distribution of a poster to publicise CISJEU;
- Radio quiz (with answers sent to CISJEU and prizes to be collected there);
- Radio broadcasts about CISJEU activities;
- Advertising boards with the CISJEU logo, one at a main road close to the Centre, the other at the entrance of the Centre, with the programme for the month (see Table 1 for an example);
- Distribution of articles with the CISJEU logo (T-shirts, sunglasses, pocket mirrors, key-rings, caps, waist bags) during the quiz and other activities;
- Tour of the PAJERS drama group to youth clubs and churches, other youth associations and film clubs; meetings with parents, etc.

Strengths	Weaknesses
<ul style="list-style-type: none"> • The Centre is easy to reach for young people and accepted by their parents. • No rent and low running costs. • The opening hours seem to suit young people. • The site is perfect for the activities of the Centre. • The Centre is well attended by school pupils. 	<ul style="list-style-type: none"> • Few girls attend the Centre. • There are no regular weekend activities. • Out-of-school youth do not attend the Centre.

Operation of CISJEU

Description of Activities

Criteria

CISJEU aims to provide information, counselling and leisure activities, primary care in the field of SRH and referrals to more specialised health care structures where required.

Decision made

CISJEU activities are divided among three technical units, responsible for Information, Education, Communication (IEC), individual counselling and preventive and curative care respectively. Two back-up units provide reception services and are responsible for the administration and management of the Centre.

IEC Unit

The IEC Unit is responsible for a) documentation/reading, b) videos/discussions c) educational activities/debates and d) games. In an effort to make attendance a habit among young people, each activity has its regular slot (Table 2). Figure 2 gives an overview of attendance, by activity, during the first half of 1999.

a) Documentation/ Reading

The library is open on Monday afternoons, but books may not be borrowed. One session a week was felt to be enough, because the library attracts relatively few youth. The library is also used by people preparing talks or presentations.

The library comprises documents on STDs, HIV/AIDS, family planning, unwanted pregnancies, abortion, sexuality, anatomy and physiology. All points of view, including those of the churches, are represented.

The management of the library (keeping order, updating and diversifying the materials in line with the specific needs of boys and girls in each age group) demands special attention.

b) Videos/Discussions

Videos are shown on Thursdays. The Centre has acquired about thirty different videos. A facilitator prepares the session, ensures that the projection runs smoothly, and directs the discussion. The questions asked by young people are noted and categorised, and used in the preparations for the next sessions, or for planning other activities.

c) Educational Activities/Debates

These activities are held on Wednesdays and Fridays. They generally take the form of talks or discussions. The sessions foster participation, and encourage young people to discuss among themselves. The events are facilitated by either CISJEU staff or by an invited guest (doctor, nurse, witness, lawyer, environmentalist, community representative, etc.).

The topics dealt with are selected on the basis of the needs expressed by young people, either during the debates and counselling or through the suggestions box (see Table 3 for some examples).

Table 2: CISJEU timetable

Afternoon	Activities
Monday	Documentation / Reading
Tuesday	Games
Wednesday	Educational activities / Debates
Thursday	Videos/Discussions
Friday	Discussion / Debate

Figure 2: Attendance by activity in the first half of 1999

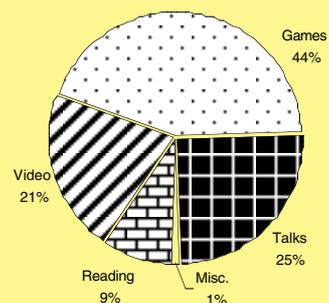


Table 3: Topics of educational activities and talks

- Anatomy of the male and female genitals
- Risks of HIV infection in a one-off unprotected sexual encounter among young people
- Consequences of unwanted pregnancy
- How to avoid AIDS
- Consequences of early sexual relations
- Causes of sterility in men and women
- Responsibility of young people for their sexuality
- Mother-to-child transmission of HIV
- Problems linked to drug consumption
- Socio-economic and cultural factors which favour fresh outbreaks of STDs
- HIV propagation tree for young people in the community
- The survival of AIDS orphans
- The case for responsible love among young people
- Young people, let us work together for family planning
- Calculating the menstrual cycle
- Quarterly forum to discuss CISJEU activities
- Taking care of people living with HIV in a professional environment
- AIDS prevention for young professionals
- Polygamy vs. monogamy – a difficult choice
- How to transmit and prevent gonococcal infections
- Civil marriage
- STDs
- Sexual violence towards adolescents

As regards pedagogical work, the young people particularly like role-plays (along the lines of 'not now – later', or 'only with') to strengthen their negotiating skills. These exercises are particularly interesting when a boy plays the part of a girl and vice versa.

d) Games

Initially, games were organised on Tuesday afternoons. Thereafter, three additional sessions were organised in the mornings, which greatly increased the number of participants. It was necessary to set up an additional voluntary trainer team to facilitate these sessions.

The games are varied: Parlour games, games on the topic of SRH, table tennis, table football, etc.

Tools and Procedures for Managing the IEC Unit

- Use an educational activity/discussion card to prepare and evaluate sessions (see Figure. 3 for an example).
- Note and categorise the questions asked at the sessions. Archive presentations if possible. This information makes it easier to prepare subsequent sessions.
- Set up a record of use of books in the library to see which books are most appreciated, and to calculate how many copies are needed.
- Add a short summary of each video to the video inventory, which will enhance the documentation and facilitate preparations.
- Use the numerous local sources to increase stocks of books or video cassettes: University, international agencies, the Internet, television stations (ask for a copy of a programme), video centres (consider drafting an agreement).
- Organise internal training for young people interested in facilitation techniques, and in becoming peer educators.

**Figure 3: CISJEU educational activity/
Discussion Card**
(Before and after the event).

Family and first names

Topic

Day and date of event

Date of submission of contents of talk

Objective: At the end of the event, participants should know and be able to do the following:

1.

2.

3.

Techniques used /_/ Talk followed by debate
 /_/ Discussion in large and small groups
 /_/ Discussion in a large group

Didactic materials required:

 /_/ Overhead projector /_/ Board, paper, markers
 /_/ Slides /_/ Video /_/ Blackboard + chalk
 /_/ Other

Time planned:

 for the talk :

 for discussion in small groups:

 for discussion in a large group:

Total :

Seating arrangements:

 /_/ Circle /_/ Semi-circle /_/

 Square/rectangle /_/ Other, specify:

Language used:

(CISJEU is attended by youth from the informal sector
Sango /_/ French /_/ Sango and French /_/

Observations

Summary of the event:

Evaluation of the event by the leader/speaker
(Impression–participation of youth–difficulties–suggestions–recommendations other points...).

Signature of leader/speaker

Counselling Unit

This unit offers young people support in the form of one-to-one counselling to help them resolve problems regarding adolescence and SRH. A card ensuring anonymity is filled in for monitoring purposes. If necessary, the young person is referred to the Health Point.

The counselling services aim to help and support the young person to make an informed choice. The subjects most frequently broached are:

- The precocity of sexual relations;
- Detecting and treating STDs/AIDS;
- Contraception for young couples;
- Multiplicity of sexual partners;
- The use of condoms for casual sex.

CISJEU uses voluntary counsellors as far as possible, because the voluntary nature of these services is a mark of commitment, and because of the low costs involved (FCFA 1,000 transport costs per session) compared to wage costs.

CISJEU's counselling service was set up in two stages: The first 20 voluntary counsellors (of all ages) were trained in two weeks. By the end of the first year, most had already left. In the second stage, a peer counsellor training course was set up. After being selected, about fifteen young people were accepted for a longer training course (two afternoons a week and some weekends over a three-month period) which allowed them to learn technical aspects in more depth, to assimilate the concept of confidentiality and to develop an appropriate attitude for counselling. The peer counsellors were then supervised by two senior counsellors. Monthly meetings were organised with all counsellors for monitoring and further training purposes.

Health Point

The IEC and counselling activities only have an impact if the public health care structures offer quality services. Our analysis of the Ministry of Health statistics indicates that youth rarely use the public health centres, possibly because the services offered do not address their needs.

To bridge this gap, CISJEU opened a Health Point within the CISJEU grounds, in order to reduce the number of young people that are lost from sight when the counselling service refers a case to the public health centre for medical consultations.

The reproductive health consultation is provided by a nurse and a part-time doctor who provide counselling, family planning, pregnancy tests, antenatal consultations, and treatment for STDs in line with the syndromic approach, on the basis of a national algorithm. The aetiological treatment is prescribed on the basis of additional examinations. If necessary, young people are sent to a specialist. The pill and condoms are proposed as contraceptives and are subsidised by the project, as are the drugs.

The quasi-free nature of the care is an important factor in the rate of attendance, because of young people's very limited financial resources. The consultation fee at the Health Point is lower than fees charged by public health centres. The prior counselling service governs access to the Health Point to increase the impact of the health intervention measures.

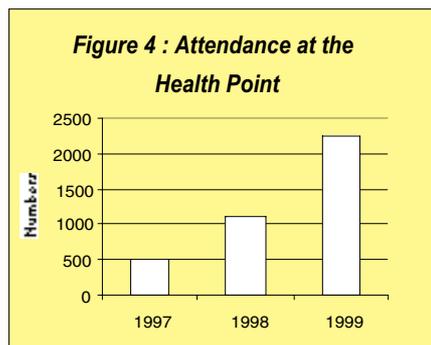


Figure 4 shows a steady increase in the attendance of young people at the Health Point between 1997 and 1999, indicating that the services offered are valued.

In 1999, STD treatment was the main reason for consultation (92%, as compared to 5% for family planning and 3 % for antenatal consultation). Special emphasis is placed on treating partners. Measures are taken to encourage young people to bring their partners for treatment (invitation cards, reduced rate for partner treatment, etc.).

Back-Up Units

- a) The reception unit is often responsible for the initial contact between young people and the Centre. It informs young people about the Centre's activities, distributes information leaflets and points the young people towards the unit of their choice. The reception unit controls entry, maintains order and records requests for information and attendance for statistical purposes, ensuring anonymity. Daily statistics cards are analysed along with other documents by a Centre executive to compile biannual and annual statistics (attendance by sex, age, home neighbourhood, number of years' schooling, former contacts).
- b) The administration of the Centre is undertaken by a secretary, assisted by young volunteers. She is in charge of day-to-day management, bookkeeping and stocks. She takes part in preparations for receiving visitors. If necessary, she assures order among the young people.

Strengths	Weaknesses
<ul style="list-style-type: none"> • The units have clearly separated rooms. • The summaries of videos and the list of questions asked by young people exist. The data gathering and processing system is operational. • The cost of the counselling service is relatively low. • The Health Point is separate from the other units, guaranteeing a certain degree of anonymity. It has been well accepted by young people for providing STD treatment. • Access to the peer counsellors is in line with the needs of the youth. 	<ul style="list-style-type: none"> • Discontent among young people because the Health Point does not treat common complaints (such as headaches, high temperature, malaria). • Lack of human resources, in particular to offer weekend activities. • Few girls attend CISJEU. • It is difficult to find new documents and new videos adapted to the needs of young people. • The Health Point is rarely used to obtain contraceptives.

Human Resources

Criteria

Human resources must be motivated, with organisational skills, trained in SRH and in touch with the problems of young people. The staff must be used to dealing with young people, without prejudice, and must respect absolute confidentiality.

The evaluation of staff is an important activity for developing the Centre. It is essential that young people participate in this evaluation. Regular team meetings and on-the-spot staff supervision facilitate the evaluation of the needs of both permanent and voluntary staff in terms of support, upgrading or training.

The training of peer counsellors and facilitators is a recurrent task, because the trained youngsters are not available for long. Some use their new skills to obtain gainful employment (see Blankhart in this publication).

Unit	Qualification	Function and Duties
IEC	1 sociologist	Responsible for the IEC Unit, for training peer educators, for the Co-Management Committee, for reception
Counselling	1 social worker	Director of CISJEU, responsible for the Counselling Unit. He manages the centre, supervises the different units, participates in discussions and debates
Health Point	1 nurse, 1 doctor (part-time)	Provide reproductive health consultations: Counselling, family planning, pregnancy testing, antenatal consultation and STD treatment in line with the syndromic approach
Back-up	1 secretary	Administration, day-to-day management, book-keeping, organising visits to the centre
	2 support staff	1 caretaker responsible for night-time security and garden maintenance; 1 housekeeper to keep the rooms in good order

In the Central African Republic, this problem is further aggravated by the lack of co-operation with multilateral co-operation agencies which advocate levels of remuneration well above the national standards. Thus, the recurrent training courses, which must be planned because of the high turnover, are a serious burden on the Centre's budget.

Decision made

A team of 7 full-time staff has been set up, with an occupational profile drawn up for each of them (see Table 4 for an example) setting out qualifications, function and main duties of each one.

Strengths	Weaknesses
<ul style="list-style-type: none"> The use of volunteers reduces the staff costs. 	<ul style="list-style-type: none"> The high turnover of young volunteers is a problem. CISJEU activities are limited by the shortage of trained, competent staff.

Financing

Criteria

We must seek ways of minimising the operating costs of the Centre, for this is one of the key factors in the viability of the structure after completion of the project. The following items must be taken into account when drawing up a budget and evaluating the operating costs of the Centre:

- Salaries of full-time staff
- Travel expenses of counsellors
- Fees for guest speakers
- Telephone, water and electricity costs
- Maintenance costs (buildings and furnishings)
- Office equipment
- Drugs, reagents and expendable supplies for the Health Point
- Purchases of books, videos, etc.
- Promotion materials (articles, posters, etc.)

Decisions made

CISJEU's budget, the costs for training of team members not included, is around FCFA 1,200,000. Given the 16,500 contacts with young people recorded in 1998 and the 18,500 recorded in the first six months of 1999, this translates as FCFA 850 (US\$ 1.24) and FCFA 250 (US\$ 0.55) per contact respectively. This is comparable for example to the costs of the Family Planning Association of Kenya (US\$ 0.31/1996).

To date, the project meets its costs. Since the Centre was opened, one of the main objectives has been to seek long-term sources of financing for CISJEU. Some income-generating activities have been planned to supplement revenue:

- Provision of services for a fee, such as photocopying, weekend video sessions, a cafeteria, a beauty salon, etc.
- Search for subsidies from other public organisations, private companies and international agencies, for a long-term financial contribution. The official recognition of CISJEU by the Central African Government as a model structure in view of the results obtained, and facilitates the search for funding. The Kreditanstalt für Wiederaufbau (KfW) has agreed to rehabilitate one large multi-purpose hall (seating 350) at the Protestant Youth Centre. This hall could then be used again by CISJEU for awareness activities, and hired out as part of the income-generating activities (carrying out training for other organisations, theatre performances, video shows, etc.).

Strengths	Weaknesses
<ul style="list-style-type: none"> ● The operating costs of CISJEU are reasonable in terms of the number of contacts made. 	<ul style="list-style-type: none"> ● The services available are limited because of the lack of resources. ● The high turnover of colleagues and trained young people pushes up costs.

Participation of Young People (and their Parents) in the Management of the Centre

Criteria

Firstly, young people and their parents (with the acceptance of the young people!) must be integrated into the organisation and management of the Centre, in order to foster the feeling that it is their Centre and that they should take on responsibility. Another important aspect is the sustainability of the Centre. From the outset, it must be made clear to the young people and their parents that existing resources must be well used and new ones tapped. Finally, it is clear that close co-operation with adolescents ensures that CISJEU activities are optimally adapted to the needs of youth.

Decisions made

The involvement of youth and their parents, and their accepting responsibility rests on:

- The Co-Management Committee, made up of elected representatives of the CISJEU youth. This committee has effectively become involved in running the Centre, for instance deciding to change decor (replacing anatomical and physiological posters and family planning information with posters of pop stars) and putting down a poster indicating the point of condom sales at the Centre. It was important to give young people the chance to make these changes so that they feel at ease in *their* Centre.
- A team of 'senior youths' has been set up to train the newer, younger ones.
- The introduction of compensation to motivate volunteers, with no regular salary (articles, organisation of dinners, reimbursement for attending a youth conference in Ghana, etc.).
- Organisation of information meetings on CISJEU at the schools, and open days aimed at parents to encourage them to allow their children to take part in CISJEU activities and to place co-operation with them on a good footing.

Strengths	Weaknesses
<ul style="list-style-type: none"> ● During the unrest in Bangui, young people came to protect their Centre from pillagers. 	<ul style="list-style-type: none"> ● The participation of and support from parents at CISJEU is low.

Evolution of CISJEU Activities

CISJEU's activities have increased steadily since it was first set up (Tables 5.1 to 5.3). The figures correspond to the number of contacts. The number of contacts of the Health Point is greater than the number of counselling sessions, because several contacts may be required at the Health Point to treat a case.

Several trends emerge:

- The strong growth of IEC activities;
- The rise in the level of use of the Health Point;
- The relative stagnation of counselling services;
- The low level of use of the Centre by girls.

Recommendations

Long-term project: The creation of a youth centre requires time and patience because it takes a while to gain the confidence of the young people and bring about a lasting change in their behaviour.

Participation of young people: A youth centre must be launched in close co-operation with all actors involved in youth promotion, and with the young people themselves. Their opinion is important when selecting the location, organising activities, publicity, etc.

Further training: The features of adolescence must be taken into account (instability, impulsiveness, moods, lack of staying power, etc.). This is why training should be seen as an ongoing activity to replace those who leave.

Discipline: Some measures are needed to ensure discipline, especially at the entrance to the Centre and for certain very popular activities (games, discussions/debates, films).

Good external relations: To obtain the support of the state departments concerned with the problems of youth, and to establish good relations with the health structures, it is essential to keep both as fully informed as possible.

Activities to attract girls: Specific activities should be planned to encourage girls to take part in the Centre's activities, such as sessions especially for girls, free gifts for third-time girl visitors or to people who have brought more girls in the course of a month, etc.

Special emphasis on contraception and antenatal consultations: It is essential to raise the awareness of young people so that they make use of the health services to obtain and use a method of contraception in order to avoid unwanted pregnancies. In the same way, pregnant girls and their partners should be encouraged to attend antenatal consultations regularly to ensure proper monitoring of pregnancies, which are often high-risk pregnancies at this age, and to avoid a second pregnancy too soon after the first.

Reaching out-of-school youth: Out-of-school youth do not like to hang out in the same places as pupils. Appropriate means of communication must be found to reach this target group (offer of mobile services to establish contact with these young people).

**Table 5.1. Number of Contacts
(excluding Health Point)**

	1994	1995	1996	1998	1999	Total
Boys	1,833	3,276	6,369	11,507	14,038	37,023
Girls	514	1,036	2,104	4,941	4,433	13,028
Total	2,397	4,312	8,473	16,448	18,471	50,101

**Table 5.2. Breakdown by activity
(excluding Health Point)**

	1994	1995	1996	1998	1999	Total
Reading		1,535	1,733	1,809	1,662	6,739
Games		183	809	3,948	8,127	13,067
Video		1,191	2,645	4,112	3,879	11,827
Talks		615	2,195	5,921	4,618	13,349
Counselling	156	411	607	618		1,636
Other		377	484	39	185	1,085
Total		4,312	8,473	16,448	18,471	47,704

Table 5.3. Use of the Health Point

	1994	1995	1996	1998	1999	Total
Boys	145	369	553	650	1,330	3,048
Girls	136	266	354	450	920	2,125
Total	281	635	907	1,100	2,250	5,173

Figures for 1994 only cover the second half of the year; 1999 figures only cover the first half of the year. Figures for 1997 are not available because of withdrawal of technical assistance.

A team of effective, full-time staff members: The success of CISJEU is largely due to the continuity of activities ensured by a few full-time staff members who must be paid regularly.

A three-month cycle: We have noted that the majority of young people attend the Centre for about three months. We suggest this as the minimum cycle for repeating activities.

Affordable operating costs: The costs of a centre tend to diminish over time. Initially, the fixed costs are high because few activities are run. Gradually, however, as activities expand, the fixed costs fall.

Evaluation/monitoring: To ensure high-quality services, it is important to closely monitor the activities of each unit, and to analyse the motives of young people leaving. Young people must play a key role in the evaluation process. This is why the Co-Management Committee, made up of young people, is important. An external evaluation should be carried out every 2 to 3 years. Meetings should be arranged with different centres to exchange ideas, information and experience.

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2.6 Youth-friendly Health Services

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Introduction

Although many adolescents prefer other sources for SRH services, e.g. pharmacies, private doctors, kiosks, there are a number of good reasons to remind the public health facilities of their responsibility towards young clients and to make them attractive to them:

Cost-effectiveness: Public health services are already available in many places. Integrating youth friendly services into existing health structures and using existing resources is no doubt less expensive than creating new structures like stand-alone youth clinics.

Comprehensive services: A wide range of SRH services including a full array of contraceptive methods as well as STD diagnosis and treatment are commonly only available at health clinics.

Client recruitment: A number of adolescents use already public health facilities for reasons like general health problems and delivery. This could be used as a starting point to extend services and to deliver comprehensive SRH services to them.

Kinds of Services for Adolescents

What kind of services do adolescents need? A comprehensive array would include (Senderowitz 1999):

- SRH education and counselling related to development and maturation, boy-girl relationships, decision-making about sex, gender issues, sexual abuse and exploitation, sexual and contraceptive negotiation, adoption of contraceptive methods and pregnancy options should pregnancy occur;
- STD screening, counselling and treatment;
- HIV testing (voluntary) and counselling;
- Contraceptive method choice, adoption and follow-up including emergency contraception;
- Pregnancy testing and options counselling;
- Abortion services (where legal) and post abortion care;
- Prenatal, perinatal, and postpartum care;
- Well-baby care;
- Physical examinations;
- Nutritional services;
- Cervical cancer screenings.

Most health clinics will have to undertake a needs assessment among their target group of young people to determine the priority of the services they are able to deliver which in many places is called an essential or minimum service package. For services they are unable to cover a referral system should be in place. Since young people are not a homogeneous target group, segmentation might be needed to plan for selected subgroups such as:

- Younger/older youth
- Boys/girls
- Pupils/Out-of-school youth
- Rural/urban youth
- Street youth
- Adolescents using drugs and/or alcohol
- Sexually abused children and adolescents
- Commercial sex workers
- Young people with mental and physical disabilities

It would be ideal if SRH services were integrated into general adolescent health programmes that take care of all specific adolescent health problems. That way SRH services might lose their character of being something 'special' and instead be considered as 'normal' part of adolescent health.

Making Services Youth-friendly

Finding out what keeps young people from using existing public health services reveals exactly what you have to do to make them attractive to them. Thus, a situation analysis/needs assessment is an indispensable prerequisite for the introduction of youth-friendly SRH services (see Girrbaach in this volume).

Public health facilities have typically been avoided by young people for their lack of friendliness, especially provider attitudes and concerns of confidentiality: In a number of interviews young people indicate that they'd rather pay for contraception or treatment than run the risk of the nurse's delivering moralistic lectures or telling their parents why they have come to the clinic. Sometimes they are sent away and told to come back when they are older and/or married. Other impediments to adolescent access and use of SRH services include legal hurdles, operational barriers and lack of information as described in the table below.

Reasons for avoidance of public SRH services by young people	
Policy constraints	<ul style="list-style-type: none"> • Restricting access to services according to age and/or marital status
Operational barriers	<ul style="list-style-type: none"> • Inconvenient hours of operation • Lack of convenient, affordable transportation • High costs of services
Lack of information	<ul style="list-style-type: none"> • Poor understanding of their changing bodies and needs • Insufficient awareness of pregnancy and STD/HIV risks • Little knowledge of what services are available • Lack of information of RH service locations
Feelings of discomfort	<ul style="list-style-type: none"> • Belief that the services are not intended for them • Concern that the staff will be hostile or judgemental • Fear of medical procedures and contraceptive methods, including side effects • Concern over lack of privacy and confidentiality • Fear that parents might learn of their visit • Embarrassment at needing or wanting RH services • Shame, especially if the visit follows coercion or abuse

Since the International Conference on Population and Development in Cairo 1994 it is widely acknowledged that adolescents are entitled to a full range of reproductive health services and the same kind of respectful treatment as any other client seeking help at a health facility. The following table provides a list of the characteristics a youth-friendly health service ideally should possess. To which extent all or part of it is feasible and practicable depends on the respective setting. It might be convenient to start with services already existent like those for pregnant young women and extend them to increase e.g. the women's use of contraceptive methods after delivery. Obviously, if the public health facilities in a given setting are not in a position to deliver basic health services to the general population it will be hard if not impossible to make them especially youth-friendly.

According to many studies the crucial aspects of establishing youth-friendly services are provider attitudes and the embodiment of the services in the community. Hence, it is enormously important to foster an enabling environment before embarking on activities and to select staff for specialised training that is already open for and interested in adolescent SRH issues. The most ideal youth-friendly health facility will not see many young clients if they are stigmatised by going there. Thus, it is advisable to involve the community – adults and adolescents – in the planning process, to build networks with other organisations/people that work with young people, to publicise and discuss the planned activities in the open in order to gain the acceptance and the support of as many key stakeholders as possible. Other important factors that need to be considered when designing a youth-friendly SRH service are:

- Client recruitment: e.g. word of mouth, use of media;
- Development of protocols, guidelines, and standards for the staff;
- Availability of a wide range of services;
- Referral structures.

Some GTZ health projects have started to include youth-friendly health facility based SRH services in their approaches to address adolescent SRH. Two examples from Madagascar and Mozambique are presented here. In both countries existing public health facilities are used to deliver SRH services to adolescents.

Main features of youth-friendly SRH services

Provider characteristics

- Specially selected and trained staff
- Respect for young people
- Non-judgemental attitude
- Privacy and confidentiality
- Adequate time for client and provider interaction
- Peer counsellors available

Health facility characteristics

- Adequate space and sufficient privacy
- Convenient hours: after school/work, weekends
- Convenient location or possibly satellite clinics (branches of the main clinic close to where young people meet)
- Comfortable and confidential surroundings
- Catering for drop-in clients
- No overcrowding; short waiting times
- Provision of comprehensive SRH services
- Boys and men welcome and served
- Affordable fees

Other possible characteristics

- Adolescent-sensitive education materials available on site and to take away
- Group discussions available
- Delay of pelvic examination and blood tests possible

(Senderowitz 1997, 1999)

Primary Health Care Project, Mahajanga, Madagascar

Approach: Within the context of a sex education programme in schools set up in 1998 a pre-existing school health centre was restructured to additionally deliver SRH services. A target group analysis and needs assessment among the students had found out that the young people wanted to be advised by professional health staff and teachers. In case of health problems, suspected STD, and requests for condoms or other contraceptives, teachers refer the young people. The school health centre serves all the schools in Mahajanga-town and to a lesser extent it is also accessible to non-school going youth. It is connected to a public health centre but constitutes its own unit. Contraceptives, counselling on STDs/HIV/AIDS, diagnosis and treatment for STDs (syndromic approach) are provided by trained health personnel (1 midwife, 1 medical doctor). STD treatment was introduced in 2000, and the demand for this service is increasing. A workshop for all health interventions for young people in Mahajanga town is held once a year to co-ordinate and to provide further training for all providers (health personnel, teachers, peer educators).

Strengths: Referral between the schools and the service works well. The service guarantees confidentiality and privacy. Information material focusing on the needs of young people is provided, but needs to be improved. The location of the facility is very convenient and well-known and young people can drop in during school hours and after school. Contraceptives have to be paid for, but they are quite inexpensive.

Constraints: The health centre cannot provide STD medication, but a public pharmacy is 20 meters away. The school health centre cannot offer safe abortion services for legal and organisational reasons. Another constraint is the restricted choice of public health personnel who have to be trained intensively.

Future activities: Counselling services for victims of sexual violence will probably be offered from the beginning of 2002.

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Both projects are still new and need to be monitored and evaluated (see Schümer in this publication, and annex of this paper for indicators specifically for health facility based youth-friendly SRH services). In the case of Madagascar one of the major constraints in youth-friendly SRH services becomes visible: to find and identify suitable health staff for training in adolescent SRH. In Mozambique they encounter the also rather common predicament that public health services are mainly used by girls (menstruation and pregnancy-related problems) and boys do not go there. The future will show whether and how the projects are able to deal with these difficulties, and ways of replicating the activities in other parts of the respective country need to be explored. Overall, the projects illustrate how public health services can be made attractive to young people.

Centro de Atendimento para Adolescentes e Jovens do Hospital Central de Maputo, Mozambique

This youth health centre was opened in November 1999 within the compound of the central hospital in Maputo, Mozambique. The leadership of the maternity unit had recognised in their daily work the unmet need of SRH services for adolescents. The infrastructure was jointly financed by GTZ and United Nations Population Fund with Pathfinder International acting as long-term technical consultant.

Youth-friendly service characteristics:

- Separate space and sufficient privacy: the centre is a building on its own and the young people can use a side entrance to the hospital campus which is not used by other clients.
- Comfortable surroundings: the centre uses a 'coffee-shop approach' with a waiting area that invites to sit and watch educational videos and films. Information materials on adolescent SRH topics are on display and for carry-away.
- Comprehensive SRH services are available: the centre offers counselling on all relevant SRH topics, diagnosis and treatment of STDs, family planning and pregnancy-related services. A referral service to the maternity unit next door is available for pregnancy-related problems including abortion services.
- Specially trained staff: suitable staff for training in adolescent SRH is selected from the maternity unit and works at the centre. There is a doctor present daily from 08.00 to 12.00 a.m. and twice a week a psychologist is available in the afternoons.
- Affordable fees: consultation, counselling and contraceptives are free of charge. For STD drugs the young people have to contribute 20% of the actual costs and abortion services have a fee of approximately 13 US\$.
- Client recruitment: by word of mouth.
- Convenient hours: The centre is open from Monday to Friday from 07.30 a.m to 03.30 p.m. Every fortnight on Saturdays there are special events on SRH topics.

Strengths:

- The centre is well accepted and increasingly used by young people: from January 2000 the monthly users increased from 135 to 500 on average during the last months of the year 2000.
- Sustainability is secured since the centre is part of the central hospital and hence part of the public health system. Staff is recruited from the nearby maternity unit and the centre's running costs are covered by the Ministry of Health.
- There is an appropriate age limit ranging from 10-24 years in boys and 10-20 in girls which is handled flexibly.

Constraints:

- The centre is currently mainly used by young girls (on average 88% girls during the last 6 months of 2000). The proportion of young males needs to be increased.
- Since the centre is located in the city centre of Maputo difficult-to-reach youth e.g. young people from the poorer suburban areas or illiterate youth are hardly covered.

Future plans: The centre plans to expand its services.

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A different but also promising approach to make health services more youth-friendly is currently pursued in South Africa. The National Adolescent-Friendly Clinic Initiative (NAFCI) is introducing an accreditation system for youth-friendly public health clinics comparable to the Gold Star Initiative for family planning clinics in Egypt. NAFCI will work with health care providers in the

public sector to assist them to improve the quality of adolescent health care, so that services will become more accessible and acceptable to the majority of young people, without having to set up stand-alone youth centres. They established national standards and criteria for adolescent healthcare in clinics throughout the country.

The ten NAFCI standards for accreditation of clinics are as follows:

1. Management systems are in place to support effective provision of the essential service package for adolescent-friendly services.
2. The clinic has policies and processes that support the sexual and reproductive rights of adolescents.
3. Clinic services appropriate to the needs of adolescents are available and accessible.
4. The clinic has a physical environment conducive to the provision of adolescent health services.
5. The clinic has drugs, supplies, and equipment to provide a defined essential service package.
6. Systems are in place to train staff to provide adolescent-friendly services.
7. Information, Education, communication (IEC) consistent with the essential service package is provided.
8. Adolescents receive an accurate physical assessment.
9. Adolescents receive individualised care based on standard service delivery guidelines.
10. The clinic provides continuity of supplies and services for adolescents.

A clinic that scores 30 to 59% will be awarded a bronze star; 60 to 89% earns a silver star and 90% or more a gold star. To date, 10 NAFCI pilot clinics have been identified in four provinces. Baseline assessments have been conducted in all the sites, and the clinics are currently in the phase of improving their quality of adolescent health care. The first youth-friendly clinics should have been accredited by early 2001 (South African Health Report 2000).

These few examples show that there is more than one way to establish public health facilities that are able to attract and serve young people. At the risk of being redundant it can only be reiterated that the respective settings, e.g. the conditions one finds in a particular setting have to be the starting point from where to go on and to decide which approaches towards young people are the most adequate.

Annex 1: Checklist for Monitoring and Evaluating Youth-friendly SRH Services

PROVIDERS AND STAFF			
Characteristics	Yes	No	Comments
Staff is friendly and responsive to young clients			
Staff is respectful to and ensures privacy of young clients			
Staff is understanding of and knowledgeable about youth concerns and needs			
Counsellors spend adequate time with young clients			
Counsellors use language that is understandable to young people			
Counsellors are non-judgemental and approachable			
Medical providers spend adequate time with young clients			
Medical providers use language that is understandable to youth			
Medical providers are non-judgemental and approachable			
Information provided during counselling is clear and helpful			
Information on need for and timing of follow-up visit(s) is provided and clear			
Medical providers offer choices, including abstinence, contraception and withdrawal			
POLICIES AND PROCEDURES			
Youth drop-ins are welcome and accommodated (for drop-ins only)			
Services are offered to both male and female young clients			
Facility provides informational and/or audiovisual materials on SRH services and concerns of young clients			
Facility provides contraceptive methods that are most popular among young clients			
Facility offers wide range of services			
Services are linked to other youth service and programme networks			
Cost of SRH services is affordable			

ENVIRONMENT AND FACILITIES			
Characteristics	Yes	No	Comments
SRH services are provided at convenient (and separate) hours for young clients			
Décor and surroundings are inviting to young clients (<i>i.e.</i> non-medical)			
Counselling and examination rooms ensure privacy for young clients			
Separate space is used for young clients			
Facilities are conveniently located for youth			
IEC materials are displayed and available to young clients			
Young clients report overall satisfaction with SRH services			

(Adamchak *et al* 2000)

Annex 2: Indicators for Youth-friendly Health Facility Programmes

Indicators	Notes
Facilities conveniently located for youth	'Conveniently located' depends on perceptions and needs of youth, determined through needs assessment. It could mean being near schools, universities, recreation centres and/or affordable transportation. It could also mean a place where young people feel like they have privacy.
Facilities with separate and/or convenient hours for SRH	Convenient hours may be before or after school, early evenings and/or weekends.
SRH service protocols adapted for adolescents' needs	Protocols should recommend appropriate contraception (e. g., condoms and/or pills as opposed to IUDs); protocols should not require parental or spousal consent in order to provide SRH services to youth.
Private consultation or examination rooms for young people included in facilities	
Adequate quality of SRH counselling by staff	Adequate quality includes the following criteria: <ul style="list-style-type: none"> • Coverage of essential points in SRH service protocol • Demonstration of appropriate counseling techniques • Development of rapport with target youth audience • Explanation of potentially frightening medical procedures, such as medical exams, both in advance and throughout the procedure • Availability/use of quality IEC materials
No./% of programme sites with trained health care providers or formal links to nearby providers	
Clinic's existence, location and hours promoted/publicised to potential youth clients	
No./% of youth who received SRH-services	
No./% of youth served by facility who report favourably on key service characteristics	

No. of youth's <i>first</i> clinic visits by type of SRH service(s) provided	SRH services include: <ul style="list-style-type: none"> • STD screenings and/or treatment, • HIV/AIDS testing, • Contraceptive counselling and/or method provision, • Nutrition counselling, and • Pre/postnatal services.
No. of youth <i>follow-up</i> visits by type of SRH service(s) provided	
No./% of youth referrals by source of referral	Referral sources include schools, private providers, and peer educators. These referrals can be made to hospitals, clinics or wherever young people go for services.
% of youth among all clients who received services	This is for clinics serving both young and adult populations. If numerator and denominator are the same, then the indicator can measure this at one facility, or you can aggregate service facility statistics for a particular group of facilities or all clinics in a given district.
No./% of staff who welcome and accommodate youth drop-ins	

(Adamchak *et al* 2000)

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Web-Site:

<http://www.pathfind.org/guides-tools.htm>: above documents can be downloaded from this site

2.7 Youth Involvement in IEC Material Production

*Regina Grger, Reproductive Health Project, GTZ, Tanzania
with Babette Pfander, Juma Bakari & Akwillina Mlay*

Introduction

There is no doubt among development experts that an active involvement of the target group in media development is indispensable for ensuring that health messages are appropriate and effective. This also applies to adolescent sexual and reproductive health (SRH) and AIDS prevention programmes. However, what this means at implementation level is still relatively unexplored and guidelines are few.

In this article we present our experiences of successfully involving adolescents in the design and production of two kinds of SRH education materials:

1. Professionally made, attractive question and answer-booklets, providing answers to frequently asked questions by adolescents on sexuality, love, sex, reproduction and disease.
2. A youth soap opera suitable for triggering discussions on adolescent health issues without being 'too educational'.

When involving adolescents in developing health education materials, two key questions must be answered: Firstly, who are the right young people to involve in the production process? Secondly, at what stage should they be involved and what form will their involvement take? (In the planning phase? During production? For testing the drafted product? Or in all those steps?)

The two cases presented below are specific experiences from projects running in Tanzania. In other situations, it might be appropriate to choose other types of young partners and the steps to follow might be slightly different. However, we believe that involving young people as the key collaborators for media development is the best way to reach adolescents' hearts and minds, and to have an impact on their attitudes and their behaviour.

Producing Question and Answer- Booklets with Young People

Background

Since 1998 the GTZ-supported Reproductive Health Project has been working in two regions of Tanzania, namely Tanga and Lindi Regions. In 1999 a comprehensive piece of research focused on the Knowledge, Attitude, Practice (KAP) of adolescents with regard to SRH and HIV/AIDS. The study involved approximately 1500 pupils, between 12 and 19 years old, from 50 schools who filled in a questionnaire on these subjects. In addition, a qualitative assessment was undertaken with about 500 boys and girls in separate groups.

One major yet anticipated finding of the survey was that adolescents know very little about SRH, while a large proportion of them is sexually active. For example, only a minority of the respondents knew that pregnancy can occur after having sex only once or that a healthy-looking person can carry HIV. On the other hand, approximately 65% of all boys and 35% of all girls involved in the survey reported to have already had sexual intercourse. About 85% of the sexually-active boys and 50% of sexually-active girls have had multiple sexual partners. Finally, about one third of the girls who had already had sexual intercourse indicated that they had been forced the first time.

In response to the alarming discrepancy between adolescents' knowledge and their actual behaviour, it was decided to develop youth-friendly information materials. These materials were to contain the most crucial facts of human physiology and reproduction, issues of sexuality, as well as information on preventing unplanned pregnancies and sexually transmitted diseases (STDs). The ultimate goal of providing knowledge to adolescents is to enable them to make informed choices. The basic set-up of the planned booklets was question-answer style, using simple language and many illustrations for clarification. The booklets target literate adolescents, who are 12 to 20 years old, however, the reading skills required are modest. The booklets were intended to be used by adolescents in schools and school clubs, youth organisations and sports clubs, youth centres and clinics, and distributed upon request to all interested individuals

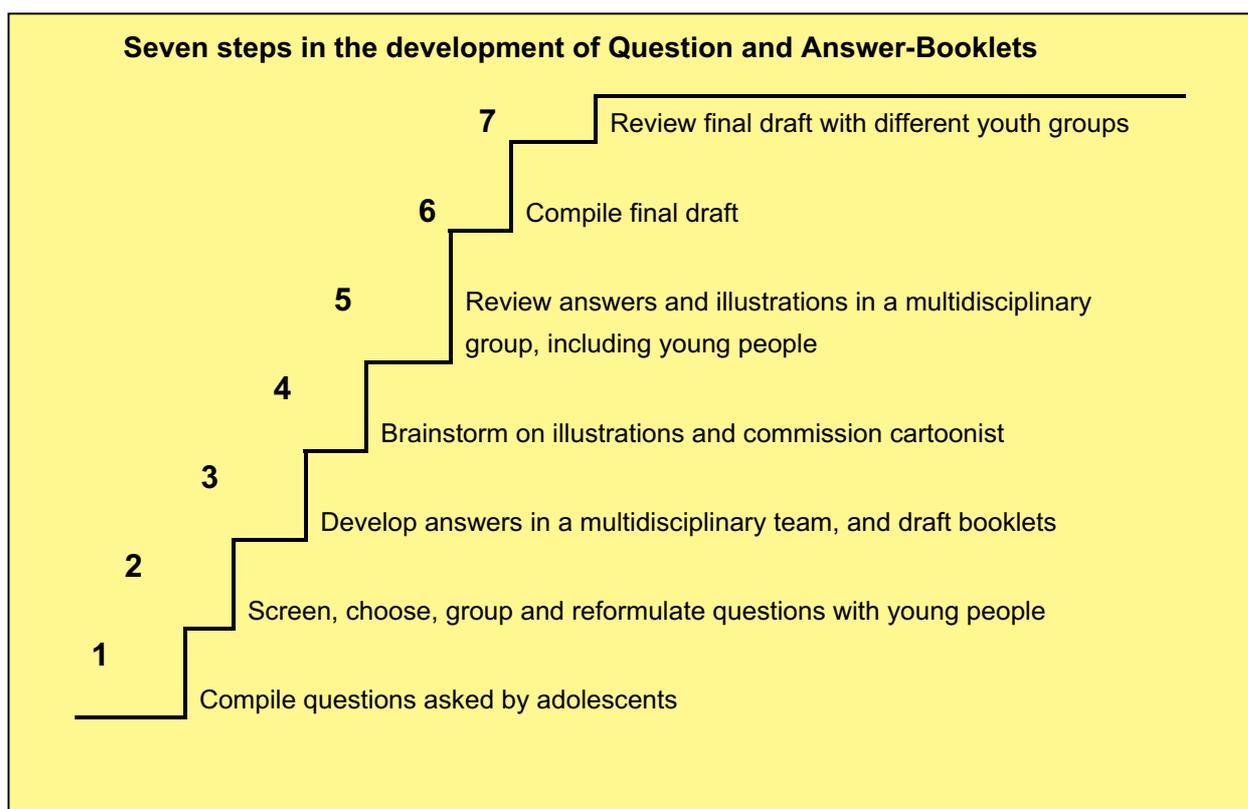
Human Resources Involved

First of all a chief editor is needed, *i.e.* a local or international consultant in adolescent SRH, who is able to guide the whole process, speaks the local language(s), is experienced in working with young people and committed to producing high quality print material. In our case a young Swiss anthropologist (Babette Pfander) took this role.

In addition, three categories of young people played important roles:

1. Primary school pupils and out-of-school youth from rural and urban areas (Görgen 2000);
2. Adolescent peer counsellors from a local non-governmental organisation (NGO), UMATI, who were familiar with the topics, literate 'unexposed youth' from the neighbourhood, as well as a multi-disciplinary team of experts, including medical doctors, social scientists and an education specialist;
3. A group of peer educators in a youth centre.

Steps in Developing the Booklets



The process of developing the booklets went through seven stages:

In a first stage, adolescents both in school and out-of-school were encouraged to **ask questions** on the theme of reproductive health within the framework of counselling sessions, and various research activities were compiled. The result was a list of over 200 questions.

Subsequently, this list was **screened** by a group of twelve adolescent peer counsellors (aged 16 to 19 years), who judged each question on whether it was understandable and relevant for adolescents. If necessary, 'unexposed youth', representing youth experts, reformulated questions to make them easy to understand. Afterwards, the peer counsellors categorised the selected questions into the following six groups – now forming one booklet each:

1. Growing up
2. Male-female friendships among adolescents
3. Sexual relationships
4. Pregnancy
5. Safe sex and contraception
6. HIV/AIDS

As a third step, a multi-disciplinary team of social scientists, medical doctors and education specialists developed a first draft of six booklets containing simple, yet scientifically accurate, **answers**. The first draft of the information material was then shared with other experts in relevant fields.

Then, the team assessed the appropriate character of illustrations and commissioned a local cartoonist to make the booklets livelier by designing **illustrations** attractive for adolescents.

A group of adolescent peer counsellors and other experts **reviewed** the draft and reformulated or shortened the answers where necessary. The group also commented on the illustrations and expressed the need for additional images.

Subsequently, a group of experts, including adolescent peer counsellors, reviewed the **final draft** with all illustrations. A group of eight peer counsellors read the booklets and made comments.

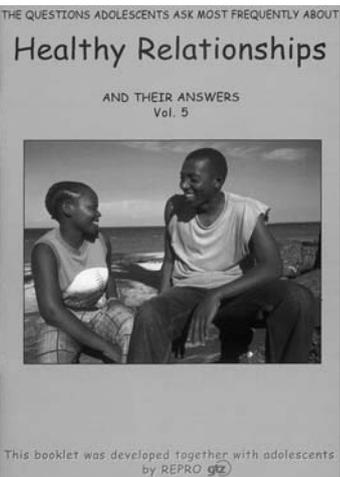
The ready-for-print proof was submitted for final corrections to all reviewers involved in the process. The booklets were **produced** in the local language Kiswahili and translated into English to make them available for the Southern and Eastern African Region. The entire production process took approximately seven months.

Official Approval and Distribution

The project team together with the reviewers decided not to seek official approval by the Ministry of Education or the Ministry of Health prior to publication for fear that this would lead to a lengthy process of months or even years. The first edition was therefore published under the full responsibility of the project team.

The distribution strategy was to make the booklets known through word-of-mouth, and distribute them on request to ensure that the recipients are really interested in a copy.

The series of booklets were sent to all partner organisations in Tanzania – governmental, non-governmental, bilateral and multilateral – working with young people. Small numbers of copies were offered free. For larger numbers (more than 10 copies) the booklets were delivered against printing costs (US\$1 for a set of six booklets). The project also offered a reprint service for partners/organisations that wanted to appear as co-editors on the cover. In the near future newspapers will feature an article about the booklets and a TV program for youth will make use of them in group discussion with adolescents.



Examples of the Booklets (English version)

Now, four months after the initial printing, we can state that:

- Many organisations requested copies, making use of all three modes of ordering (free, against payment, reprint). Reprint requests have ranged from 1000 up to 50,000 copies.
- The government officials from different Ministries gave very positive feedback regarding the booklets and requested them for their staff, their children and their neighbourhood. However, no official decision has been taken so far to make them available, for example, to schools, however distribution has been accepted in all primary schools of the capital.
- Individuals from all over the country have been writing letters asking for a copy or to give comments. Some offered to buy them and to resell them in their environment.
- Educators who read them reported that they now feel more comfortable about answering youths' questions. Parents like to read the booklets themselves in order to be prepared.

Lessons Learned

- Involving young people as key collaborators in media development is feasible, cost effective and a good way to reach adolescents' hearts and minds – a necessary condition for having an impact on their attitudes and their behaviour.
- Short and simple material can be read and appreciated even in a primarily non-reading culture like in Tanzania.
- Several small booklets are more appropriate than one book especially if people are not skilled readers.
- Attractive layout is needed to capture the readers' attention.
- Government ownership is not necessarily appropriate in sex-education matters because leading civil servants are often conservative and not keen to take a risk.
- Putting a product on the market and offering it to other partners for common reprints allows large-scale distribution far beyond one project's capacity.

Experiences with a locally produced Youth Soap Opera ZAWADI

Background

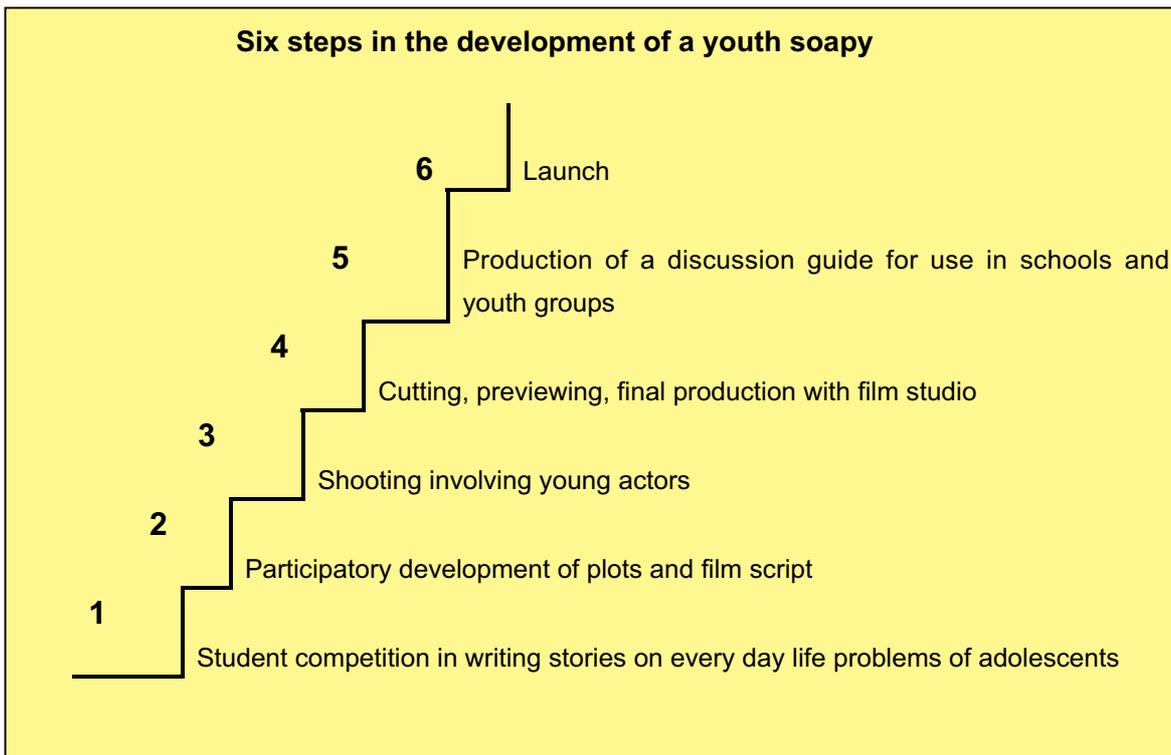
The negative consequences of unprotected sex (unwanted pregnancy, unsafe abortion, STD/HIV infection) and of drug abuse are a widespread concern to parents, teachers and young people in Tanzania. However, information alone does not suffice to influence people's attitudes and behaviour towards increased responsibility, but role models may be able to play a crucial part in this endeavour. Against this background, and given that modern media, like television and video shows, is gaining in popularity, especially in urban and semi-urban areas and among young people, the GTZ-supported Reproductive Health Project in Tanzania embarked on producing a youth soap opera for the different Tanzanian TV stations (national and private), and for use in schools and youth clubs. The soap opera comprises six half-hour programmes, focusing on everyday problems young people face in easily understandable terms. The subjects covered include health problems, such as unwanted pregnancy, induced abortion, and drug abuse. The series intends to show positive role models for youths and their parents.

Human Resources Involved

First, we ran a trial with 12 secondary school students (15 to 19 years of age) inviting them to write down topics and stories for a film about young people’s lives, loves and sorrows. While these did provide some valuable ideas, they were difficult to translate into a proper film script. Therefore, we decided to work with more experienced young people, namely drama students, who turned out to be well able to conceptualise themes visually. Moreover, they were highly motivated to contribute to our film project, which offered them a good experience and a chance to become known. Hence, the students took on both script writing and acting. The students’ motivation was enhanced through a competition promising them a present for the best three writers.

The key consultant to conceptualise, initiate and guide the whole process was a lecturer of drama in the Bagamoyo College of arts (Juma Bakari), already experienced in the production of films on HIV/AIDS issues.

Steps of Developing the Soap Opera



In a brainstorming session with lecturers from the Bagamoyo College of Arts about ways to reach young people effectively, the idea was born to invite college students to take part in a **story-writing competition** for a youth soap opera based on a broad description of the task formulated by the lectures of the college together with the team-leader of the Reproductive

Health Project (November 1999). They were asked to write either true or fictitious stories on issues including:

- Love, sex and jealousy
- Conflicts with parents regarding leisure time activities, choice of friends, clothing etc.
- Clash of values between young people and the older generation (virginity, pre-marital sex, obedience etc.)
- Unwanted pregnancy
- Failure in school

During the Christmas holidays, 13 students of the drama department drafted different stories, which they subsequently developed step-by-step into proper plots in consultation with a jury of four drama tutors from the community theatre department. The jury awarded all eight completed scripts a prize, and merged them into one final **film script**.

In the next step, the Bagamoyo College took on the production of the film,¹ including camera, sound, and costume design. Undergraduate students played all of the youth characters, while their drama teachers played the adult roles. The participatory, flexible **production process** ensured that the youth determined the storyline, outfits, jokes, etc. to reflect their priorities.

The **cutting and final production** of the soap opera were done in collaboration with a professional film studio in Dar es Salaam. The draft soap opera (all six parts) was shown to the college students and to select secondary school pupils, whose feedback informed production of the final cut. It appears that the soap opera succeeded in triggering discussions among young Tanzanians about values, expectations, setting priorities for one's own life, risky behaviour and prevention. It also provides an impetus for parents and other adults to reflect upon the limitations and advantages of their perhaps more traditional behaviour patterns. The open-minded adult behaviour depicted in the film provides a model for inter-generational communication based on trust and co-operation.

A team of reproductive health experts and educators developed a **discussion guide** to support teachers and other educators in leading discussions for each of the six parts. The 20-page guide was developed based on the LEPSA Technique² which is well known to most of the trainers and educators in Tanzania.

In August 2000 the film *Zawadi* was officially **launched** in Dar es Salaam in the presence of high-ranking officials from the Ministries of Health and Education, the donor community and the press.

The whole process took ten months.

¹ The whole film production project was co-ordinated by the College and funded by the Reproductive Health Project. The College had to hire expertise when needed and subcontracted a film studio. The copyright belongs jointly to the College and the GTZ-supported project.

² LEPSA (Learner-centered, Problem-solving, Self-discovering and Action-oriented) is a technique that involves the audience by asking and discussing a series of simple questions on their perceptions of the events and actors.

Distribution

All four TV stations in Tanzania (two governmental and two private ones) were interested in showing the soap opera. The GTZ-supported Reproductive Health Project together with the Bagamoyo College set the following conditions for broadcasting. Firstly, the TV station must not be paid to broadcast the series. Secondly, all six episodes of the soap opera must be aired with the date for the next episode announced at the end of each programme. Thirdly, the TV stations will help organise a contest whereby viewers are invited to send in their comments on the film by post and their names will be entered in a prize draw to win a bicycle, radio-cassette-player, or a copy of the film, provided by the project. This proved very popular. Following one programme, for example, about 2500 youth sent in their comments. One TV station produced a half-hour discussion with adolescents, including some of the actors, on select issues raised in the film, like 'the importance of maintaining virginity' or 'how to say no'. Another station organised discussions with school children from secondary schools after each of the six parts.

The project funded the filming of a trailer, copies of which were given to all governmental and non-governmental partner organisations working with young people in Tanzania. Single copies of the video are provided free on request. Senior staff of the Ministries of Health and Education showed interest in obtaining copies for all the schools in Tanzania which have access to video equipment. Presently, fundraising efforts to continue the dissemination of the video are ongoing.

Lessons Learned

- The production of a moving soap opera by involving youth experts together with theatre experts and SRH staff is feasible and provides a product at relatively low cost.
- The approach of a script-writing competition was a good idea.
- The technical quality, specifically sound and light in this case, were acceptable but not good. We would recommend involving technical expertise from a professional film production company at an early stage and to make sure that the equipment used is of a high standard. This is especially crucial if many copies are needed.
- The production of copies by a copy company needs strict control. Quality is not guaranteed especially if large numbers are needed.
- During the filming process photos of key scenes should also be taken in order to have enough material for publicity, video covers etc.
- If copies are sold at a price considerably higher than commercial copies on the market, people will be likely to make their own copies themselves. In our context it meant that we could only request the money needed to buy a high quality tape (US\$5).
- Dealing with TV stations requires some experience. They all want to be the first to broadcast it because a brand new film is like a hot cake. We recommend allowing the most important station to broadcast first and deal with the others later.
- Encouraging the young audience to send in their opinion is a good way to get feedback from the audience. The promise that letters will participate in a lottery serves as an incentive for people to send in their comments.

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Links

<http://www.dsr-inc.com/DSR2/filmvid.htm>

Development Through Self-Reliance (DSR) helps produce and distribute dramatic 'social message' films in the developing world, especially Africa. Its productions highlight teen pregnancy, family planning, health, training, AIDS and women's rights.

<http://www.fhi.org/en/aids/aidschap/aidspubs/handbooks/bccmedia.html>

Behaviour Change Through Mass Communication provides a basic understanding of how to use mass media for HIV/AIDS prevention, including guidance on choosing media to reach different audiences and achieve specific objectives. It contains chapters on writing radio and television scripts, getting articles printed and publicising projects. This handbook was created by Family Health International.

<http://www.jhuccp.org/mmc/>

The Media/Materials Clearinghouse (M/MC) is an international resource for health professionals who seek samples of pamphlets, posters, videos, and many other media/materials designed to promote public health. M/MC is part of the Johns Hopkins Population Information Program, which is funded by the USAID.

www.bbc.co.uk/worldservice/sexwise

A joint BBC and IPPF initiative that aims to provide radio listeners, readers and on-line users with accurate information about sexual health issues along with useful contacts about sexual and reproductive rights. The web site provides background information, links, frequencies of broadcasts as well as downloadable versions of the *Sexwise* book in 22 languages. Six 15-minute Learning Zone programmes entitled *Sexwise: The True Story*, chart the making of *Sexwise*, and include excerpts of the programme that never went on air.

2.8 Peer Education

David M. Blankhart, Medical Services and Reproductive Health Consultancy, Curaçao, Antilles

Introduction

Peer education has been popularly accepted as an important component of sexual and reproductive health (SRH) promotion programmes, because it typically combines several crucial factors in health promotion: strong identification of the young facilitators with the social and cultural environment of the target group, promotion of positive attitudes and healthy behaviours, and real involvement of young people in programmes targeted at them (Fee 1993). Peer educators are people belonging to a group in a specific setting (school, workplace, army, prison, youth or sports club, gang, neighbourhood etc.) who are trained to educate their age cohort. They are usually, but not necessarily, young, and the approach is often related to SRH. Peer education can be especially beneficial for youngsters that are otherwise difficult to reach, and in environments where adults are generally reluctant to talk about sexuality with young people.

This paper addresses the peer-to-peer approach in the context of a SRH promotion programme for adolescents between 12 and 19 years of age. After a discussion about the sensitive issue of sexual education for young people and a description of the barriers young people face with regard to access to appropriate and accurate information, we present some of the features of the peer-to-peer approach, its advantages, challenges and limitations. This is followed by a more practical section, which presents various issues concerning the implementation of peer education programmes with 'to-do' checklists.

The Peer Education Concept

Adults versus Peers

Adolescence is a period of life full of fundamental changes in which young people attempt to achieve autonomy from their parents/guardians. It is an important time for them to form their identity and define their places and roles in society. In this phase adolescents are particularly susceptible to peer pressure, not least with regard to relationships, and sexuality. Perceptions about what their peers are doing and what is accepted in their peer group is usually more important in the establishment of their sexual behaviour than the opinions of parents, teachers, or other adults (Gage 1998). Moreover, most adolescents find talking about sex with adults uncomfortable. Likewise, adults often have difficulties seeing adolescents as people who have a sexual identity and are reticent in talking about sex with them because of embarrassment and ignorance. In many cultures the whole idea of talking about sex across the generations is practically unthinkable. Therefore peers often constitute the most important reference group for information and support regarding relationships, sexuality, and SRH. Nonetheless, peer education must not take place in isolation from adults. Senior family members, teachers, health personnel, and others must complement peer-to-peer approaches.

Peer educators must be able to fulfil the different roles of educator, facilitator, counsellor, skills trainer and coach. They must be trained to fulfil these multiple roles, but should also reveal certain personal characteristics like flexibility, good interpersonal communication skills, and an openness to further learning and self-development. Peer education can be used in small and large groups or in a one-to-one situation, both in formal as well as informal settings: wherever adolescents are found. Some young people need to be actively sought out, *i.e.*, met in their seclusion, like drug addicts or juvenile prisoners. Theatre, cultural events, or sports competitions can function to attract and reach young people for peer-to-peer activities, or can be produced by peer groups to reinforce a message (see Kreiß & Loewen, and Klink in this publication).

Sex Education and Services for Young People

Because the quantity and quality of information and support on sexual issues received from either adults or friends tends to be insufficient, it is important to provide adolescents with alternative sources of good information, knowledge and advice. Peer education is an excellent channel for transferring these. However, in addition, adolescents require a fundamental set of skills and competence, like risk reduction and life skills, in order to be able to plan, seek help and form positive relationships (Hughes 1998). Peers can only partially convey these skills, firstly because they would require more substantial training, and secondly, such roles could inadvertently create too great a distance between the peer educator and the target group, endangering the very concept of peer education. Mature peer educators could be given the necessary training for life skills teaching.

Increasingly peer educators are confronted with delicate issues like sexual violence and exploitation. Addressing such matters can be beyond the competence of the peer educator, but they should be able to recognise the problems, provide adequate information, and refer the peer to appropriate, youth-friendly services like social, legal, medical or reproductive health services (SEATS 2000). The service providers in turn should collaborate with the peer educators by giving some feedback on cases of referral, or directing young clients to the peer educator for confidential communication.

Distribution of condoms and other contraceptives can be done by peer educators and could eventually be extended to other (over-the-counter) health products. However, it is very important to guard against the danger of peer educators replacing qualified medical personnel, giving medical advice or prescribing drugs.

Peer educators can cover a broad range of subjects, including friendships and relationships, anatomy and physiology of the reproductive system, appropriate family



Peer educators demonstrate how to use a condom

planning methods, signs and symptoms of sexually transmitted diseases (STDs), female genital mutilation (FGM), and sexual dysfunction, as well as for instance safe needle use in drug addicts. Among adolescents, rumours and half-truths tend to be rampant, and the peer educator must be well informed to effectively dispel these. The messages should be clear, straightforward and in line with the national policies on SRH. At the same time, it is very important that the peer educator acknowledges his or her limits and should be comfortable with not being able to address, let alone solve, certain problems. SRH promotion should include a mix of well co-ordinated strategies, with messages and key players that complement each other.

Impact and Sustainability of Peer Education

Sustainability is a major concern in peer education programmes. The most important problem is the turnover of the participating peer educators: Adolescents can quickly lose interest, and initial enthusiasm can wane if new impulses are lacking. Often they are volunteers, working hard for few rewards and are likely to gradually seek a stable income elsewhere. Besides, as they get older, young peer educators tend to move away from their (target) group because they get married, seek further education or simply show their age. Furthermore, the programmes initiated by foreign donors are often dependent on erratic funding, which makes continuity a precarious issue. Therefore, it is important to diversify resources and advocacy.

The high turnover amongst peer educators and participants makes measuring the impact of peer programmes over time almost impossible. The diffusion of information, awareness and change of behaviour take time to materialise; in the meantime, however, members of the initial target group also change in other regards: they get married, finish their studies or take up a job. No sufficient process indicators have been developed to show the impact and effectiveness of peer education. While an increase of knowledge concerning SRH matters has been demonstrated through peer education, changes in sexual behaviour, and thereby programme cost-effectiveness, are difficult to establish. However, it has been proven that a peer education programme is cheaper per established contraceptive user than a programme based in a fixed youth-centre (Townsend 1987).

Besides, peer education not only has an impact on the age cohort, but also on society at large. Firstly, the professional peer educators with acquired skills and knowledge regarding SRH are likely to continue to propagate safe sexual behaviour in their social environment. Secondly, the participants who actually change their sexual behaviour because of the peer approach, will also influence others. It has been proven that young people participating in a peer educator programme share their newly acquired information and skills with others in their immediate environment.

The Peer Education Programme

Conceptualisation

The first step is to define the peer educator programme, for which essential considerations are:

- What are the constraints on adolescents for getting information about sexual issues?
- What cohort of young people, and geographical area, is going to be targeted?
- What will the general objective of the programme be?
- Which subjects of SRH or related issues will be addressed?
- Which methods are necessary to offer information and support?
- What kind of training for the peer educators will be needed?
- Who will supervise the peer educators?
- Which existing structures will be used in the programme?
- What other complementary channels to reach the adolescents will be used?
- Where will funding come from?

These issues must be discussed by all of the stakeholders, *i.e.* donors, organisations/individuals involved in the implementation and supervision of the training and practice of peer educators, the educators themselves, and the targeted adolescents. The programme should not be over-ambitious, and concentrate on quality rather than quantity. A modest start with an 'organic' growth of the programme is the best approach. Especially in the beginning, peer educators will require considerable supervision and support from the programme staff; only later will they be able to strengthen each others' roles. A peer education programme should focus on disseminating information to, as well as exchanging experiences with, participants with the aim of helping to change attitudes and behaviour. Once the programme has been defined, official recognition should be sought and links with youth-friendly (SRH) services officially established.

Concept development

1. Decide what approach will be used: informal, in groups, individual, etc.
2. Decide where the activities will take place: schools, meeting points, sport events etc.
3. Decide what kind of activities will take place: informal communication, meetings, role plays, practical demonstrations, production of Information, Education, Communication (IEC) material (like magazine, radio/television spot, brochure) etc.
4. Define the exact terms of reference for the peer educators.
5. Prepare official documents (internal organisation, letter of understanding with collaborating organisations, registration of the organisation, request for permission of the ministries involved etc.).
6. Establish a kind of supervisory body (board of directors, monitoring committee or advisory committee etc.), with involvement of the community.

Management

Given the problems of sustainability it is necessary to give ample attention to financial planning. The available budget should be carefully allocated according to pre-set criteria. To tackle the

usually high turn-over of the peer educators the programme needs to set aside resources for a long term replacement plan.

A peer education programme should involve the targeted adolescents in all stages of the programme. While primarily ensuring the participation of young people, it is also important to engage adults in the programme in order to reduce existing anxieties, to lobby for acceptance of the activities, and to facilitate better communication between generations.

The role of all of the partners in the network of complementary programmes and services should be clear and formalised in official documents like contracts or letters of understanding.

Financial planning

1. Establish a budget per activity;
2. Set priorities;
3. Diversify sources of income;
4. Estimate the number of peer educators to be replaced per year, and develop a replacement scheme for peer educators;
5. Establish binding agreements with other organisations, especially donors.

Selection of Peer Educators

Young people play an essential role in the identification of their leaders. Most often they will select the most dominant individuals of their cohort, but the selection process should ensure that the identified peer educators sufficiently reflect the interests of the group in question. (Likewise young people should be involved in identifying and defining the health messages, and choosing the setting(s) where the activities will take place.) The selection of peer educators has to be transparent and comply with pre-established criteria. Most obviously they have to be members of the target group, and they should also show:

- Willingness to work hard and with irregular hours;
- Self confidence and potential for leadership;
- Good interpersonal communication competence, including listening skills;
- Commitment to SRH issues;
- Discrete and confidential manner in dealing with their peers;
- Respect for other opinions and behaviour without judging others;
- Ability to motivate and persuade others;
- Openness to further learning and self-development;
- Willingness to 'practise what they preach' and serve as a credible role model for the behaviour and attitudes they will advocate ;
- Shared characteristics with the target group;
- Good reputation with their peers, good social skills and ability to establish good relations within a group.

Academic talents and achievements are usually not very important, but they must possess basic intellectual skills. Gender concerns should be considered.

An example from Nigeria

The Adolescent Health Program, part of Action Health Incorporated (AHI) in Nigeria, trained 72 boys and girls as peer educators, drawn from 33 public schools. AHI started to recruit the peer educators based on nomination by the school principal, but it soon became clear that this selection was inappropriate; the principals selected the studious, respectful and well-behaved students, who are not necessarily the most respected amongst their peers. The recruitment procedure has since changed to include young people in developing the selection criteria and choosing the peer educators.

Motivation

To secure the ongoing motivation of the peer educators, several strategies of intrinsic and extrinsic motivation should be developed. Intrinsic drives for youth to engage in peer education include altruism, to feel good when helping others, or social acceptance. Much of the non-financial motivation depends on the environment; if the atmosphere is stimulating, the activities innovative and a sense of friendly competition reigns, it will be easier to motivate young peer educators. Giving responsibility to adolescents is often contentious, yet possibly one of the best forms of motivation. Such intrinsic reasons facilitate sustainability better than extrinsic ones.

Intrinsic motivation for peer educators can be generated or heightened by:

- Providing ongoing training;
- Awarding training certificates;
- Delegating responsibility for data collection and analysis;
- Highlighting the positive social implications the role carries;
- Reiterating the benefits the work brings for their own personal development and professional career;
- Offering internships in projects or similar activities;
- Offering gifts and prizes such as T-shirts, baseball-caps, shoulder bags with logo;
- Offering regional and international exchange programme for young people.

Extrinsic motivations include future career opportunities, compensation in kind and material or financial incentives. The latter is often the most appreciated, especially where peer educators are un(der)employed. At the same time, remuneration is difficult to ensure, and salaries will hardly be feasible except in donor-driven programmes, especially given that adolescent SRH is not a high priority for most governments. The most appropriate kind of financial remuneration is performance-related pay, whereby a small fee is paid per activity and there is some mechanism for gauging the effectiveness of such activities. Through such compensation, the peer educators' skills are acknowledged and their self-esteem strengthened. The trained educators could also seek contracts with (other) SRH measures or programmes. Potential peer educators themselves are usually not willing or able to spend much money on their training. Hence, generally attention should focus on alternative ways to motivate the peer educators.

Financial motivation for peer educators:

- Compensation of costs or expenditures;
- Allowance as sign of appreciation;
- Fixed salaries;
- Payment per activity;
- Encouraging peer educators to raise their own funds, by social marketing of health products (contraceptives, condoms, vitamins).

Peer remuneration

1. Calculate how much money is available for the payment of peer educators;
2. Discuss the options with the peer educators;
3. Make written contracts with peer educators;
4. Establish a transparent system of incentives or payment for the peer educator.

Training

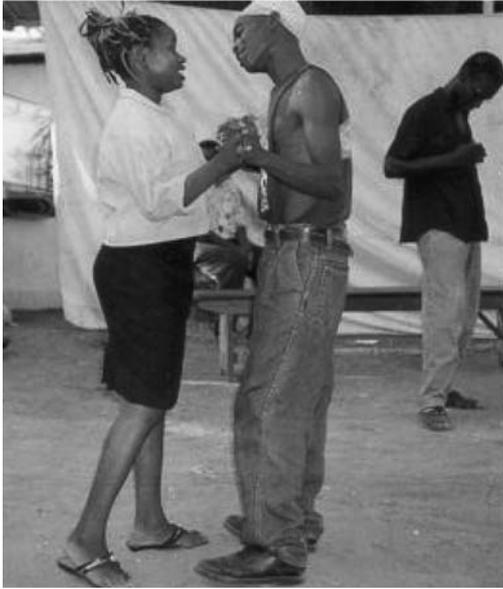
In a peer education programme, the adolescents need to be trained, but also their supervisors, and project staff, including administrators, need to be sensitised to adolescents' social and health issues. However, the key lies in the training of the educators. The amount of training depends greatly on the tasks and types of programmes in which they will be involved. For instance, if they are expected to counsel or convey prevention strategies in addition to simple health messages, considerably more input is required. Continuous training at routine meetings of peer educators as well as special refresher courses are essential. A comprehensive initial training course tends to reduce the number of dropouts and also reduces the amount of supervision and re-training needed. In addition, the peer educators should receive some reference materials on technical issues and on educational techniques. Peer training should cover basic information on adolescence, relationships, SRH, communication and life skills, mobilisation or motivation strategies, use of IEC material, how and where to seek further assistance, and more. The training should be undertaken by an experienced organisation.

Peer educators require close supervision and continuous training, as well as extra support to cope with the emotional pressure encountered through this work. Regular meetings with a knowledgeable and experienced resource person are essential, and will improve the performance of the peer educators. They need such a forum to ask questions, exchange experiences and discuss difficulties and solutions. Preferably the programme should be

Training components

1. Select a module for the training of peer educators
2. Identify appropriate trainers
3. Organise/develop training of trainers and supervisors
4. Organise the training of peer educators
5. Distribute reference, background and IEC materials
6. Organise regular meetings with peer educators
7. Encourage peer educators to exchange experiences
8. Ensure regular updating of reference materials

attached to an institution (youth home, school, sports club), association, or informal group (street children, sweatshops), in order to facilitate supervision and assure proper follow-up. To minimise turnover of peer educators, older educators can function as coaches.

IEC Material

Scene from the play "BURIAN II",
Angenige Theatre Group, Tanzania

The form of presentation of a health message is as important as its content, especially when working with adolescents. The peer educator should always employ interactive methods, and allow sufficient time for all peers to engage or ask questions. To support these aims, they should utilise IEC material for information and inspiration, which is clear, accurate, interesting, relevant and attractive. Videos and comic books, but also radio or TV broadcasts and theatre plays, can help start discussions between peer educators and their clients. Peer educators must be trained to use teaching aids effectively. They can also contribute to the development of youth-friendly material (see G6rger *et al* in this volume).

IEC Material

1. Identify appropriate existing educational materials;
2. Procure and produce educational materials;
3. Train peer educators in the effective use of educational materials;
4. Use feedback of the target group to adapt educational materials.

Monitoring and Evaluation

Although assessing the impact of peer education is not yet well developed, it is necessary to monitor and evaluate the progress and outcomes of the programme to some extent. An evaluation plan and monitoring mechanisms should be built in from the start. Peer educators should be part of the conceptualisation and execution of such system, with sound supervision. They represent an important source of information on the running of the programme, feedback from the target group, the daily problems they encounter and possible solutions.

Neighbourhood peer educators in Mali

In the PRADO (programme des adolescents), each peer educator keeps a notebook in which they record useful details about their home visits, discussion groups or counselling sessions, the themes discussed, number of female and male participants, how many were younger than 25 years old, etc. Such information helps staff strengthen and focus their assistance.

Some possible indicators to monitor the activities of a peer education programme:

- Number of young people reached;
- Changes in youth's knowledge (about physiology, family planning methods, HIV/AIDS);
- (Positive) changes in attitudes to key messages (attitudes, intentions);
- Number of referrals made by the peer educator to family planning or STD services;
- Number of contraceptives distributed (e.g. condoms sold or distributed free);
- Changes in behaviour/practices of the target group (see Schümer in this publication);
- Cost of the programme per person targeted or per contraceptive user.

Positive evaluation findings provide a concrete way to demonstrate the effectiveness of a project and enable the project to raise funding. A successful programme will also strengthen the (future) position of its peer educators on the job market.

Impact Assessment

1. Assign responsible persons for monitoring and evaluation;
2. Study local health information management systems;
3. Define specific objectives, and indicators;
4. Formalise an evaluation and monitoring system (who, when, how often, where);
5. Prepare all the forms for this system;
6. Train the people who will execute the system;
7. Collect the data;
8. Analyse the data;
9. Report and share the data;
10. Market the results of the monitoring and evaluation.

Epilogue

Young people have a right to reliable information about SRH issues, and they require opportunities to talk about their concerns and questions. In some situations, they are faced with a multitude of sometimes confusing messages; in other situations there is a lack of youth-friendly information and/or services altogether. Therefore it is necessary to create an environment in which adolescents are given the opportunity to interact and explore their feelings and queries amongst themselves. Peer educators are well placed to create such environment, because of their proximity to and identification with the target group.

However, embarking on a peer education programme requires the firm commitment of all involved, including the project co-ordinators. Peer educators need substantial input in their training and supervision, particularly against a backdrop of high turnover amongst the young educators, who need to be kept motivated to ensure a sustainable programme.

Other programmes and services that address the needs and potentials of young people need to complement peer education programmes in order to achieve positive changes in attitudes and behaviour. Once the constraints of such programmes are taken into account, peer education plays an important role in the healthy development of young people.

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2.9 Theatre for Development

Marita Klink, Lecturer and author of learning media

Introduction

In Theatre for Development (TFD), community members together develop a play which looks at social and political conflicts, using a mixture of traditional and modern techniques. The audience is deeply involved in the performance, and is encouraged to help shape processes. Ideally, this interaction between actors and audience generates new impetus and helps resolve conflicts. This form of presentation for pedagogical and development purposes emerged from the Forum Theatre which in turn originated in Augusto Boal's Theatre of the Oppressed of the 1960s.

TFD with Young People

Theatre for Development lives from audience participation. The fact that young people enjoy acting, that they are curious and open to new ideas, and that they express themselves spontaneously, can be used as a driving force in theatre work. If plays are developed by the young people themselves, and performed by them, the works are generally well accepted by peers. They see their own situation, hear their language and music, and are involved in the proceedings. This is not only extremely entertaining, but also boosts the self-confidence of the performers who become trend-setters, are taken as role models and thus achieve greater status and social prestige. At the same time, the self-confidence of the audience is raised, because they see themselves and their situation as the focus of a cultural event.

Acting is particularly appropriate for young people, because they have fewer reservations than adults, and are more open to new ideas. It is easier to convince them with messages, and easier to influence their attitudes and behaviour patterns than those of adults.

TFD for Reproductive Health

In developing countries, existing health care concepts and structures in the field of sexual and reproductive health (SRH) often fail to reach large numbers of the population. This applies above all to young people, who thus less often obtain information, counselling and care. To reach them, and other groups that are difficult to reach, new, creative procedures must be tested, in addition to improving the quality and quantity of existing health services. Theatre performances are one means of improving young people's knowledge about SRH, and paving the way for pertinent health services.

TFD can, however, promote SRH indirectly too, and not only at a cognitive level. Working in a theatre project gives young people an opportunity to acquire experience which can enhance their self-confidence, particularly in the case of young women. Dealing with members of the

opposite sex, the chance of testing other roles within the theatre framework, gives young people a chance to question traditional gender roles, and to change these (see also Loewen in this publication for the impact of physical activity on adolescent SRH).

TFD in the Project Context

The theatre offers both performers and active members of the audience the following:

- A population group that is difficult to reach obtains access to information about SRH.
- Theatre helps break down barriers. Its many and varied approaches can permit discussion of topics that would otherwise be taboo.
- Women and girls are involved.
- The theatre is attractive for young people in particular. Collaboration heightens their status, and boosts their standing because they are doing something for the community.
- Theatre promotes activity. It invites young people to take a creative role. It strengthens self-confidence and self-esteem, and allows them to gain new experience.
- Artistic forms are cultivated or re-invented, based on the roots and cultural heritage of the players. This goes some way to preserving their cultural identity.
- Artistic work is a means of perceiving experience and working through this experience, for instance violence-induced trauma. This helps victims take a step forward and can even promote reconciliation.
- Theatre is a vehicle for information, that can be transmitted in a fun way. It is not hierarchical (no teacher-student gap), and addresses more than one sense.

The preparations and production of a play will vary, depending on the region, topic and the active group. Here, we can thus only give very general guidelines.

Various experiences indicate that any **point in time**, when TFD can be used in a project cycle, can be the right one. Theatre is a good way of opening doors, in order to disseminate information on SRH, and to remove the taboos that surround the subject. It is also valuable, however, as an advertising medium, in order to publicise and render more attractive existing health care services. TFD can be integrated in ongoing campaigns and used alongside radio, TV, posters, etc.

The chance to use TFD might equally well come only in the later stages of a project. In one project in Guinea, for instance, the idea emerged only after a range of SRH services in refugee camps were already up and running. The size of the camps, however, demanded a method of providing information to a very large number of young, often illiterate individuals as rapidly as possible. TFD proved not only to be a suitable form of relaying information, but also a welcome cultural event in the otherwise monotonous life in the refugee camp.

Naturally, TFD activities must also be included in annual and budget planning; there should, however, be scope to identify suitable points to pick up on, and to act when the time is right for each specific project.

Only rough guidelines can be given for the **time required**. This will vary depending on the topic involved and several other variables. If we take a play with 15 actors, lasting about 90 minutes, experience shows that some 210 hours of preparatory work will be needed, of which about one-third will be spent preparing and developing the play, one-third on rehearsing smaller sequences and one-third on rehearsing larger parts of the play.

Rehearsals should be fixed for a set time, and agreed with all group members. The everyday life of the young people and their concentration span will determine the frequency and length of the rehearsals. Immediately before a performance, rehearsals will be more time-consuming than at the start of work on a play. It is important to allow time at every rehearsal for all members to arrive, cast off their everyday concerns and open their minds to the work on the play.

Actors

Schools, youth centres, youth groups or organisations, church youth groups, health counselling sessions, informal youth meeting places and contacts via streetworkers and youth workers are good ways of recruiting **young people** for a theatre project, in particular within the scope of reproductive health. When selecting the cast from the generally large group of candidates, acting skills can be tested. In order to bring individuals with various motivations together and form a genuine drama group, the individuals involved should have time to get to know one another. They should learn relaxation and concentration techniques, which foster creativity and are indispensable for all rehearsals and prior to performances.

The adult reference persons and local authorities should be encouraged to accept these drama activities. Special efforts must be made to obtain approval for girls and young women to participate, and a specially sensitive approach is needed.

In contrast to traditional theatre, TFD depends on interaction between the actors and the **audience**. The audience does not merely consume what is offered. They are involved in both the story line and the subsequent discussion. This increases the chances of a performance of this sort becoming more than just a short, entertaining evening. An event, in which the audience is involved, is more likely to leave its mark than a mere presentation of information. The event can act as a catalyst to make a topic public within a community.

A **facilitator**, often also known as a **joker**, leads the performance, and encourages the audience to participate. He/she asks questions, and moves the audience to make suggestions. He/she ascertains whether or not the audience has understood the content matter, and whether or not questions remain unanswered.

The part of the joker is an integral part of TFD, and the skills of the joker determine to a great extent the success or failure of the performance. He/she should be as well prepared as possible and must be:

- Able to see risks of escalation, and develop strategies to avoid this;
- Able to deal with aggressive elements of the audience who wish to create a disturbance;
- Able to encourage a very shy audience to participate;
- Competent on the technical issues, to enable him/her to respond appropriately to audience reactions.

For most projects, the greatest challenge will be to find a good joker. Options include:

- Using professional actors who have been given the necessary information (risky for complex topics, especially if detailed information must be given during the performance);
- Using experts in the field (for instance from the health services, facilitators, youth social workers) who must have the information they require at their finger tips and the acting and communication skills needed;
- Training some of the young actors in the topic (medical knowledge).

Both the use of professional actors and the use of young people mean a significant financial input. If young people are selected, it must be borne in mind that the frequent changes in their life or professional situation will mean a high fluctuation of jokers.

Depending on the context in which a play is drafted and performed, the young people will need **expert support**. Health service staff, social workers or consultants can provide the (medical) expertise, and develop the pedagogical messages. Medical refresher courses will be needed for the actors at regular intervals. Professional actors or drama students can help improve the acting skills. Involvement of famous actors increases motivation, and is a good public relations instrument.

If a stable group emerges, the medical back-up can be limited to the phase of developing and learning new topics and plays. The further-reaching quality assurance can be ensured by specially qualified managers within the group.

Drama teachers, actors and other practitioners in the world of the theatre can provide the methodical knowledge, the way to get across the message. They help actors draft and produce the play. Here too, there should be regular consultancy and quality assurance.

In view of the activities and the funds needed to launch TFD activities, they are not generally one-off, short-term projects. On Madagascar, for instance, the group Salohy, which has now achieved international acclaim with its puppet shows, was founded as a non-governmental organisation (NGO), and has become largely financially independent of the GTZ-supplied project that initiated it within the last five years. It has successfully advertised its services with other international organisations, and has the commissions it needs to ensure its survival. This was possible in part because the group can now adapt numerous other (youth) health topics for the stage, and because its repertoire now includes a wide range of topics from several different fields (e.g. the environment) as well as 'educationally neutral' shows, such as fairy tales.

The Play

The young people should be given as much scope as possible to **choose the topic**. The topical focus (SRH, violence, etc.) will mostly be determined by the framework of the project. The people providing the sector-specific and methodical support, should always be aware, however, that within this framework there is a great scope for design, and should let the young people use this scope as independently as possible, and with as few limitations as possible. Otherwise there is a danger not only of manipulation, albeit with the best of intentions, but an important part of the essence of undertakings of this sort will be lost.

One way of identifying ideas, is to hold a brainstorming session, where proceedings are led by a facilitator and the results evaluated. The need to respect certain rules of play (every contribution is equally valuable, ideas are recorded in a generally comprehensible way, wordings are found and improved) also encourages communication skills on the part of participants, and prepares them for interaction among one another and with the audience. The decision as to which topic is to be made into a play should be accepted by the entire group.

The **drafting of the topic for a play** is done in several steps. Firstly, ideas are collected as to how to present the topic selected on the stage. Everybody should try to think up suitable scenes or recount things they have experienced or heard about. At this stage, the contents and the objective of the play should become fully clear to all group members. A rough framework is sketched out for the play. It is important always to bear in mind the message.

The incidents are made into scenes. At this stage, guidance staff should give the young people the tools they need to promote creative processes, without providing ready-made solutions. All ideas should be recorded carefully, and checked again and again. Are the images suitable for the expected audience? Is the message clear? After first rehearsals, scenes will be developed further or scrapped and completely rewritten.

Pointers

- Every play should have a clearly defined main topic. Sub-plots can support the main plot, but should never compete with it.
- Make polarisation clear as good and evil, black and white, as a conscious exaggeration and way of making a point; remain comprehensible, probable and believable at all times.
- Clear structures are important for actors and the audience: Who? Where? When? should be clear at all times in the play.
- Use a language that is appropriate and comprehensible for the audience (local language, dialect, jargon).
- Consider in good time how to animate the audience to participate.
- Do not lose sight of what is feasible: Use simple solutions, keep transport/storage costs and technical inputs to a minimum.
- For groups that stay together over a longer period of time, suggest competitions with other groups to keep motivation high.
- Make use of additional skills that the young people bring in (dancing , music, arts, etc.).

Publicity, Logistics, Transport

Publicity for the event should include all the pertinent information on the contents of the play and where and when it will take place. In towns it is often much more difficult to attract the interest of the potential audience, since the expectations are higher, whereas in rural areas people are usually happy for any sort of cultural variety. The more creative the play, the more people will be interested. Possible forms of publicity include traditional local ways of making announcements (crier, drummers), involving local authorities, posters, banners, radio broadcasts, publicising the event by megaphone, TV, special invitations sent to selected individuals, and the development of a logo for the drama group.

Young people can be reached at schools and youth centres and at informal meeting places. Local authorities too should be informed about the activities, and encouraged to attend performances.

The location and timing of the performance should be agreed on in consultation with the local partners. It is important to take account of regional factors (holidays, market days, taboos). Variations in working time and spheres of men and women, young people and adults, should be taken into account.

The **transport** of actors and equipment is always a particular problem. Even groups that perform primarily in one place feel the need to act occasionally for a different audience. This helps them develop, and offers an opportunity to increase the spread of information. Good organisation (accommodation at other groups that already exist or in the homes of members of the community where the performance is to be held) can reduce costs. All projects agree that the keeping of a car (generally a cross-country vehicle) and the follow-on costs are the greatest financial hurdle to overcome. Public transport can also be used, although this has other disadvantages, such as organisational problems, frequent breakdowns and resulting delays. Climatic conditions and rainy seasons must also be taken into account in terms of both transport and the performances themselves.

The Performance

A 'classical' TFD performance embraces three stages:

1. The actors present a play that they have planned, written and produced themselves. A problem is presented in such a way as to provoke the audience. The development or end of the play are unsatisfactory and the audience is to be encouraged to help change that.
2. The audience becomes involved in re-drafting the play. Some audience members direct proceedings, giving the actors instructions, or taking over one of the roles themselves. The other members of the audience assess the proposals, and some may intervene with their own proposals. This goes on until (ideally) a version is found, which is generally accepted.

This phase places enormous demands on the skills of the facilitator. He or she must not only direct communication between the audience and the actors, but has to take an analytical look at audience inputs. Is this a new idea? What is the message? The facilitator, or joker, must ensure that the audience understands the new story line.

3. Finally, there is a discussion between the audience and the actors, with the participation of health service staff. This looks in more detail at the information gained through the play, and gives more information. At this stage, the chance of integrating the solutions of the play into everyday life is examined, and the necessary support identified.

Naturally, sometimes several solutions will be proposed, and no one solution attracts a majority of the audience. Or, the solution proposed might not be the one hoped for by the project, or not beneficial to the health of the young people. But these performances also provide valuable insights. The complexity of a problem might become clear for the first time; different positions are advanced and thus become more visible. These are important findings for future work. New discussions and activities can pick up on these.

Styles, Forms, Media

Theatre does not only address the audience at an intellectual level, its chief impact is emotive. Interesting and varied entertainment grabs the attention of the audience and makes it more willing to discuss controversial topics. It is advisable to combine various of the following forms of theatre, as well as regional, traditional styles. Cultural factors and norms should be respected.

- Music, stage and choir singing
- Traditional and modern dancing
- Drama, comedy, musical
- Puppet theatre and use of masks (provide distance when portraying undesirable social behaviour)
- Image Theatre, where the audience puts forward its comments on a sort of still life, or living image, triggering a discussion
- Simultaneous Dramaturgy, where the audience is asked to finish a scene or to develop an alternative to the unsatisfactory solution presented
- Satire, comedy

Satire in particular is effective, since this is a way of voicing exaggerated criticism of individuals, norms and behaviour patterns, which can be softened by laughter and 'depersonalised' by means of exaggeration, robbing it of the personal injury it could otherwise contain. Satire makes it possible to act out new situations, which go against prevailing norms, but indicate behaviour patterns that are desirable from a medical, ethical or any other point of view. Comedy and laughter break down tension, and allow the audience to see new situations of this sort in a positive light. For sensitive or taboo topics often found in SRH, ironical, humorous or satirical presentations represent a suitable approach. A confrontation with a direct discussion without the distance achieved through irony could be considered offensive and be rejected by the audience.

TFD, with its variety of forms, offers advantages in non-literate, and/or rural regions and slums, over measures that depend on infrastructure (radio, TV) or literacy (information leaflets, etc.). In projects, it was ascertained that the interest in theatre was particularly high in rural regions and poor areas where few cultural events are held. Performances are greeted with enthusiasm and not quickly forgotten.

Long-term experience indicates that events with a mixture of music, dancing, disco, quiz questions and drama, are extremely popular. Because the audience is not confined to their seats the whole time, they are very willing to take part and get involved.

An example from Guinea: Refugees perform for refugees

Observations made in a regional health project in Guinea show how TFD activities can develop 'from the inside'. Here – with professional support – refugees developed educational plays that give practical guidance for other refugees.

The initiative started with a group of women who had fled from Sierra Leone and Liberia to Guinea. They were trained as voluntary facilitators, to enable them to support nurses and health service staff, primarily in the field of SRH. In their originally closed group meetings, at which they were trained in antenatal care, vaccinations, sexually transmitted diseases (STDs), and HIV/AIDS, the idea originated to put on plays with other refugees, so as to reach a wider audience.

In the first phase, mainly young people from various refugee camps put on amusing, action-packed plays with the guidance of the facilitators. The idea was very well received, and drew full houses. Initially though, only conventional entertainment was offered, with no audience participation. Since 1996, this initiative has been supported by the GTZ.

At a workshop in January 1999, with the help of a consultant from Ghana, the transition was made to an interactive performance with the audience. Today, the audience is confronted directly by the characters at the critical point of the play. The actors then discuss the opinions voiced, and pass the ball back to the audience. Within the framework of a final discussion, the action is summed up jointly by actors and audience.

In efforts to improve the SRH of refugees in Guinea, theatre is one method employed alongside health services and home visits by facilitators. In order to use the limited inputs to achieve maximum impact, the project co-operates with existing structures such as health services and schools with health facilities.

The drama groups continue to be supervised and guided by the facilitators. It has proved a very good idea to have facilitators or representatives of the health services present at every performance. They are introduced to the audience, and can present their range of services and make appointments for counselling. This gives members of the audience a chance to put the knowledge they have acquired in the play directly into practice.

The actors always play to a full house. To enable them to respond to the needs of the extremely highly motivated audience, they must also develop their capacities in fields other than TFD-specific methods. They should be given a thorough basic training on SRH, and refresher courses must be held at regular intervals. To this end, workshops can be held, with small sums being paid as training support to motivate all actors to attend.

Limitations and Dangers

Almost all publications on TFD point out how important it is that all activities are determined by the participants themselves. The type and scope of external influence should be considered and reduced as far as possible. Manipulation and dominance on the part of project staff, whether intentional or unintentional, cannot be fully avoided, but on the other hand, guidance is needed to allow actors to learn about the content matter and to practice acting techniques. The most difficult task facing experts who provide methodical and thematic guidance to a TFD drama group, is to ensure that a TFD project does not unintentionally become a health training rather than a chance for actors to gain experience and to develop as individuals.

Professional local groups with TFD experience can be helpful. They can provide support at the play-drafting stage, and can train the budding actors in acting techniques (see bibliography).

Some factors can act as obstacles to the success of theatre activities:

- TFD to improve the reproductive health of young people is only expedient if parallel health services of this sort are available. If young people have no opportunity to consult appropriate facilities in order to put into practice their newly acquired knowledge about family planning or antenatal care, it is doubtful if the activities will be successful.
- The TFD activities do not offer any further support and counselling beyond the performance. After a performance, young members of the audience and possibly also the actors might be once again left alone. They must make their own decisions, say, whether or not to attend a health centre or to use condoms in spite of conventional habits/practices, etc.
- Local power relations and rivalries (defined in terms of gender, age hierarchy in families and communities as well as traditional and religious leaders or other elites) influence the success of TFD activities. It is best if persons of authority can be won over to the side of the project. However, if these structures are highly internalised, they can also hinder the openness and willingness of the audience to participate or to voice their own opinions without reservation. A good facilitator can encourage the audience to do so, but cannot force them to be open.

Evaluation

Conducting health education in an entertaining and memorable way, moving the audience to participate in the performance and subsequent discussions, getting otherwise uninterested individuals interested – theatre activities are generally felt to provide high quality and tangible results. Nevertheless, at the moment, no quantifiable impacts or concrete results can be ascertained. Nor can the call for clear criteria to evaluate the activities be satisfactorily answered. Critics disapprove of the high costs and limited audience reached in comparison to radio or TV advertisements, posters or other similar methods.

In order to prove that an impact has been achieved, statistical data, say on the use of contraceptives, the use made of health services, or the drop in the incidence of certain diseases is needed within the context of TFD activities. Frequently, data of this sort is not available, however. When planning a TFD project, the chance of collecting data of this sort should nevertheless be considered. Should it prove impossible to collect the data, a few methodical aspects should nevertheless be respected in the evaluation.

Qualitative studies, such as open interviews and observations made during performances, are important for an effective evaluation of TFD activities, **combined with quantitative data collection methods** such as before-and-after questionnaires, which check on the increase in knowledge (see Görden in this publication). The qualitative data gives good examples of changes in opinions and attitudes and perhaps in behaviour. They are suitable for making accurate statements, and give us a well-founded impression of TFD activities, but they are not representative.

Additional quantitative studies allow us to estimate the scope of impacts, and help us generalise the scattered qualitative findings, provided the qualitative and quantitative data is coherent. For quantitative data, the data collection process should be as representative as possible. It should include surveys of a larger number of TFD performances, involvement of reticent audience groups, and the survey of illiterate groups as well (*i.e.* surveys shouldn't be purely in written form).

Conclusion

Theatre for Development is a particularly good way of giving young people information on SRH. When peers take on the role of actor and mediator, the message is better accepted.

The focus of SRH activities must be on awareness-raising and popularising the necessary changes. Theatre allows us to look again and again at certain topics, in an entertaining and unthreatening way. For complex taboo topics, this must be done several times if the message is to get across. It is a genuine success when a topic is first accepted as a topic.

Interactive theatre between actors and audience allows for more than cognitive processes. Entertaining, creative, sensory experience is made possible. The effectiveness of experience of this sort should not be underestimated.

Conventional evaluation is not effective for TFD, because it is difficult to prove any direct causal link between TFD activities and objectives achieved, such as desired actions or changes in behaviour. It is, however, quite clear that TFD raises the audience's general level of knowledge. TFD is one activity of many in development co-operation. Depending on the project concept, it can, for instance, complement the work of health facilities or help achieve the objectives of health services in conjunction with other media such as radio or television.

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2.10 Sport and Physical Activities

Tanja Kreiß, Sports therapy and public health

Babette Loewen, Consultant with focus on youth

Introduction

Although the positive effects of sport and physical activity have long been known, they are still only used to a limited extent for the promotion of adolescent sexual and reproductive health (SRH). Alongside the direct physical impacts (strengthening the cardiovascular system, building up muscles, enhancing fitness, etc.) sport contributes to a positive encounter with one's own body, and allows experience of solidarity and trust, which in turn encourage (gender-specific) identity formation. Sport and physical leisure activities for young people offer an appropriate and accepted framework to raise the topics of their own bodies, their anatomy and questions of nutrition and sexuality.

Sport plays a particular role for the SRH of youth, since it targets them directly, and is linked to their lifeworlds. The topics of health and SRH are usually unattractive to adolescents, but leisure activities represent an important vehicle to establish trust. Sport offers access to individuals or to existing youth groups, or it can function as a starting point, in order to set up new sports groups. Many youth cultures are expressed through sport activities, such as skateboarding, baseball, yoga, martial arts, street football, certain types of dancing (rave, breakdance, techno, folklore, etc.), or artistic activities (juggling, stilt-walking), which can be harnessed for project measures.

Sport activities can promote adolescents' SRH at three complementary levels:

- Individual level, and experiencing one's own body;
- Group level, and the feeling of belonging to a group;
- The level of the social environment of the young people.

The positive impacts at **individual level** are primarily the result of the physical activity itself: Adolescents get to know their own bodies, their strengths and limitations, giving them a better feel of their own body, which is good for their general well-being. This is especially useful in cultures where there are few open opportunities to get to know one's body, because of taboos, excessive beauty ideals, the general disregard of sexuality or the reduction of the female body to the functions of child-bearing. Fun and competition involved in sport activities help strengthen the self-confidence and physical awareness of young people, allows them to understand their own bodies, and thus themselves, strengthening their personality, which is an important prerequisite for a responsible attitude to their sexuality and to SRH. Sport is good for good health general well-being.

In a group, sport can help develop trust among peers. The young person must be able to rely on others, experience a sense of community, and get to know his or her positioning within the group. In team sports, alongside trust, responsibility for themselves and others is also encouraged. Within the group, rules are developed, and the young people become familiar with alternatives to the violence, injustice and exclusion they experience all too often in their



Built on trust

Ecuador 2001. B. Loewen

immediate social environment. They learn to establish fair relationships, including respect for their own health and that of other people. In the trusted atmosphere of the sports group, the sensitive topics of SRH and the physical side of life can be broached and discussed more easily. In sports activities with adolescents, the group leaders often act as role models – a situation which bears the opportunity to raise certain issues of SRH, and to offer positive models with which the young people can identify.

Finally, the **social environment** of the young people can also be directly integrated in the work, by organising special public events or tournaments. Whole neighbourhoods can be targeted, say by offering inter-generational activities (games for smaller children, and information or sports for adults). Depending on the interests of the young people, specific youth sports (rap, breakdancing, skateboarding, etc.) can be offered.

This allows parents and families to observe the youth activities, and understand them, which encourages inter-generational support and exchange. Other youngsters see that sports can be fun, successful and foster group cohesion, motivating them to join, too.

The general social recognition of sport can be used positively in the field of youth health, and expanded. It is important here to understand the cultural background, and to incorporate this in planning. For this reason, this paper gives an overview of various ranges of activities and their impacts offered in practice by GTZ-supported projects. It has been discovered that a combination of different activities is particularly suitable for promoting all-round health.

Sport as a Tool to Promote Reproductive Health

Sensitive and professional leadership of the group is an important precondition for the promotion of individuals and of the group. If the activities offered are geared too one-sidedly towards competitive sports, and problems and conflicts are not discussed in time, sports can become exclusive and frustrating, and can even spawn violence. In this context, it is very important to assign qualified trainers or facilitators who make a conscious effort to promote fair play and the idea that physical activity is fun.

Sport and physical activities, individual and team sports are important instruments and access roads for addressing and reaching adolescents. Various positive impacts, relevant for the SRH of young people, can be achieved.

Impacts of sport

1. Generally improving physical awareness and fitness
2. Specific promotion of SRH
3. Emancipatory and gender-specific work
4. Developing positive values and standards
5. Public Relations (PR) work for youth
6. Sport as therapy
7. Preventing violence and juvenile delinquency
8. Other positive impacts

Sport enhances adolescents' **physical awareness and fitness** with individual experience of their own body and physical activity. Normally, high-performance work and tension in alternation with 'deserved' relaxation gives individuals positive experiences that boost their general happiness and sense of well-being. Alongside the general health-promoting effects, this has a positive impact above all on their self-assurance and self-reliance. Sport fosters fitness, and a fitter body is generally approved and recognised by society, meaning that the young people have a more positive self-image.

Sporty people have a better feeling for their own body, get to know the power and limits of their physical performance, and learn to value their own body, which specifically **promotes sexual and reproductive health**. Young people who know and accept their own body will protect it better than those for whom the body has only negative connotations.



Aiming high
West Uganda 1993, H. P. Thumm

This has an impact, above all, on the prevention of sexually transmitted diseases (STDs) and unwanted (teenage) pregnancies. The self-confidence acquired through sport enables young people to decide more easily and informedly, for example, if, when, and with whom they wish to indulge in sexual activity or have children. Team sport creates a group atmosphere of trust which furthers an exchange of information and experience among peers. Since sport always focuses on one's own body and other peoples' bodies, it is also easier to discuss topics related to the body, such as health, disease and sexuality. When tackling these sensitive issues it is important that young people learn from one another. Young facilitators might be able to provide appropriate inputs, pick up on topics, or current events (see also Blankhart in this publication).

Sport and physical activities provide a forum for individuals as well as their wider social environment to acquire valuable experience as regards **gender-specific approaches**. Even if the world-wide largest form of organisation for women is sport, in most societies girls have less access to sport than boys. They are taught that their bodies should be beautiful above all else, and that the primary role of their body is to bear children. Sport can give these girls physical experiences that have nothing to do with reproduction. Sport in mixed or single-sex groups (in many societies the first option is not feasible) offers the chance to make adolescents aware of the roles society expects them to play, and to demonstrate alternative roles.

The sports group offers girls a chance to be listened to within a socially acceptable framework, to be perceived as individuals and to express themselves. Sports can also allow girls to experience their own bodies and to learn self-defence techniques. 'Strong girls' are also made visible to the world outside the sports club. The single-sex group can consider the limitations of and alternatives to gender roles, and discuss these, helping both boys and girls find their gender-specific identity. In mixed groups, members learn to deal fairly with the opposite sex, on the basis of the observation that girls and boys might have different, yet equally valuable skills.



*Playing catch at break-time;
Namibia 1991, H.P.Thumm*

In sports groups and within the framework of physical activities, behavioural forms are demonstrated and practised, which offer alternatives to predominant practices in society, such as corruption, violence as a means of conflict resolution, and the

contravention of rules. A framework is offered which makes it possible to act in an easily comprehensible and transparent way, to define goals and achieve these with effort (and as a group). Through sporting activities an alternative form of socialisation emerges, which supports the **development of positive values**. On the basis of these new values, a link can be established with adolescents to the topic of SRH, for instance, accepting responsibility for their own bodies, alternative conflict resolution models and dealing with risks.

From a societal point of view, youth are often stigmatised, and associated with acts of violence, theft, prostitution and drug abuse. This denies them a positive participation in society, and they are generally branded as hopeless cases with no future. This is often accepted at face value by the young people themselves, and thus becomes a self-fulfilling prophecy. Sport activities *per se* and the presentation of sport in the form of tournaments or shows gives adolescents an opportunity to display some of their positive qualities, to conduct **PR work**, as it were, on their own behalf. This can trigger an exchange of ideas and the integration of youths from different socio-cultural backgrounds. Co-operation with parents and adults, with schools and other organisations can also be utilised in order to improve the public image of young people, and to demonstrate behaviour patterns of youth which are rarely perceived within society, including

drive and enthusiasm, willingness to work hard, communication skills, team spirit, strength, leadership qualities, trust and respect.

In addition to the strengthening effects of sport, **therapeutic work** in the field of SRH is important. For young people who have experienced violence, rape or female genital mutilation (FGM), such topics as sexuality or bodily feelings are extremely sensitive. Sport or physical activity can open up these topics and provide a framework within which they can be discussed. The focus here should be on the positive experience of one's own body, self-esteem, the sense of achievement, and fun.

Moreover, sport can generate attitudes conducive to the **prevention of violence or addiction**. Within the scope of violence prevention, sport gives adolescents a way of channelling their physical tensions, allows them to learn about positive competition and non-aggressive behaviour. This contributes also to the prevention of sexual violence. Alternative patterns of action and orientation are learned and rules are defined jointly, which along with identification with and the feeling of belonging to the group, can help counter addiction. Sport helps, in general, to overcome fears and stress, and to resolve conflict. The experience that one can do something well, and having a meaningful leisure activity can help prevent young school leavers and the young unemployed in particular from drifting into delinquent sub-cultures.

In work with **handicapped youth**, sport offers a good point of access for sensitive physical and sexuality-related topics. Physical activity and achievements not only enhance motor skills, but have a positive impact on self-confidence.

Examples and Experience

A well-considered approach in technical co-operation projects for the promotion of SRH can foster the positive impacts laid out above. Here are some examples taken from GTZ-supported projects. In sport too, it is important to realise that, in different countries and different cultures, the preconditions vary, among others with regard to the chance to involve girls, access to formal education or co-operation with the existing sports infrastructure.

Approaches for project work

1. Regular leisure activities (indoor – outdoor activities)
2. Sport within formal education
3. Tournaments, festivals and other sports events
4. Social work on the streets offering physical activities
5. Training of Trainers
6. Co-operation with sports clubs
7. Co-operation with top sportsmen and women
8. Work with facilitators
9. Sports camps and youth trips

Regular Leisure Activities

Sports offered as out-of-school leisure activities can be initiated by the project or offered in conjunction with non-governmental organisations (NGOs), youth groups or other institutions. It is important that the sport activities offered are in line with the interests of the youths, are easily accessible, and held at times at which the target group is likely to be able to attend. (Girls are frequently not permitted to leave the house in the evening, school times and vacations must be taken into account, as must work in the home or in the fields). In the Primary Health Care Project in Western Uganda, indoors sports are offered in the morning and afternoon. The timing aims, in particular, to ensure that out-of-school and unemployed youths have access to the activities too, since they are a high-risk group with regard to SRH. The sports activities are linked to the health centre, which facilitates access of adolescents to the centre (for information and counselling). The focus should be on the sports that are particularly 'in' for youth, as the INTERJOVEN project in Chile demonstrates, where the activities on offer range from breakdancing, hip-hop and skateboarding to capoeira, a Brazilian form of dance and self-defence.

- Primary Health Care Project, Uganda; Dr. Chris Baryomunsi (bhsuga@imul.com)
- INTERJOVEN Youth Project, Chile; Horst Steigler (interjoven@inj.cl or hsteigler@inj.cl)

Sport within Formal Education

In many countries, little attention is paid to school sport, neglecting its positive impact on the promotion of general well-being, of group cohesion, and of individual development. SRH projects can provide curriculum consultancy and in-service training for teachers to sensitise them to the positive impacts of physical education. It is important to depart from the prevailing attitude that it should be taught with discipline and drills, and that at school, too, the principle of enjoying physical activity takes over. Physical education also offers the chance to tell youths about out-of-school activities (tournaments or major events), or again to integrate information events. School breaks can be used for physical activities and games, where pupils learn that sport is fun rather than looking only at performance. In addition to the positive physical impacts, this also has a positive impact on the learning behaviour and the attitude to school itself. The experience of the TESAIRA project in Paraguay shows that no expensive equipment or instruments are needed for this.

- Reform of Teacher Training, Peru; Dr. Wolfgang Küper (wkuper@minedu.gob.pe)
- Promoting Integral Youth Health, TESAIRA, Paraguay; Evi-Kornelia Gruber (gtzsalud@highway.com.py)
- The Moving School Concept, Prof. Hermann Gall (gall_hermann@ph-ludwigsburg.de)

Tournaments, Festivals and Other Sports Events

Sport and sporting activities are significant in every culture and have traditional forms of expression. The proximity to games and festivities means that a large portion of the target group can often be reached at public events. Tournaments, competitions, or festivals can be used to

reach the target group youth and to pass on information. In the RIAS Project in Ecuador, young facilitators of the project have developed significant artistic skills, which they present at various events. Physical control and expression give the individuals self-assurance, and offer them a starting point for questions and discussions. In many instances, the artistic activities are so attractive that other adolescents are moved to join the group.

Before any sports tournament, for instance, a preliminary procession with a special motto can publicise the event (Women's Health Project PROSIM in Nicaragua). Sports events are also ways of reaching young people and offering sexual counselling, distributing condoms, publicising telephone hotlines that can provide information on safer sex, and conducting (anonymous) AIDS tests as the HIV/AIDS and Youth Sexual Health Project in Argentina does. This project also holds an annual AIDS charity run, which the youths organise on their own.

In Senegal, women's football tournaments are held with Information, Education, Communication (IEC) components that take the form of posters and word of mouth. In principle, there is little in the way of leisure activities, and so events of this sort are well attended both by young people and by adults.

- HIV Prevention and Promotion of Youth Sexual Health, Argentina; Dr. Peter Weis (saludgtz@datamarkets.com.ar)
- Women's Health promotion, PROSIM Nicaragua; Dr. Regine Meyer (regine.meyer@gtz.de)
- AIDS and Family Planning, Senegal; Dr. Gerd Eppel (gtzsante@sentoo.sn)
- Reproductive Health, RIAS, Ecuador; Dr. Dörte Wollrad (gtz-rias@uio.satnet.net)

Social Work on the Streets offering Physical Activities

To address young people and create a direct link to their lifeworld, social work on the streets is an option for the sports sector too. In this context, the project can sound out the places frequented by youths (parks, street corners, etc.), and build on existing sports activities. The PAISAJOVEN Project in Columbia supports an NGO which combs the town systematically in this way, and has now established contacts to most existing street football groups (Fútbol por la paz). As a second step, the various street football groups from different neighbourhoods are brought together for tournaments with extended fair play rules. Under other circumstances, these groups would regard each other as enemies. The work in the actual surroundings of the adolescents allows them to stay in their own familiar environment, where they feel secure. This creates an atmosphere of trust, which also offers a basis for more youth participation or for information events.

- Youth Project, PAISAJOVEN Columbia; Klaus D. Tangermann (gtz@paisajoven.org.co)
- Fútbol por la paz; Jürgen Griesbeck (Jgriesbeck.bsj@t-online.de)

Training of Trainers

In co-operation with trainers (male and female) of youth sports groups, further training can look at sport-specific topics, group management and health promotion including sexuality. Training of trainers can steer the positive impacts of sports into fields relevant for SRH. The trainers or supervisors, thus sensitised, can perform important multiplication work with young people.

- Family Planning and Family Health, Mozambique; Dr. Angelika Schrettenbrunner (angelika_schr@yahoo.de)

Co-operation with Sports Clubs

Existing sports clubs offer a means for reaching young people. Depending on what is agreed with the club, life skills training and education and orientation work can be offered, as practised in the Health Project in Mongolia. Work with an existing group often has multiplication effects, and the trainers can be involved in a concrete way in the work. Here it is important that the sport offers a link to the topics to be broached; it might be proposed as a further training course for the groups.

- Reproductive Health, Mongolia; Dr. Wolf Wagner (reprohealth@magicnet.mn)

Co-operation with Top Sportsmen and Women

Young people often have as their role models top sportsmen and women. For this reason, co-operation in the field of SRH offers an important way of reaching adolescents and passing on information. In Mozambique, with the co-operation of the GTZ-supported AIDS and Reproductive Health Project, the JOGA SEGURO Initiative – AIDS Control in Football, was launched. The initiative ran parallel to the national first division football championships with various preventive activities: Information for football players, referees, linesmen and physiotherapists; promotion games with media coverage, interviews in sports broadcasts, contracts with sports newspapers (information on HIV/AIDS), advertising at the side of the pitch, contracts with football idols and the distribution of educational materials along with tickets for football matches. A large number of young fans can be reached this way because of the hugely popular nature of football.

- Family Planning and Family Health, Mozambique; c/o GTZ Office, Mozambique

Work with Facilitators

Work with young facilitators or peer educators is of crucial importance for SRH projects, and can be used in the field of sport in particular. For instance, the training of referees among young people helps strengthen their willingness to obey rules and to play fair. Communication skills and leadership-building are supported. In the PROSIM Project in Nicaragua, young people organise training and manage the sports equipment, boosting players' sense of responsibility and discipline.

- Women's Health Project, PROSIM, Nicaragua, Dr. Regine Meyer (regine.meyer@gtz.de)

Sports Camps and Youth Trips

A weekend with the sports group, a trip with common sports activities, a training week for multipliers or a meeting with other young people is a great experience for adolescents. The new experience with the group, the absence of parents and families and the adventure are felt to be exciting and support the group-building process. Many adolescents see this as an important step on the way to assuming responsibility for themselves and to becoming independent. In the sports camp, or on the trip, the framework is ideal to strengthen the health-promoting behaviour of the group. Alongside the sport (which could take the form of discovering new exciting sports together) and the fun, the focus is on training, meeting other youths and on the commonly assumed responsibility.

Conclusion

- The use of sport and physical activity in the field of SRH offers a great chance to gain access to young people.
- The positive impacts of sport (getting a better feeling of one's body, boosting self-esteem, trust-building) are encouraged if the focus is on the group and on enjoying the activities rather than purely on performance and competition.
- Sport has an important socialisation function; alternative patterns of behaviour are learned in the group.
- Sport activities help directly to promote SRH, but also encourage adolescents to learn democratic behaviour.
- Contact with parents, teachers and representatives of neighbourhoods and communities can be established and used to promote SRH.
- Sport can well be complementary to other measures for the promotion of SRH, such as youth health centres, open youth work, peer education, trauma work, policy advisory services, etc.

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2.11 Rural Youth as a Target Group

Petra Ruth, Consultant

Introduction

The other papers forming part of *Hands On!* look at various methods and approaches of working with young people on sexual and reproductive health (SRH). This paper will focus on a specific target group: Youth in rural areas. The conditions they live in can vary significantly from those in an urban environment. The specific characteristics of this group, in the field of SRH as elsewhere, give rise to the following opportunities and problems, which must be taken into account when selecting appropriate procedures for development co-operation with rural youth, if a sustainable contribution is to be made to improving their situation. When selecting a method, it is often possible to fall back on tried and tested approaches of youth work in other fields (e.g. peer education, drama, sport and media development). On the basis of some of the characteristics of life in rural areas, proposals will be made below for the design of projects or measures relating to SRH of rural youth.

Characteristics of Rural Youth

The development opportunities of rural youth depend largely on such factors as mobility, education and training opportunities, and access to work, land and credit. The tension between gainful employment and unemployment, migration and quality of life is thus the main concern to many rural youth. In the countryside, the traditional social security net is often very close-knit and rigid. In conservative systems, adolescents frequently have a low status, marked by few opportunities to act, voice their concerns, make decisions or develop their own personalities. They often feel isolated, since the infrastructure in rural areas is less well developed than in more urban areas: They are particularly badly hit by poor traffic connections and public transport, education and culture, health care and municipal services. The opportunities for rural youth to obtain information and participate in communication are also significantly more limited than those in towns and cities. (For a description of the living conditions of rural youth in Africa, see also Djedje 2001).

In work with rural youth, like with their urban counterparts, it is important not to perceive adolescents as aimless or as a problem group, but above all as equal social actors. Many young people have exceptional potential in terms of creativity, commitment, the ability to learn, a sense of responsibility, solidarity and the ability to organise themselves. If they are to be helped to use these skills to improve their own situation, certain rules must be respected. Young people are particularly sensitive to behaviour patterns and attitudes, such as authenticity, acceptance, transparency, interest, respect, understanding, willingness to enter a dialogue and honesty. When designing and implementing measures on SRH, adolescents can generally be best reached by adopting the following methods and procedures.

Basic Procedures

Gaining Acceptance in the Social Milieu of Youth

Often rural youth, unemployed or employed on the family farm, are socially and economically dependent on their parents and the other adults who make up the social security net. On the basis of the assumption that they are firmly integrated in their environment, appropriate methods of co-operation must be selected: Before we can work with adolescents, not only to shape the room for manoeuvre accorded to them, but perhaps even to change and extend this space, it is essential to gain a minimum of acceptance on the part of adults living with them. It is difficult for adolescents to develop their own initiative against the will of parents, family members, neighbours, teachers, co-operative members, trainers or local authorities. It is not always possible for the project to gain the full acceptance and support of the adolescents' social milieu, but it is important at least to inform key persons about the objectives of the project in good time, and to gain the acceptance of some adults who can play the part of mediator or perhaps even ally.

The acceptance or trust of the village community cannot, in our experience, be gained through one-off, costly activities. In rural areas more than anywhere else, daily life is geared to growth processes, which are constant and follow their own dynamics.

The following procedure is thus advisable for **processes of confidence-building**:

1. Co-operate with local experts at the preparatory stage;
2. Build on existing contacts and contact persons;
3. Mainstream the project in a context comprehensible to the village community;
4. Announce the project and agree on a suitable date for a visit well in advance;
5. Ensure that the first meeting is conducted carefully and modestly;
6. Respect authorities at local and district level and the advised sequence of local appointments;
7. Explain the project to key persons in the village (e.g. politicians, administrators and religious leaders) and topic-specific key persons (e.g. health service staff);
8. Leave them a written outline of the project and a contact address;
9. Plan the course of further activities jointly (overview of steps to be taken);
10. Keep up contacts until the next meeting;
11. Send a co-ordinated, joint invitation to local authorities and project team to a first meeting with adolescents from the area ;
12. Invite adults to a first informal meeting with rural youth, (e.g. in the form of a barbecue).

If the villagers and the local authorities not only know about the project, but have been involved in its planning and design from the onset, the probability is greater that they will later allow the project team direct access to adolescents and allow them to work with these, without constantly controlling the process. This creates room for manoeuvre which can be used creatively.

Creating and Using Room for Manoeuvre

If a project manages to get the parents and local authorities in a village to accept direct access to adolescents, it is both possible and advisable to hold participatory planning meetings for topic-specific and common leisure activities in the absence of adult members of the community. This gives adolescents a new space, accepted by adults, which they can shape and in which they can develop new ideas with their peers. They feel less controlled and express themselves differently when no adults are present. The opinion leaders among young people stand out more clearly and can be involved in planning work as important actors and facilitators. The design of project measures by young people themselves, and thus also their identification with implementing these measures, becomes more probable, because it is simply easier for them to develop new ideas and organise themselves in their own social space.

In the best-case scenario, the new space for adolescents will not only exist for a limited period, and apply to certain processes (planning, preparations, training), but will be institutionalised. Young people can get together and talk in largely independent places such as youth centres. They meet their friends outside the domestic, school or job framework. Places like this can also be used as information points for an exchange of experience and for training on topics of SRH. Seminars and information evenings can also be used to open these facilities to a wider audience occasionally (see Supé in this publication).

One tried and tested form of designing planning meetings with rural youth is to conduct workshops, which last a minimum of one day, ideally a whole weekend. Dates should be fixed with people who know the daily pattern of the young people's lives and their leisure times. The practical organisation should be left largely in the hands of local adults, in order to involve them in the process. The project team should focus on the content matter with the participation of the youth. Care should be taken to ensure a balance between topic-specific blocks and leisure activities.

Here is one example of **the structure of a weekend workshop**:

1. Welcome and introduction of the project team;
2. Explanation of the project, the objectives of the workshop and the working methods;
3. Relaxed introductory round with activities to allow participants to get to know one another;
4. Clarification of the different expectations placed in the meeting (using participatory methods, such as cards);
5. Initial topic-specific work, e.g. participatory situation analysis of the village with regard to adolescent health care;
6. Working groups with facilitators, e.g. to look at the question: What do I like/dislike about my environment in terms of health services?
8. Presentation of the results of the working groups to the whole group;
9. Questions and discussion, facilitated by the project team;
10. Looking at individual aspects in more depth in working groups;
11. Development of initial ideas and planning concrete activities and projects;

12. Binding agreement for the following steps laid down in a work plan;
13. Identification of volunteers to put some of these into practice;
14. Evaluation of the workshop, comparison with expectations;
14. Summary of results;
15. Farewell and promise of reliable support after the workshop;
16. Ongoing backstopping support for the process by the project team;
17. Support for the adolescents on request;
18. Information and Public Relations (PR) work in the village.

The elaboration of various topics can also be tackled at different short meetings over a period of several weeks or months. More intensive methods include project conferences, youth excursions or exchange visits, at which concentrated work is performed on topic-related fields and leisure time and group-building are encouraged.

If the project or measure is developed and proposed by the rural youth themselves at one or more planning workshops, the topics will be directly geared to their situation, whereby day-to-day worries and concerns are taken as the starting point for the considerations and proposals of the young people. In rural areas, it is expedient to combine social, communal and income-generating projects. Adolescents can thus try out new sectors with their own production or group-supported production on a small scale, and thus generate additional income.

In a GTZ-supported project in Uruguay (Promotion of Participatory Rural Youth Work) the rural youth, for instance, were asked to devise productive micro-projects, which were assessed, supported and monitored by the project co-ordinator. The development of fundamental ideas, the first planning steps and the elaboration of work plans with those responsible, took place within the scope of meetings with rural youth over several days. Under these circumstances, the adolescents began to develop a commitment to small-scale projects in experimental branches, such as ecological vegetable production, or nandu and coypu breeding. Their parents and neighbours, as sheep and cattle breeders, were initially sceptical about these innovative projects, but in time their interest in the project grew, with the first small successes of the young people (Ruth 1998: 4-7).

The information flow relating to topics tackled, but also PR and lobbying work are crucial to the success of youth projects, and not only in the field of SRH. Ways of imparting topic-specific information or communicating directly include notices on the village information boards, articles in newspapers and magazines, information material, publicity posters, communal radio programmes or videos. In rural areas in particular, young people often have few opportunities to obtain comprehensive information.

Methods to Reach Rural Youth with Health Services

In rural areas, hygiene and primary medical care are generally inadequate. In Paraguay, for instance, only 6 percent of rural youth have health insurance (as compared to 25 % of urban youth). Almost half of the 15 to 19-year-old girls surveyed in rural areas had at least one child. The main health problems are unwanted teenage pregnancies, miscarriages, HIV/AIDS, sexually transmitted diseases (STDs), and alcoholism (Acosta 2000: 3-4). Against the background of the poor infrastructure, adolescents in rural areas rarely take up education or health services that are available (the same applies to cultural and leisure programmes). This should be taken into account in approaches involving rural youth.

Building on Regular Community Activities

One possible way of responding to poor infrastructure is to link project appointments, meetings and activities to other events at which the village community or certain groups already meet regularly. An adult will rarely refuse a request to take their adolescent offspring to one of their meetings, such as a village meeting, a local church council meeting, co-operative meeting etc., or to allow them to attend a parallel event for young people.

During this time, the project team can work without being observed and in an age-appropriate way with the adolescents. As was pointed out above, it is advisable not only to deal with topics such as SRH, but also to allot time for recreational activities. After an initial preparatory phase in which the ideas will come mainly from project staff members, the rural youth should plan the meetings themselves. Experience shows that the more the adolescents take responsibility for their activities, the more attractive they will be in the long term for the target group.

The following procedure is appropriate for **planning regular group meetings**:

1. Identify interested youth;
2. Agree on a time and place for the first meeting;
3. Project team facilitates and prepares the first meeting;
4. Get to know group members;
5. Organise activities to lighten the meeting, e.g. games, drama;
6. Introduce the topic of youth health in a well-planned manner;
7. Arrange further activities to lighten the atmosphere, e.g. music, games;
8. Establish a preparatory group for the next meeting;
9. Evaluate the group meeting;
10. Rural youth design meetings in a participatory manner.

Mobile Youth Work

Another option is to bring the services to young people. One good example of this is offered by the community of Nordhausen in Thuringia, Germany, where youth work is mobile, going to the target group. The approach is in the process of being adapted in the context of the GTZ-supported Project Promotion of Children and Youth in Uganda.

The Mobile project embraces a youth culture centre with fixed opening times and subject-specific events. In addition, mobile services are offered within a 40 km radius to adolescents living in this area with its scattered settlements. Activities are organised as required, e.g. street football tournaments, handicrafts, drama workshops, climbing, music, rollerblading or abseiling. The activities take place in streets, squares, parks or village greens, where the young people usually hang out. The activities are also held at times suitable for the potential user groups. The mobile services are thus also available in the evenings or at weekends. This goes some way to overcome rural youth's lack of mobility (Pape 2001: 3-6).

Mobile youth health services could also be applied in the field of SRH. This could give young people support and advice on a flexible basis (in terms of geography and time). This help could take the form of talks and discussions with peers or professionals. Additional offers, such as information materials, books, games, videos or condoms or medicines are also conceivable. The initial inhibitions of adolescents to make use of services of this sort will decline, the more attainable, close, accessible and affordable the option appears to them.

Decentralised Health Posts

Yet another option to discuss the topic of SRH with rural youth and to enhance their situation is to set up decentralised health posts. For social and financial reasons, it might be expedient to attach these to existing decentralised facilities. It is, however, important that the adolescents find a place where they can discuss important topics with one another, and receive additional professional help, without being controlled and made accountable by adults. The project must accept fluctuations in the willingness of adolescents to help.

The GTZ-assisted project Tesaira has been working for some years now in Paraguay in the field of integrated youth health. In this context, the establishment of decentralised youth health posts has proved extremely successful. As well as socio-cultural and leisure activities, these give young people access to primary medical care. Adolescents play an active part in the design of their centres, e.g. in the selection of further training courses in the field of integrated health. While adolescents attend existing health stations only in a medical emergency, a more comprehensive offer of services reduces their inhibitions to contact health facilities. Education work and further training are possible in this framework (Acosta 2000: 8).

Adolescent Community-based Peer Counsellors

Another approach to reaching rural youth with health care is the training of peer health counsellors. Experience shows that young people discuss SRH topics primarily with trusted

friends. If young people can be specifically trained in this field, information can be relayed to the peer groups (see Blankhart in this publication).

In Kenya, the GTZ has been supporting the Ministry of Health for 10 years in the recruitment, training and supervision of adolescent and adult community-based distributors (CBDs). These volunteers inform their communities on SRH and family planning, provide oral contraceptives and condoms, and make referrals to the nearest health service for STD treatment (see Neckermann in this publication). When adult agents proved to be rather inaccessible to adolescents, the project began to also recruit youth as community-based peer counsellors, in order to make information and condoms available to young people in a confidential manner. The youth counsellors are supported by adult CBDs (van den Hombergh 2001).

Conclusion

When planning and designing measures for adolescent SRH, the target group of which lives primarily in rural areas, it is important to take into account the special features of the rural context. Both prevailing social norms and the existing infrastructure differ from those in urban areas. Scope for action accepted by the village community can give young people the opportunity to obtain information, discuss and form their own opinion. The chance to look at the topic of SRH should be available to adolescents at suitable times and locations.

Project staff should monitor the process of awareness-building and support it as required, but they should leave the practical realisation and design largely to the rural youth themselves. In this way, the adolescents gain not only subject-specific and methodical knowledge, but they gain experience in organising groups (see Loewen in this publication), the social function of which can, in time, go well beyond the initial objectives.

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