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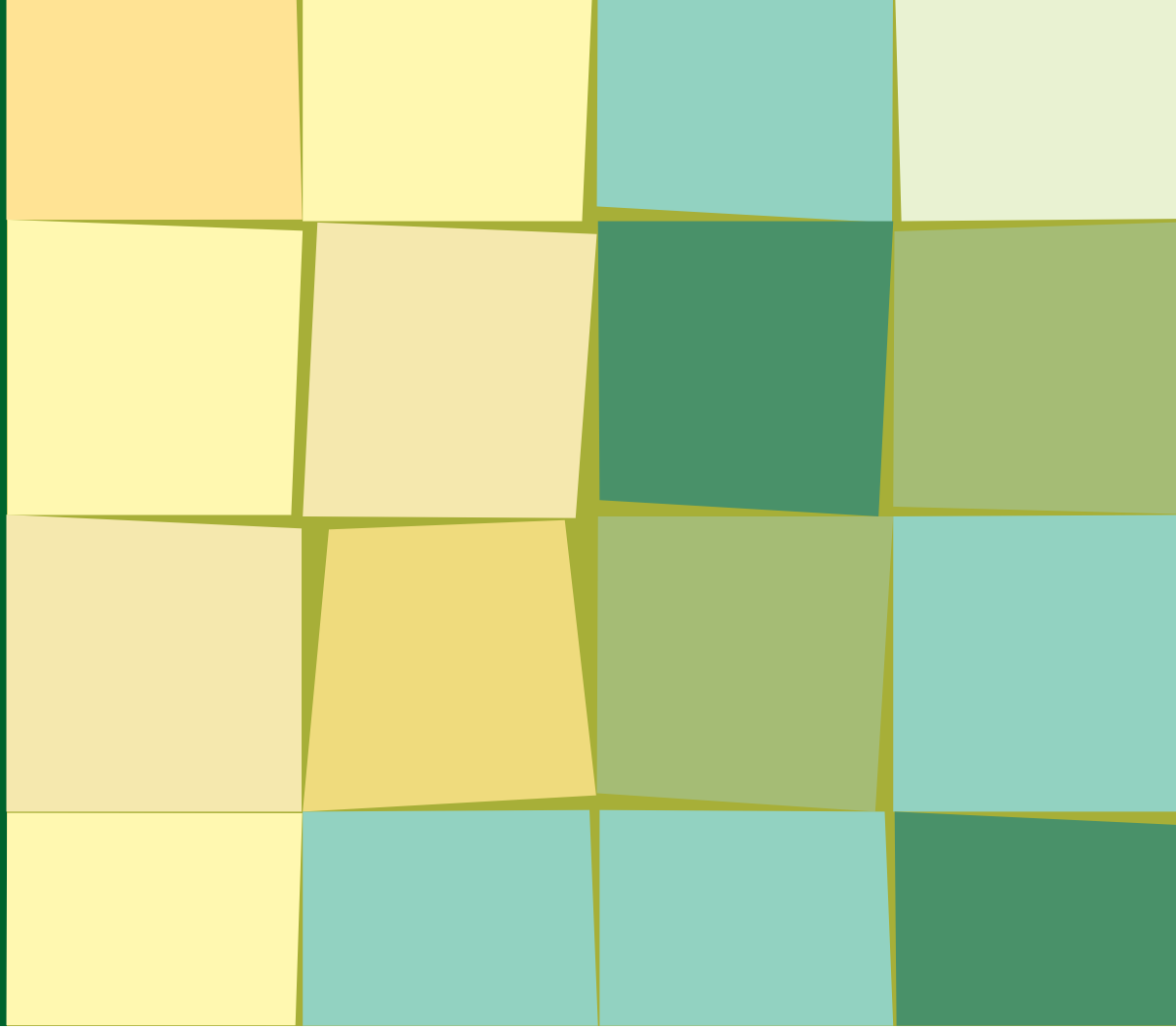

Lessons for life

HIV/AIDS and lifeskills education in schools

Neil Casey and Anna Thorn
Edited by Dr Lieve Fransen and Chris Willott

EU HIV/AIDS PROGRAMME IN DEVELOPING COUNTRIES

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List of acronyms

ACET	AIDS Care Education and Training
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
CBO	Community-based organisation
EC	European Commission
EU	European Union
HIV	Human Immunodeficiency Virus
IGP	Income generating projects
IIED	International Institute for Environment and Development
MoE	Ministry of Education (Uganda)
MoH	Ministry of Health (Uganda)
NGO	Non-governmental organisation
ODA	Overseas Development Administration
PLA	Participatory Learning and Action
PRA	Participatory Rural Appraisal
RRA	Rapid Rural Appraisal
SHAPE	Schools HIV/AIDS and Population Education programme (Swaziland)
SHEP	School Health Education Project
SNAT	Swaziland Nation Association of Teachers
STD(s)	Sexually transmitted disease(s)
STI(s)	Sexually transmitted infection(s)
TASO	The AIDS Support Organisation
WHO	World Health Organization

Foreword

As developing countries enter the new millennium, their economic and social development and the future of their youth is strongly threatened by HIV/AIDS. The educational world, and especially the school system, offers a unique opportunity to halt the progress of the epidemic among the young generation: an opportunity we cannot afford to miss.

Through lack of information and education, young people's behaviour puts their lives at risk. Lifeskills education will not only help reduce HIV/AIDS by teaching adolescents how to modify this behaviour, it will also reduce sexual violence, sexual coercion, unwanted pregnancies, drug use and other negative factors. In order to produce strong and sustainable effects educational interventions need to be correctly researched, formulated and implemented. This manual highlights the means and methods by which this goal can be efficiently and effectively achieved.

Both governments and international organisations such as the European Union (EU) face the task of protecting the young generation's health and future through education and information. In my country, the European Commission (EC) has worked jointly with the Swazi government to formulate an educational programme that targets adolescents in secondary and high schools. It is imperative that health and lifeskills programmes are not at odds with the communities in which they are to be implemented. That is why the views of teachers, parents, community leaders and medical practitioners have been solicited, in addition to young people themselves, and why care has been taken to respect and value local custom and tradition.

Educational programmes for schools represent only one component of integrated policy strategies formulated by governments and international organisations. They aim to improve young people's environments as well as their ability to protect themselves and others and are therefore vital. In years to come, lifeskills education programmes may prove to be the cornerstone of HIV/AIDS prevention for the developing world.

Dr Phetsile Dlamini
Minister of Health and Social Welfare
Swaziland

Introduction

By the year 2000, 40 million people are expected to be infected with HIV/AIDS worldwide. HIV/AIDS has become recognised as an individual, family, community, national and global problem. Ethical and religious beliefs and values, traditional notions of social order, cultural norms and practices, attitudes and customs have all been challenged by the infection and the disease.

HIV/AIDS infections continue to increase in most developing world countries at a disproportionate rate to the western world. The economic, political and social mechanisms that keep developing countries poor interact to produce a context in which HIV/AIDS thrives.

Young people in the developing world are most vulnerable to HIV/AIDS, but they also present the opportunity to halt the epidemic with targeted prevention strategies. Young people at school are a relatively accessible group. They are more likely to adopt sexual behaviours that prevent HIV/AIDS since their sexual habits are not as firmly established as those of adults. And by offering new and viable patterns of behaviour for the next generation to follow, young people offer hope for the future.

The European Commission has been a major contributor to HIV/AIDS initiatives in over 90 developing countries during the last decade. From 1987, the EC started to support HIV/AIDS and lifeskills education programmes in the developing world, both within and outside of school structures.

These programmes have been developed in partnership with both governments and non-governmental organisations (NGOs). Much has been learnt from the programmes, as this is a relatively new area that was inadequately researched.

In June 1997, the EC organised a workshop to bring together delegates from various programmes involved in EC-funded lifeskill and HIV/AIDS education programmes, expert consultants and EC representatives, in order to:

- explore the results of the programmes
- allow participants to exchange ideas, information and experiences; report findings, ascertain outcomes and draw conclusions
- enable participants to network both nationally and internationally
- assist the EC to develop a strategy to realise its maximum effectiveness and inform future EC policy and practice.

Papers presented covered such topics as sex education theory and best practice, cost issues and cultural values, gender and several national and project experiences. This guide is based on the events and content of the workshop.

Schools in developing countries represent the most efficient and effective means to target young people and help prevent HIV/AIDS, other sexually transmitted diseases (STDs) and unwanted pregnancy. Those who formulate sex education and lifeskills interventions must ensure that these programmes are adequately researched and developed, so their impact on young people is both positive and sustained. This guide is aimed at those who prepare and implement lifeskills interventions in the developing world: educational policymakers, head teachers and NGOs.

The goal of this guide is to provide those formulating lifeskills interventions with the tools they need to make projects both effective and motivating for young people, and to harness local knowledge and culture to adapt interventions to specific circumstances.

A WHO document illustrates the depth of the problem to be tackled:

> *'In many developing countries, more than half the population is below the age of 25 years. In many countries, over two-thirds of adolescents aged 15 to 19, male and female, have had sexual intercourse. Adolescents and young adults (20 to 24) account for a disproportionate share of the increase in reported cases of syphilis and gonorrhoea worldwide. In addition, at least a fifth of all people with AIDS are in their 20s, and most are likely to become infected with HIV as adolescents.'*
> (World Health Organization AIDS series, no 10, 1992)

Young people are the key to future prevention of HIV. If schools-based interventions are effective at altering behaviours that lead to harm, the impact of HIV/AIDS can be substantially mitigated, and progress can be made towards reducing its impact rather than merely watching it increase.

Dr Lieve Fransen
Principal administrator, EU HIV/AIDS programme in developing countries DG8/A/2: Human, social, cultural development and gender/AIDS, population and health

Executive summary

1. This guide is a framework to prevent and reduce HIV/AIDS and improve health through developing national-scale lifeskills education programmes that include sexual behaviour and HIV/AIDS information targeted at young people in school.
2. To develop effective lifeskills education programmes that are appropriate to national and local contexts, programme developers should assess both broad- and client-based needs.
3. A broad-based needs assessment is important to gain an overall view of the current HIV/AIDS situation. It determines the strategy of programmes.
4. A client-based needs assessment identifies the context: actual and perceived needs, environment and culture. Gender and religion are both key factors.
5. Broad- and client-based needs assessments enable programme developers to define specific objectives, which provide essential benchmarks against which to measure achievement.
6. Information interventions such as booklets or leaflets and project interventions including curriculum development, extra-curricular activities and improving the school health environment are effective starting points towards developing more comprehensive lifeskills education programmes.
7. Information interventions provide knowledge and can encourage limited changes in values and behaviours.
8. On a small scale, project interventions:
   - provide knowledge about wider sexual health issues, HIV/AIDS and preventive behaviours
   - inform young people at school that they can be at risk and when this risk is most likely
   - teach young people at school to take personal responsibility for their actions through the development of lifeskills
   - empower parents, teachers and other gatekeepers (those who provide or prohibit access to young people) such as village or religious leaders.
9. Effective policy interventions – national-scale lifeskills education policies including sex and HIV/AIDS education targeted at young people in school – are based on empirical research and involve young people, teachers and other gatekeepers in their development.

10. Although the most common progression is from information interventions to project interventions to policy interventions, needs assessments enable programme developers to decide the most appropriate progression. The different interventions often run concurrently. Progression requires the ownership of all those directly involved.
11. Programme developers must ensure that lifeskills education programmes provide:
    - knowledge and identification
    - lifeskills and empowerment.
12. Programme developers should also heed the elements that constitute successful information and project interventions.
13. Policymakers should ensure that programmes:
    - are regarded as a priority and allocated adequate time and resources
    - are considered an integral part of the national curriculum
    - preferably cover nursery school to late secondary school
    - use interactive and learner-centred teaching methods, often requiring teacher training.
14. Both policymakers and programme developers should make programmes and teacher training applicable and accessible to young females at school and women teachers.
15. Healthy environments are extremely important in developing coordinated, coherent and sustainable programmes and are the joint responsibility of policymakers, programme developers, governments, NGOs, communities, schools, families and individuals.
16. It is essential that programme developers use monitoring and evaluation to develop and improve lifeskills education programmes.
17. Monitoring and evaluation are continuous processes that assess actual achievements against the original goal, the specific objectives and on-going expectations:
    - process evaluation monitors expectations throughout programmes
    - impact evaluation assesses the immediate and short-term effects of programmes
    - outcome evaluation reveals long-term effects and the bigger picture.
18. Programme developers should own, plan and budget for monitoring and evaluation from the initial stages of programmes.
19. Monitoring and evaluation involve programme developers using a variety of techniques to collect data.

Chapter 1: Needs assessment

To develop effective lifeskills education programmes that are appropriate to national and local contexts, programme developers should assess both broad- and client-based needs.

Broad-based needs assessment

A broad-based needs assessment is important to gain an overall view of both the current HIV/AIDS situation and other related issues such as coerced sex, unwanted pregnancy and sexual attitudes. It should review past and current lifeskills education programmes; it must assess the commitment, support and capabilities of allies, owners and partners such as government departments, NGOs, local communities and parents, who may be supportive of or opposed to programmes.

A broad-based needs assessment determines the strategy of lifeskills education programmes. It informs their point of entry – for example, for a programme targeting young people at school with sex and HIV/AIDS information leaflets, the point of entry might be through teachers. It helps to plan the stages of development necessary to implement programmes.

Client-based needs assessment

A client-based needs assessment should:

- research the actual needs of young people at school in a sensitive, gender specific way, and the needs of gatekeepers
- research the perceived needs of young people at school and those of gatekeepers, which may differ from the actual needs
- consider the environment within which any programme will take place – such as the human, material and financial resources available
- consider culture, including religious norms and values and gender roles, to help formulate appropriate interventions.

In considering actual and perceived needs, environment and culture, Participatory Learning and Action (PLA) or Participatory Rural Appraisal (PRA) techniques can be employed.

PLA is the name given to a range of participatory methodologies including PRA and Rapid Rural Appraisal (RRA). The guiding principle of these methodologies is that those whose livelihood strategies are the subject of research and development must be fully integrated into the decision-making process. Only if this occurs will solutions be both sustainable and culturally appropriate.

PRA aims to utilise the skills and knowledge of poor, marginalised rural people to produce interventions which are most beneficial to them. PRA asserts that participation in development is open to all individuals and communities, so they can make informed decisions about their own lives.

Culture

Culture is a complex set of multidimensional relationships. Cultural beliefs, norms and values:

- give a society direction and meaning
- govern the way in which people within a culture live
- inform rules, arrangements and hierarchical and power structures
- set the boundaries between what is allowed and what is prohibited.

Culture is often invisible, intangible, unmanageable and difficult to define. Individuals may be unable to describe clearly the culture in which they live but they are influenced by it and pressurised to conform.

However, culture is not static. It is dynamic and alters from one generation to the next as new possibilities and dimensions are learned. Culture adjusts to incorporate beliefs, norms and values from other cultures. And, as cultures change, groups and individuals within a culture also change in terms of, for example, religion and gender roles.

During a client-based needs assessment it is essential that programme developers investigate and understand cultural realities. Transferring lifeskills education programmes wholesale, from one culture to another, will not work.

Gender

Gender refers to the roles played by and relations between men and women and how these affect their lives. Gender roles and relations form the core of a person's sense of identity and the backbone of society.

Gender roles, relations and identities within a culture are defined and enforced by activity, class, economics, ethnicity, history, legislation, politics, psychology and religion – and the perceptions and expectations of that particular culture. Tasks and the division of labour do not relate to the sex of a person and are not common to one sex across different cultures.

Although women often need to conform to gender identities to provide security for themselves and their children, women are not a homogenised group with a single interest. In certain contexts, the relations between women of different backgrounds may be more important than those between women and men. Programme developers need to consider gender alongside other issues such as class and race.

Programme developers should also note: education programmes have often based gender definitions on western-world assumptions of the nuclear household with the dependent 'unproductive wife'. No two cultures would completely agree on the precise roles that distinguish one gender from another, so it is essential not to use imported notions of gender or to regard the community and household as basic units.

Gender and HIV/AIDS

It is predicted that more women than men will be infected with HIV/AIDS by the year 2000. In Malawi, the number of HIV-positive girls aged 15 to 19 is four times that of boys and, in some places, girls as young as 10 are being infected. Several explanations for these trends are offered below.

1. Women often have little access to education, economic development and political and social power:
   - strategies against HIV/AIDS are often designed by men and embody male priorities. For example, programmes may:
   - neglect women's status and rights by focusing on the needs of men
   - misrepresent and misunderstand women – from a male point of view, women may be viewed as a resource that can be taken for granted. From a female point of view, women are exploited and have less time than men to complete income-generating activities and household and community duties

  - operate on the assumption that benefiting men will have a positive effect on women. However, men do not always act benevolently towards their female partners and family members. It cannot be assumed that income is pooled or spending priorities shared
  - some economic policies make women's work more insignificant, contributing to a deterioration in women's status.
2. There is a strong link between poverty and HIV/AIDS. Women are the only financial support for as many as a third of the world's families and produce 70 per cent of the family food in Africa, but they have little control of wealth or property. Where women do have access to earnings, male partners may pocket the money. Wife inheritance means that a husband's family inherits a widow's possessions, contributing to women's poverty. Poor women have less information and less access to commodities to protect themselves and their daughters.
3. Barriers of tradition and custom:

> *'Women are at the receiving end of discrimination, exploitation and abuse in the name of tradition, especially in the developing world.'*
> Dr L T Kanya, Swaziland

  - when men have more than one wife, a sick wife will be banished from the home
  - available means of protection are often in conflict with cultural values, making it extremely difficult for women to protect themselves
  - women share a culture of silence and do not complain.
4. There is a proven link between gender inequality and the spread of AIDS. Unequal relationships between men and women put women at higher risk of HIV/AIDS infection:
  - women often have little choice about what they do sexually and are coerced into sexual relations
  - many women are infected by male partners but most dare not refuse unprotected sex for fear of violence

- it is difficult for many young women to negotiate safer sex. Young men are allowed and even encouraged to be sexually active, but young women should be virgins. Knowing too much about sex can stigmatise young women; pretending not to know means they cannot ask to use a condom – and condom use is generally seen as a female responsibility
- with high rates of infection, the practices of sugar daddies (who obtain sexual favours in exchange for money, school fees, clothes and other 'gifts') and men using prostitutes are changing. These men are entering into relationships with progressively younger girls. Having sex with older males increases power imbalance and threatens girls with sexual exploitation and HIV/AIDS infection.

5. The sexual health of rural women in developing countries is largely ignored. Women often lack access to information or health services.

Addressing gender issues

Although addressing gender inequality is frequently taboo, programme developers should position lifeskills education programmes within a gender context to make them more socially relevant and just and therefore more effective.

It is also imperative that programmes examine sexual issues other than HIV/AIDS. Appropriate and effective interventions can alter sexual behaviours, and this can have a positive impact on attitudes towards women. Issues such as coercion, rape, unwanted pregnancy and STDs other than HIV need to be examined within the course of schools-based interventions, the goal being a fundamental change in attitudes towards sexual behaviour. Thus, decreases in HIV transmission can go hand-in-hand with reduced levels of forced sexual encounters and unwanted pregnancy.

Religion

Programme developers should also consider religious beliefs. For example, religious beliefs may include myths such as that HIV/AIDS is a curse from God or the result of witchcraft. These beliefs contribute to discrimination against people with HIV/AIDS.

Religious beliefs may also support or obstruct healthy sexual behaviour. Some beliefs inhibit early sexual relations and encourage monogamy, thus minimising risky behaviours. Other beliefs encourage female circumcision or sex with several women to prove masculinity and are therefore detrimental to healthy sexual behaviour.

Specific objectives

Broad- and client-based needs assessments enable programme developers to define specific objectives. For example, a specific objective could be: sexually active young people at school are expected to experience a 50 per cent increase in condom use per sexual act over two years. Specific objectives provide essential benchmarks against which to measure actual achievements.

The results of needs assessments should give programme developers some indication of who should be targeted (sexually active young people at school) and what change is required (in this case, condom use).

How much change and when (in this case 50 per cent increase over two years) are called standards of acceptability. Programme developers can determine these standards using one of the following methods.

Arbitrary approach: Programme developers decide what standards are acceptable.

Scientific approach: Standards are based on research and experiments. Expected results are suggested.

Historical approach: Standards are based on last year's performance.

Normative approach: Standards are based on what comparable programmes have achieved in similar contexts.

Compromise approach: When none of the above can be applied, programme developers come to a consensus or compromise as to what would be a reasonable outcome.

Needs assessment case study

Mwanza, Tanzania

Previous EC-funded research in Mwanza indicated that sexual activity began at an early age with more than 50 per cent of the population reporting having had sex before the age of 15. Despite the resulting high prevalence and incidence of unwanted pregnancies, abortions, sexually transmitted infections (STIs) and cases of HIV/AIDS in adolescents aged 15 to 24, those adolescents had little access to reproductive and sexual health services and information.

With the goal in mind of responding to the reproductive and sexual health problems and needs of adolescents by improving access to services and information, further research was carried out. The magnitude of problems and needs and the effects of current programmes were measured within an initial needs assessment.

The research was conducted in four district headquarters of Mwanza Region. Through focus group discussions, HIV, other STIs and unwanted pregnancies were all identified as key problems among adolescents. An anonymous self-completion questionnaire about these issues was then completed by 584 primary school pupils and 308 secondary school pupils, who were randomly selected from randomly chosen schools within each of the four communities (18 primary, five secondary schools). The questionnaire focused on two broad areas:

1. The sexual experience of participants, including:
   - whether participants had experienced sex
   - age at first sexual encounter
   - number of partners
   - different types of sexual activity experienced
   - location where the sexual act(s) occurred.
2. Their understanding of sexual matters, including
   - the consequences of early sexual activity
   - knowledge of sex and contraception
   - the type of sex education received.

The results of the survey reported:

- a very high proportion reported ever having had sex (primary school: boys 80%, girls 68%; secondary school: boys 89%, girls 48%)
- most respondents reported their first sexual activity had been at an early age (median age at first sex was 15 years for primary school pupils and 16 years for secondary school pupils)
- different types of sexual intercourse were reported (approximately 50%, 40% and 9% of primary school pupils reported their first sexual intercourse to have been vaginal sex, oral sex and anal sex, respectively)
- the risks associated with early sexual intercourse were fairly well known by participants (eg over 40% mentioned infertility, and over 50% mentioned STIs)
- coerced sex was common (31% of girls in primary school and 20% of girls in secondary school stated this was the case for their first sexual encounter)
- a high proportion reported having had at least one of the consequences of adolescent sexual activity, including STIs, unwanted pregnancies and abortions

- low contraceptive use (among the primary school pupils who reported having had sex, only one quarter of the girls and one third of the boys reported ever having used a condom)
- the vulnerability of adolescents at school (4% of primary school girls reported having had forced sex with a teacher)
- the importance of gifts within sexual negotiation (over one third of the female primary school pupils who reported having had sex said they had done it to receive either money or a gift).

Two major intervention projects have been started in Mwanza Region based on these findings:

1. The first, in two of the four district headquarters (see above), is based on the training of teacher guardians, class peer educators and health workers, and community mobilisation to support these activities. It will include a 1998 evaluation of changes in reported knowledge and sexual behaviour and comparison with these outcomes in the other two district headquarters, after which the intervention will be extended to include these towns.
2. The second is a large-scale community randomised controlled trial that was due to start during the second half of 1997. The intervention will be based on:
   - the training of primary school teachers to teach sexual and reproductive health education
   - the training of class and community peer educators to support this and to act as agents of change among their peers
   - the recruitment of youth condom distributors (through social marketing)
   - the training of health workers in youth-friendly approaches to the provision of sexual and reproductive health services
   - community mobilisation to support these activities.

The main outcomes of the trial include sexual and reproductive health knowledge, reported sexual behaviour, and the incidence and prevalence of HIV, other STIs, and unwanted pregnancies among the adolescents. The trial is due to finish in 2002.

Conclusions

1. To develop effective lifeskills education programmes that are appropriate to national and local contexts, programme developers should assess both broad- and client-based needs.
2. A broad-based needs assessment is important to gain an overall view of the current HIV/AIDS situation. It determines the strategy of programmes.
3. A client-based needs assessment identifies the context: actual and perceived needs, environment and culture. Gender and religion are both key factors.
4. Broad- and client-based needs assessments enable programme developers to define specific objectives, which provide essential benchmarks against which to measure achievement.

Chapter 2: Information and project interventions

Information and project interventions are effective starting points towards developing more comprehensive lifeskills education programmes.

Information interventions

Information interventions such as booklets or leaflets are cost-effective ways to raise awareness of HIV/AIDS. They supply a broad base of information to large numbers of young people at both primary and secondary-school level (and a wider audience) in a short space of time.

Successful interventions

Programme developers should follow the guidelines outlined below to create successful information interventions.

1. Information should be presented in a clear and structured way. It should match the educational level of young people at school and contain some repetition. Young people at school may have a limited knowledge and understanding of national languages. Information interventions may need to be produced in local languages and literacy support may be necessary.
2. Simple, easy and explicit health messages, such as on condom use, work best. Complicated messages tend to confuse and be counterproductive.
   Bombarding young people with too many different messages can both hinder understanding and encourage passivity. Emphasising an individual message concentrates young people's minds.
3. Presenting facts about the risks of HIV infection, with a clear emphasis on risky behaviour, is important.
   Young people at school tend to underestimate the risk of HIV/AIDS, linking the disease with certain risk groups rather than risky behaviour. Some theories argue:
   - positive images of sex and sexuality are needed
   - risk-reducing behaviour needs to be framed in a positive way

- appeals based around young people's fears will be rejected in defensive avoidance.

Others assert that the danger of HIV/AIDS as a killer disease needs to be clearly shown. Fear messages are sometimes helpful for young people at school to accept health recommendations.

4. Information made personal through attractive, competent and reliable messengers is often more persuasive than presenting plain facts.
   Information interventions that use role-model stories can:
   - enable young people at school to identify with HIV/AIDS
   - provide information about dealing with risk and prevention
   - create social norms favouring HIV/AIDS-reducing behaviours
   - motivate young people at school to adopt less risky behaviours
   - encourage young people to be compassionate towards people with HIV/AIDS.

   To be truly effective, role models should be both female and male and close in age to the targeted young people at school.
5. An interactive approach can lead young people at school to increased self-learning and understanding of messages.
   If this approach is not applied, a non-thinking environment may be created. Examples of the interactive approach include participation with discussion ideas, games, interviews, quizzes and questions.
6. Countries differ in their culture and policies so what is effective in one country may not be the right approach in another.
   Providing straight facts can deal with people's misconceptions about HIV/AIDS. Changes beyond what is initially considered feasible are a possibility. For example, in some cultures abstinence may not be considered a viable option. Presenting it in a positive light, however, may create a new social norm where abstinence is welcomed.

Information intervention case study

Booklet project: *AIDS: The Killer Disease*

AIDS: The Killer Disease was first developed with EC support in Benin and then adapted for Cameroon and Comoros. It has since been modified for a further 10 countries in Africa and Asia.

The main of objectives of the booklet were to:

- raise awareness in adolescents aged 12 to 15 of HIV/AIDS risks before they started sexual activity
- promote positive attitudes to people with HIV/AIDS.

A secondary goal was to raise the awareness of parents, sisters, brothers, other family members and neighbours.

Each country's cultural and moral traditions were researched and surveys on attitudes and knowledge regarding HIV/AIDS were conducted. Field studies on language and the selection of personal testimonies and photographs took place. Draft copies of the booklet were presented to community leaders and gatekeepers for reactions and approval prior to printing and distribution.

The booklet used clear language and familiar vocabulary to make it self-instructional. To emphasise the reality and seriousness of HIV/AIDS, it contained personal testimonies and photographs of people considered credible by young people at school. HIV/AIDS information was given by doctors and other messages were presented by popular role models such as football players and pop stars. A cartoon story was used to describe the effects of HIV/AIDS on the immune system. The booklet was reproduced in good quality, durable materials.

The booklet was not without difficulties and its value and effectiveness were difficult to measure. It was difficult to gauge action taken and behaviour change as a direct result of reading the booklet.

However, positive results included:

- a considerable number of copies of the booklet were distributed with the actual amount of people reading it many times the distribution rate. For example, in Comoros 20,000 copies were distributed but an estimated 200,000 actually read it
- many people still had their copies one year after distribution
- the targeted young people at school had shown their copies to their families voluntarily

- communication about sex had increased within families
- both young people at school and their families had become convinced of the existence and seriousness of HIV/AIDS and had an increased understanding of the disease
- a change in attitudes to HIV/AIDS resulted and the intention to avoid risky behaviour was expressed.

Information interventions: the first step

Information interventions provide knowledge and can encourage limited changes in values and behaviours.

However, for wholesale changes in values and behaviours, programme developers must enable young people at school to:

- gain knowledge about wider sexual health issues, HIV/AIDS and preventive behaviours
- identify that they can be at risk and when this risk is most likely
- take personal responsibility for their actions through developing lifeskills.

Additionally, programme developers can empower parents, teachers and other gatekeepers to provide guidance and role modelling for young people at school.

Project interventions

On a small scale, project interventions provide knowledge, identify risk, enable young people to develop lifeskills and empower gatekeepers. Project interventions are confined to individual institutions, districts or regions and can be seen as pilot programmes for lifeskills education programmes. They might include:

- curriculum development and implementation, training and materials
- developing extra-curricular activities
- encouraging parents to participate

Project intervention case studies

Kallpa, Peru

An NGO took the lead to meet the various needs of Peru's many distinct cultures – and in particular the needs of 12 to 19 year olds.

A goal was established: to reach young people with information and to encourage a change in values and behaviours in order to prevent the spread of HIV/AIDS.

The views of young people, parents and others were researched. Teachers, parents (particularly fathers) and students were trained about HIV/AIDS, attitudes, values, self-esteem and social behaviour. A peer education model was adopted. Wide-scale action took place through a fair about HIV/AIDS, a disco and radio programmes.

Some difficulties were encountered:

- there was a problem with maintaining training quality and keeping abreast of new issues
- peer groups rejected the peer leaders chosen so alternative ways of working had to be found
- in some cases teachers hindered communication: some teachers found the topics too difficult to handle, others had excessive work commitments
- parents who accessed training were often not those of young people most at risk – problems with violence and sexual abuse at home were related to HIV/AIDS.

Findings included:

- the right choices had to be made when selecting peer leaders
- authorisation to include topics in the school curriculum was essential
- easily accessible local services able to answer concerns rather than long-distance advice and counselling services were required
- parents needed to be trained and kept informed on an ongoing basis in order to:
  - feel comfortable with new issues
  - understand what their children were learning and reinforce what was being taught
  - create better communication and improved relationships at home
- the role of parents was about teaching sex and sexuality, values and general health issues to children at a young age.

Soul City, South Africa

Soul City is an area with high levels of violence and rape resulting in STIs, unwanted pregnancies and negative sexual experiences. With recent political changes, however, there has been a rise in expectations and a wish to change the status quo.

Research identified a lack of facilities outside school where young people could discuss the issues and decisions affecting them. Further investigation indicated the issues young people wanted to discuss, which were different than initially imagined. It was decided to focus on personal identity, relationships, making choices and taking responsibility, and to use popular media most accessible to young people – TV, radio and print.

Currently, Soul City has a 13-part, prime-time TV soap opera, a 15-minute daily radio programme in nine different languages, an upbeat magazine and an extensive public-relations and advertising campaign with articles and competitions. It has published four booklets and produces adult-education and lifeskills packages. In addition, young people are given the opportunity to:

- take part in discussions
- think about what is important to them
- analyse their values and behaviour
- take responsibility for their actions by looking at the consequences of their choices.

This programme is extra-curricular and there is a need for increased coordination between this and other programmes.

Its strengths include that it:

- relates specifically to the target group – sex and HIV/AIDS-prevention education has been contextualised and offers real-life experience
- involves the support and action of the community
- provides roles models and does not blame victims
- can be used in schools

- improving the school health environment.

From project to policy

When developing lifeskills education programmes, the most common progression is from information interventions to project interventions to lifeskills education programmes. In this way, those issues being explored are gradually integrated into the school curriculum.

Programme developers need to harness effective grass-roots approaches and use them to implement national initiatives. The move from information and/or project interventions to national policy interventions is not easy and requires the ownership of all those involved.

Conclusions

1. Information interventions and/or project interventions are effective starting points in developing lifeskills education programmes.
2. Information interventions provide knowledge and can encourage limited changes in values and behaviours.
3. On a small scale, project interventions:
   - provide knowledge about wider sexual health issues, HIV/AIDS and preventive behaviours
   - identify to young people at school that they can be at risk and when this risk is most likely
   - teach young people at school to take personal responsibility for their actions through the development of lifeskills
   - empower parents, teachers and other gatekeepers.
4. Although the most common progression is from information interventions to project interventions to policy interventions, needs assessments enable programme developers to decide the most appropriate progression and different interventions often run concurrently. Any progression requires the ownership of all those involved.

Chapter 3: Policy interventions

The term policy intervention refers to national-scale lifeskill education policies that include sex and HIV/AIDS information targeted at young people in school.

The history

Since the mid-1980s there have been three generations of lifeskill education policy.

The first was based on assumptions that young people at school would avoid risky behaviours if they had greater knowledge about HIV transmission, infection consequences and reduction strategies. Most produced an increase in knowledge but few helped to change behaviours.

The second generation of policies realised that knowledge was necessary but insufficient to change behaviours. They addressed values, social influences and general decision-making and communication skills. As well as increasing knowledge, some programmes resulted in changes in values and behaviours among the people targeted.

From 1990, the third and most successful generation of policies and programmes emerged.

Successful programmes

Third-generation policies and programmes are based on empirical research and involve young people at school, teachers and other gatekeepers in their development. They identify two stages in behaviour development.

1. Knowledge and identification – young people at school may not adopt positive attitudes or HIV/AIDS preventive behaviours if they:
   - do not know about wider sexual health issues
   - have never heard about HIV/AIDS
   - do not know what HIV/AIDS preventive behaviours are
   - do not think they are at risk from HIV/AIDS
   - are not convinced that changing their behaviour will reduce the risks of HIV/AIDS infection
   - perceive risk-reducing behaviours to have serious disadvantages.

At this stage, programme developers must ensure that programmes fill in any gaps identified among young people at school with accurate information. (This lays the foundation for the next stage.) Programme developers should enable young people at school to understand that they can be at risk and when this risk is most likely, and to engage with programmes in such a way as to produce a change in values.

2. Lifeskills and empowerment – young people at school may not adopt HIV/AIDS preventive behaviours if:
   - they think they are not able to adopt positive sexual or lifeskills behaviours
   - their friends, partners or parents do not feel a need to develop their behaviours.

At this stage, programme developers should assist young people at school to:

- develop values such as respecting self and others
- take personal responsibility for actions through learning lifeskills such as assertiveness or the development of relationships
- practise lifeskills.

In addition, programme developers must empower parents, teachers and other gatekeepers in order to provide guidance and role modelling.

Effective elements

Programme developers should heed the elements that constitute successful information and project interventions. Policymakers should consider the further components outlined below.

Separate, integrated and/or extra-curricular?

One debate is about whether programmes should be taught:

- as a separate national curriculum subject
- integrated with another national curriculum subject such as science or social studies
- integrated with a variety of national curriculum subjects, such as health education, home economics and maths, in a cross-curricular approach
- through extra-curricular activities.

Policy intervention case studies

Separate subject teaching, Uganda

A team of facilitators visiting schools in Uganda taught the AIDS Care Education and Training (ACET) lifeskills programme as a separate subject.

Facilitators used an ACET manual covering HIV/AIDS and STI awareness, behaviour options, peer pressure, sexuality and relationships. The manual was split into separate lessons with a range of materials for each lesson. Facilitators selected materials most appropriate to the class being taught. Additionally, they used local resources such as videos or their own information.

Communication was critical. Facilitators were encouraged to use simple language to make understanding clear and allow young people to relate to and identify with them. This resulted in open discussion. Barriers were broken down and young people discussed the issues that were important to them.

Cross- and extra-curricular approaches, Thailand

The concept was to integrate lifeskills education programmes into the content of several other national curriculum subjects: English, health education, home economics, maths, sciences, social education, Thai and scouting for boys.

Teachers worked together to determine how to integrate and teach the old and new content together. Female and male teachers both taught the opposite sex.

In addition, the programme included extra-curricular activities such as exhibition boards, news reports and slogan contests.

The results of the programme included:

- teachers and young people at school were involved in an exciting process
- positive relationships evolved between teachers and young people, which led to open discussions and teachers feeling more able to evaluate risky behaviours
- young people at school got an idea of the HIV/AIDS phenomenon and were able to apply it to their own lives. They could select information that interested them and discuss it with peers, which helped to strengthen self-confidence.

Policymakers must ensure that, however programmes are taught, they:

- are regarded as a priority and allocated adequate time and resources
- are seen to be an integral part of, and not in conflict with, the rest of the national curriculum
- at least cover early primary to late secondary young people at school and preferably start in nursery school. This allows for continuity.

Teaching methods

Teaching methods in many developing countries are based on western scientific models of formal education and are knowledge-based and teacher-centred. Current educational theories suggest that lifeskills education programmes are best conveyed using interactive and learner-centred teaching methods such as debate, drama, games, group work, interviews, role play and questionnaires. Policies should allow teachers to:

- become facilitators rather than simply transmitters of knowledge
- understand young people at school and their dilemmas
- get young people to open up and identify with issues
- assess existing knowledge and address problematic areas
- direct and enable young people at school
- use an adequate selection of resources in order to provide flexible activities.

Some problems encountered and solutions given

1. When using interactive, learner-centred methods, teachers fear their positions being weakened and losing control.
   Actually, young people at school are usually so absorbed in activities that discipline improves. Discipline breakdown is more likely when young people have no interest in what they are being taught.
2. Participatory methodologies may focus student's minds on negative aspects of their culture and environment.
   Handled properly, such methodology can lead to the identification of areas of improvement, and help to ensure the promotion of healthy practices.
3. Class size is a problem. It can prevent group work.

In some circumstances, individuals or teams may be required to support teachers. However, if well organised, group work need not depend on class size. Classes can be adapted to changing circumstances – for example, classes can be taken outside if more space is required.

4. Many teachers do not know how to use interactive, learner-centred methods and feel ill equipped to teach lifeskills education programmes.
   The solution is one of adequate training. Any negative aspects are minimised by teachers who are trained and motivated.

Teacher training

In many countries teachers have little involvement in their training development. Often training is insufficient and, where it is given, leads to promotion with the resulting classroom expertise and skills being lost.

Policymakers must enable teachers to be trained to use interactive, learner-centred methods to teach lifeskills education programmes. Teachers need confidence and experience to enable them to dispense with pre-set texts and allow student input.

Policymakers should ensure that teacher training is included in initial and on-going training programmes. It needs to be supported by monitoring to ensure that teachers implement methods correctly.

The benefits

Interactive, learner-centred approaches enable young people at school to:

- become involved in and responsible for their own learning
- be active, learn faster and cover subjects more quickly
- consider issues, choices and consequences
- communicate, interact, break down barriers and change values and behaviours
- help to develop curricula and identify areas for improvement.

A note on women and girls

1. Policymakers and programme developers must ensure lifeskills education programmes are applicable to young females at school by assessing women's cultural position and presenting sexual equality as a:
   - right, duty and role

- political issue (rather than an individual, personal need)
- desired and just starting point from which to go forward.

2. Policymakers must ensure that more female teachers receive teacher training in order to provide role models for young females at school.
3. Policymakers and programme developers should allow women to teach boys' classes and men to teach girls' classes. Mixed classes taught by both men and women can also be appropriate. However, girls are often in a minority in secondary schools so efforts must be made to ensure they are not intimidated and their views ignored.

A healthy environment

A healthy environment at national, community, school and family levels is extremely important in developing coordinated, coherent and sustainable lifeskills education programmes. It positively influences their implementation, impact and effectiveness.

Young people at school are not free to make their own choices and decisions but are influenced by their environment. A healthy environment encourages, supports and maintains new values and behaviours.

Creating a healthy environment is the joint responsibility of policymakers, programme developers, governments, NGOs, communities, schools, families and individuals.

Government involvement

Government support is essential. Programmes are likely to be more effective as:

- specific government policy that is adequately funded
- part of wider health promotions that:
  - encourage healthy choices
  - provide appropriate services such as health clinics (particularly with the sexual health needs of women and girls in mind)
  - are combined with other supportive policies such as greater access to education for girls or job creation and economic empowerment for women.

Without government support and policy, programmes are likely to be severely hampered at grass-roots level.

NGO involvement

The links between government legislation and policy implementation at community and school levels can be tenuous. Government and NGO collaboration is vital.

Successful NGOs understand community values and behaviours and are able to encourage support for policies. They are able to implement and effect grass-roots change through adapting policies to community circumstances. They can mobilise communities, encouraging self-sufficiency rather than dependency. They can tap into community resources and skills and put them to the best possible use. They can eliminate duplication of work and gain essential knowledge of the wider context.

Policymakers and programme developers should take care in choosing the right partners, but programmes are unlikely to be fully successful without NGO support.

Community involvement

Supportive environments must be created from within communities. The approval of gatekeepers is crucial. Policymakers and programme developers should involve community members – including young people at school – in all levels of programme processes to the same extent or according to individual needs.

Positive impacts

1. Community involvement creates a greater balance of centralised and decentralised approaches.
2. Lifeskills education programmes can be tailored to meet the needs, reflect the traditions and share the goals of communities. This results in greater social cohesion.
3. Communities feel a sense of accountability and responsibility and acquire more self-confidence and self-reliance.

Problems

1. Unknowable contexts may be created and flexibility is required. Results are often difficult to measure. This is not appealing to governments, donors or aid agencies, who usually prefer clear objectives and outcomes. Power conflicts can arise within communities.

2. Being culturally sensitive and respecting the wisdom and experience of communities is essential. However, this can become cultural relativism:
   - too many community features and conventions remain relevant, including prejudices and discriminations
   - prevailing power holders gain more power and those dominated remain powerless, ill-informed and marginalised
   - culture is insulated from criticism and injustice is perpetuated
   - positive goals are not achieved.
3. Community involvement can be difficult, frustrating and unsustainable:
   - rivalries develop between classes, castes, ethnic groups and those who want different goals, for example
   - participants lack skills and expertise.

School environments

Policymakers and programme developers must facilitate healthy school environments where health is promoted in terms of food, medicine and sanitation. This is important
in helping young people to develop healthy habits and behaviours.

Supportive school environments may involve:

- extra-curricular activities such as clubs where young people can discuss issues that concern them in a relaxed and friendly atmosphere
- positive role models
- peer leaders.

Policy intervention case studies

The Ugandan experience

At the onset of the HIV/AIDS epidemic, Uganda had some of the highest numbers of HIV/AIDS cases. Politically there was denial. Medically there was a lack of knowledge, particularly about transmission modes. The religious sector suggested HIV/AIDS was a moral judgement from God or a curse. Culture as a whole believed women were responsible, and those infected were stigmatised and rejected.

The Ugandan leadership then took an interest in HIV/AIDS issues and requested a proactive response from the government. The AIDS Control Programme was set up by the Ministry of Health (MoH), directly accountable to the President's office. Each government ministry was allocated an AIDS Control Programme Officer to ensure the inclusion of HIV/AIDS issues in all aspects of each ministry's work.

Later the Ugandan AIDS Commission was created, again directly responsible to the President's office. It adopted a multi-faceted approach and included a multi-disciplinary advisory committee and thematic sub-committees to deal with finer aspects of HIV/AIDS policy, principles and practices.

Government responses were supported in terms of finances and resources by sources such as the EC and United Nations agencies. NGOs, accountable to government officials, helped to highlight the main issues and guiding principles, implement responses at grass-roots level and support and mobilise communities and local institutions. Community-based organisations (CBOs) were given appropriate responsibilities. Supportive environments were created within which coordinated, coherent and sustainable strategies were developed.

Awareness campaigns were organised using newsletters and posters, TV and video, radio and village theatre. These campaigns were designed, developed, produced and distributed by the MoH, the Information, Education and Communication group, NGOs and CBOs in order to be nationally and culturally specific and appropriate.

With increased awareness and greater openness, the need for support services increased. Care programmes and relief packages that provided items such as clothes or medical equipment became available (mainly through The AIDS Support Organisation (TASO), which consisted of NGOs and CBOs).

The Ministry of Education (MoE) developed the School Health Education Project (SHEP) to reach young people at school. SHEP was set up as an integral part of the national curriculum and SHEP was initially knowledge-based. However, following an impact evaluation that found its outcome to be increased knowledge but limited behavioural change, SHEP was revised to include lifeskills taught through interactive, learner-centred teaching methods. NGOs supported SHEP through a range of innovative activities and services.

Additionally, the MoE set up the Health Education Network. This used health and community workers to carry out similar activities with young people in the wider community. NGOs such as ACET, the Boys Brigade, Girl Guides and Youth Alive provided:

- information and activities on a wide range of issues including HIV/AIDS, drugs and drug abuse, growth and development and sex and sexuality
- lifeskills such as assertiveness, creative thinking, critical thinking, communication, decision making, problem solving, self-awareness and self-esteem.

As approaches to HIV/AIDS became more proactive in nature, prevention techniques including abstinence and condom use were emphasised. The MoH needed help with condom promotion and distribution in rural areas, which was provided by NGOs.

The Ministry of Rehabilitation encouraged both institutions and extended families to care for the sick and orphaned. NGOs supported and implemented these policies and provided training.

Campaigns on legal issues concerning women and children were spearheaded by NGOs. Agencies including the Federation of Women Lawyers of Uganda handled issues such as the legal rights of widows whose relatives wanted their property.

Being diagnosed with HIV/AIDS had become synonymous with national and international aid, which created a dependency culture. The development of income generating projects (IGPs) ensured the independence and dignity of those infected.

As the poor were most vulnerable to HIV/AIDS they also became involved in IGPs and were allocated grants. The government had no structure to deal with IGPs so NGOs and CBOs identified, selected and supported projects.

Currently, HIV/AIDS incidence among young people has been reduced.

Schools HIV/AIDS and Population Education programme (SHAPE), Swaziland

44% of Swaziland's population is under 15 years of age, and according to Minister of Health and Social Welfare Phetsile Dlamini, it ranks in the world's top ten for AIDS incidence. In addition, 27% of all babies delivered in Swazi health facilities are born to teenagers and STDs are considered to be a serious, and growing, problem.

Young women in Swaziland are particularly affected by the AIDS epidemic. The majority of affected women are in the 15–24 age group, and in 15–19 group, 28% of females are affected, compared to 11% of males. Part of the reason for this is the low socio-economic status of women, which makes them relatively powerless in negotiating sexual relationships.

It was against this backdrop that the SHAPE programme was initiated in August 1990 with the support of the EC. The overall objective of the project is to reduce the incidence of sexually transmitted diseases, HIV/AIDS and teenage pregnancies through a programme of information, education and communication about responsible sexual behaviour among the school age population, particularly targeted at pupils in secondary and high school.

Since the beginning of the SHAPE programme, much progress has been made, the programme progressing from information interventions to lifeskills education interventions:

- during the first year of operation, the SHAPE pilot project trained 85 secondary school teachers, headteachers and representatives of the Swaziland National Association of Teachers (SNAT). This training on HIV/AIDS education focused on 26 schools in urban, high-risk areas in the Mbabane-Manzini corridor
- the following four years saw the expansion of the programme to all secondary and high schools in Swaziland with the aim to have at least three teachers trained in each school
- in addition, interventions to solicit community support were undertaken. On the initiative of school youth, school committees were formed and peer education programme was launched. Experiences showed that peer education proved to be more effective than classroom teaching in changing attitudes and behaviour by strengthening the skills of adolescents in communication and negotiation
- following the increasing demand for reproductive health education, the ratification of the national reproductive health education policy was undertaken and adopted by Swaziland's Ministry of Education. Guidelines were elaborated for the creation of a support system for schools providing reproductive health education

- in order to improve the quality of the expanding programme, the institutional and technical capacity of SHAPE and the Ministry of Education were strengthened with training in strategic planning and programme management. Teacher trainers undertook instruction in counselling skills
- several training and information materials were published and distributed. A TV programme on AIDS education targeting youth was telecast for 6 months in 1994 and Anti-AIDS clubs were invited to present a programme on 'Youth and AIDS' on Swazi TV from July to October 1995
- after 5 years, more than 46 Anti–AIDS clubs (30-40 members each) were operating in the country and a positive shift of attitudes among students and teachers was noticed, particularly at the First National Conference of Anti-AIDS club members held in December 1994 and at the National Sponsored Anti-AIDS club's 'Walk to Awareness' in June 1995, an attempt to reach the out of school and rural youth
- in 1997, the programme was evaluated positively and renewed, with the main goal of creating positive environments within which to impart lifeskills education. A survey was conducted to identify the attitudes of parents and other members of the community towards the adolescent reproductive health programme. Meetings were held with private medical practitioners to discuss youth-friendly reproductive health service provision. Senior librarians were sensitised to provide youth friendly services
- support was extended to further consolidate the institutional and technical capacity of the Ministry of Education to effectively implement the Reproductive Health programme within the school system, consolidate on-going peer education in school and develop and print appropriate lifeskills educational and training materials.

SHAPE is a programme that has successfully made the transformation from project intervention to integrated lifeskills education programme. It has helped teach Swaziland's young people of the dangers of HIV/AIDS and encouraged them to understand the importance of decision-making, self-esteem and assertiveness. In addition, it has brought about greater awareness of HIV/AIDS among the population as a whole.

Conclusions

1. Programme developers must ensure that lifeskills education programmes – also called policy interventions – provide:
   - knowledge and identification
   - lifeskills and empowerment.
2. Programme developers should also heed the elements that constitute successful information and project interventions.
3. Policymakers should ensure that programmes:
   - are regarded as a priority and allocated adequate time and resources
   - are considered as an integral part of the national curriculum
   - preferably cover nursery school to late secondary school
   - use interactive and learner-centred teaching methods, often requiring teacher training.
4. Both policymakers and programme developers should make programmes and teacher training applicable and accessible to young females at school and women teachers.
5. Healthy environments are extremely important in developing coordinated, coherent and sustainable programmes and are the joint obligation of policymakers, programme developers, governments, NGOs, communities, schools, families and individuals.

Chapter 4: Monitoring and evaluation

> *'Most sexual health interventions with young people are not evaluated and, of those which have been carried out, fewer than one in five meet the minimum criteria for methodologically sound evaluation. In the absence of such evidence, we are "knitting without a pattern!"'*
> A Oakley, British Medical Journal 310, 1995

Monitoring and evaluation of sexual health interventions are essential to develop and improve programmes, to learn from past mistakes and to incorporate new approaches. Actual achievements are assessed against the original goal, specific objectives and ongoing expectations. Efficacy and efficiency are paramount in the design of sexual health interventions, and monitoring and evaluation ensure that these considerations are always prominent.

In order to minimise problems, programme developers need to own, plan and budget for evaluation from the initial stages of programmes. This should include such elements as:

- developing a work plan which includes field visits, stakeholders meetings etc.
- identifying data collection design
- specifying a reporting plan to visualise and summarise the findings.

Methods of evaluation

Process evaluation: monitors expectations throughout lifeskills education programmes. Monitoring is a continuing function throughout the lifetime of the project to provide project management with early indications of progress in the achievement of the project objectives. For example, plausibility of objectives, allocation of resources, manner of implementation, quality of staff performance or levels of participation of young people at school.

Impact evaluation: assesses the immediate and short-term effects of lifeskills education programmes. Programme developers should ask questions such as 'Is there any effect?' and 'Are these effects caused by the programme?'.

Outcome evaluation: reveals long-term effects and the bigger picture. It identifies whether lifeskills education programmes have adequately and effectively achieved both the goal and the specific objectives in the longer-term. This permits measurement of the project's success or failure in terms of sustainable benefits for the target group.

Data collection design

Historical record keeping

Historical record keeping is the necessary minimum. Programme developers should produce charts, graphs and tables that provide an ongoing account of what is occurring in lifeskills education programmes. Information about programme effects may also be included.

Periodic inventory

Programme developers should obtain additional data through conducting surveys. One example is a pre/post-test survey which examines the responses of young people at school both before and after programmes.

Comparative approach

This is an extension to historical record keeping. Programme developers should compile data from comparable programmes in similar contexts.

Controlled comparison quasi-experimental approach

In this design, programme developers should identify an audience that is identical to the target audience but not subject to any programmes. Either historical record keeping or the periodic-inventory approach are applied to both audiences.

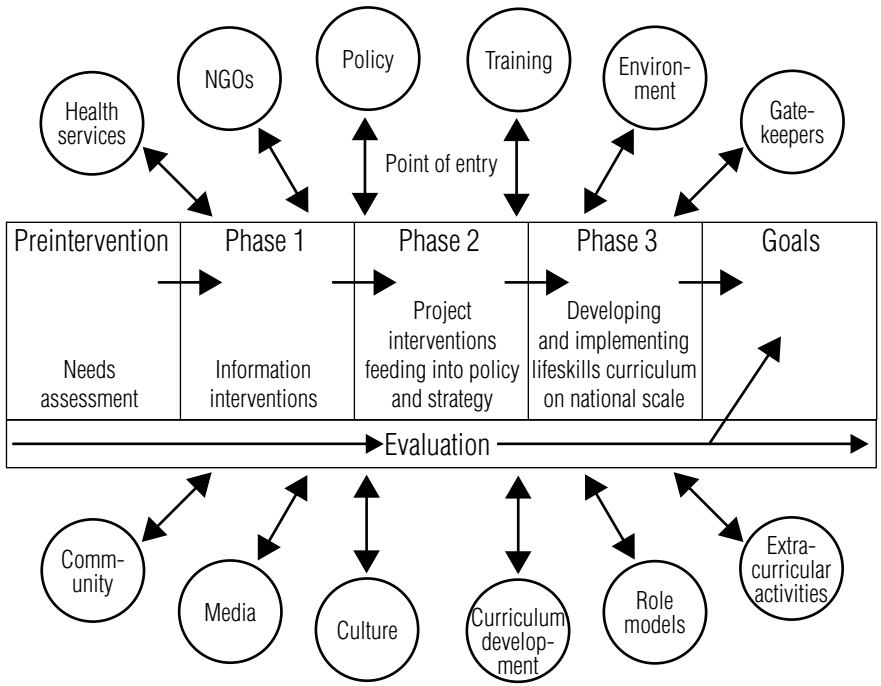
Controlled experimental approach

Programme developers should split young people at school into two or more groups. One group is subject to lifeskills education programmes, the other is subject to usual circumstances.

Evaluative research project

This is a much more complex design. Programme developers should randomly assign groups to experimental and control conditions. Multiple measures are used to evaluate attitudes and behaviours.

The more complex designs are usually carried out under highly controlled, unnatural conditions. Therefore effectiveness and findings may be limited in relation to real-life situations and programmes will need to be adapted through further evaluation.



Conclusions

1. It is essential that programme developers use monitoring and evaluation to develop and improve lifeskills education programmes.
2. Monitoring and evaluation are continuous processes that assess actual achievements against the original goal, the specific objectives and on-going expectations.
3. Programme developers should own, plan and budget for monitoring and evaluation from the initial stages of programmes
4. Monitoring and evaluation involve programme developers using a variety of techniques to collect data.

Appendix 1: The workshop

Summary of workshop findings

The following points were agreed by the workshop participants.

1. The ultimate goal should be to prevent and reduce HIV/AIDS and improve health through developing national-scale lifeskills education programmes that:
   - include sex and HIV/AIDS information
   - target young people at school
   - are an integral part of school curricula
   - are developed and implemented within a supportive environment.
2. An assessment of the current situation at local, regional and national levels – programmes and support, context and environment – should be the starting point of any programme.
3. An informed strategy should be devised based on the needs of the particular situation and should be implemented using the most effective points of entry.
4. Programmes should be as broad-based as possible, addressing issues to do with policy as well as those at grass-roots level.
5. In order for programmes to be effective, a supportive environment must be developed.

The workshop model

A model was created to show the stages of the various EC-funded sex and HIV/AIDS education programmes. Most programmes were at the first or second phase.

The model was also developed to help explain the findings, conclusions and way forward agreed by the workshop. However, this model is not rigid but should be adapted to create effective lifeskills education programmes.

Recommendations for the EC

Workshop participants felt that the EC would work best primarily as a catalyst/enabler/facilitator. In the light of the outcomes from the workshop it is recommended that the EC should:

1. Take a strategic view and influence policies at national level.
2. Invest in needs assessments to determine future strategy in each developing world context – especially where information and project interventions have taken place. The EC is in an ideal position to facilitate a more coherent and comprehensive strategy.
3. Support the development of information interventions in the light of the critical review that has taken place.
4. Disseminate best practice in the establishment of lifeskills education to key players. Pilot or micro interventions can be used to inform policy and develop macro or national initiatives.
5. Work to define the context of lifeskills education, which will enhance international understanding of its value.
6. Evaluate the age at which it is appropriate to initiate lifeskills education. The workshop highlighted the vulnerability of younger girls as well as the fact that many 13 year olds are enrolled in primary school and may already be sexually active.
7. Help those involved in current EC-funded programmes to see their work in the context of integrating lifeskills education into the national curriculum.
8. Work with those involved in current EC-funded programmes to decide a strategic way forward to achieve the goal set by each programme.
9. Help those involved in current EC-funded programmes to carry out a number of stringent evaluations, including an assessment of cost effectiveness.
10. Encourage the participation of NGOs in all levels of curriculum development and implementation, including policy and resource development, training and schools-based activities.

Workshop participants

Delegates

Africa

Tidjara Djoumoi, **AIDS/Schools project,** Comoros

Dr Happy Prince Gumede, **National Project for Lifeskills and HIV/AIDS Education,** South Africa

Edna Matasha, **African Medical and Research Foundation (AMREF),** Tanzania

Dr Catherine Mbena, **Prevention of AIDS in schools project,** Cameroon

Mcbride Peter Mkhalamba, **EC AIDS Project,** Malawi

Nomajoni Ntombela and Thandi Shongwe, **Schools HIV/AIDS and Population Education (SHAPE),** Swaziland

Denis d'Oliveira, **'New Life' project,** Benin

Simpara Mariam Ongoiba, **Project AIDS Prevention – Schools,** Mali

Lebogang Ramafoko, **Soul City's Lifeskills Education Package,** South Africa

Yatipou Singo, **AIDS Education Project/STD II,** Togo

Georges Tiendrebeogo, **AIDS Service**, Senegal

Asia

Prof Nguyen Vo Ky Anh, **AIDS Education among School Youth and their Families,** Vietnam

Associate Prof Nipa Manunapichu and Patchaneporn Samarnmit, **STD/AIDS Curricula Development Project,** Thailand

Latin America

Maria Claudia Carrassquilla, **Antonio Restrepo Foundation,** Colombia

Dr Gisela Herrera, **National Peer Education Programme on HIV/AIDS and STIs,** Costa Rica

Javier Medieta, **Prevention of STD/HIV/AIDS project**, Bolivia

Marie-Francoise Sprungli, **Centre for the prevention of AIDS in schools,** Peru

Invited guests – expert consultants

Africa

Jacqueline Bouwmans, **GTZ Regional AIDS Programme for West and Central Africa**, Ghana

Sheila Tlou, **University of Botswana,** Botswana

Asia

Dr Alessio Panza, **EC AIDS Unit,** Thailand

Europe

Vicky Claeys, **International Planned Parenthood Federation**, Belgium

M. Franquin, **Centre for Development Education,** France

Roberto Lionetti, **Centre for Health Education and Appropriate Health Technology,** Italy

Dr Regina Gorgen, **Institute of Tropical Hygiene and Public Health,** Germany

Dr Freddy Perez, **Doctors of the World,** France

Viveka Urwitz, **Swedish Association for Sex Education,** Sweden

The workshop team

Wolfram Brunger, **EC AIDS Taskforce,** Belgium

Neil Casey, **AIDS Care Education and Training (ACET),** UK

Dr Lieve Fransen, **European Commission DG VIII/A/2,** Belgium

Steve Howarth, **The Kings Centre,** UK

David Kabiswa, **AIDS Care Education and Training (ACET),** Uganda

Dr Gerjo Kok, **Faculty of Psychology, University of Maastricht,** The Netherlands

Maya Matthews, **EC AIDS Taskforce,** Belgium

Pam Mackenzie, UK

Dr Hermaan Schaalma, **Department of Health Education and Promotion, University of Maastricht,** The Netherlands

Programme summaries

Africa

Project **African Medical and Research Foundation (AMREF)**
Project representative Edna Matasha
Country Tanzania
This project aims to respond to the sexual and reproductive health needs and problems of adolescents by improving access to services and information. The sexual experience and understanding of sexual matters of young people at school in 150 primary schools and 50 secondary schools has been researched. Findings have enabled AMREF to recommend appropriate and effective lifeskills education programmes that included sex and HIV/AIDS information.

Project **AIDS Education Project/MST II**
Project representative Yatipou Singo
Country Togo
This is a national project that involves the Ministry of Health and the Ministry of Education and Research. One of its aims is to change young people's behaviour. Since 1993 the project has focused on school children and parents and has used activities such as audio visual tapes, drawings, singing, sketches and theatre.

Project **AIDS/Schools project**
Project representative Tidjara Djoumoi
Country Comoros
Started in April 1996, this is one of a number of projects being implemented in eight francophone African countries. It seeks to reduce HIV/AIDS infection through enabling young people to adopt safer sex practices and encourages the acceptance and support of those already infected. The first year of this four-year project has seen an HIV/AIDS booklet distributed to all pupils in the first four years of secondary school. In subsequent years, the booklet will be given to new pupils.

Project	**AIDS Service**
Project representative	Georges Tiendrebeogo
Country	Senegal

Begun in 1992, this project seeks to:

- prevent the propagation of the HIV/AIDS epidemic
- provide practical support for people with HIV/AIDS
- create an ethical environment favourable to the control of HIV/AIDS.

Working across the country it has combined different initiatives – such as education through school games and television campaigns, training and materials – with young people in and out of schools, their families and church representatives.

Project	**Centre for Health Education Communication**
Project representative	Roberto Lionetti
Country	Guinea Bissau

This project was created in 1991 with technical assistance from Centro di Educazione Sanitaria et Tecnologie Appropriate Sanitaire (CESTAS), based in Bologna, Italy. Its objectives are to develop interventions and material for AIDS education and other health education resources for health personnel and various different target audiences. They are also involved in mass media campaigns using TV, radio and posters. Much of their work with young people involves the development, production and dissemination of EC materials.

Project	**EC AIDS Project**
Project representative	Mcbride Peter Mkhalamba
Country	Malawi

This programme targets young people at tertiary training institutions to:

- reduce their number of sexual partners
- increase the correct use of condoms

By doing so, the programme aims to decrease sexual transmissions of HIV/AIDS.

Since August 1994, the programme has distributed condoms, produced and distributed EC materials, provided youth rallies and symposia and trained peer educators. All these activities have been monitored and evaluated.

Project	**National Project for Lifeskills and HIV/AIDS Education**
Project representative	Dr Happy Prince Gumede
Country	South Africa

Run by the Department of Education and Culture, this project aims to decrease HIV/AIDS infections and pregnancies among students in grades eight to 10 by empowering them with skills and enabling them to make informed choices. Started in 1997, those involved in the project will be developing a lifeskills curriculum, training parents and teachers, and selecting and distributing appropriate materials to schools.

Project	**'New Life' project**
Project representative	Denis d'Oliveira
Country	Benin

Project 'Vie Nouvelle' began in April 1996 to prevent HIV transmission in Benin. Targeting young people aged 15 to 25, such as those at school and in the military, the project has provided education sessions across the country. A number of institutions have been involved including national and international agencies.

Project	**Prevention of AIDS in schools project**
Project representative	Dr Catherine Mbena
Country	Cameroon

This project provides first-year students, aged approximately 12 to 15 years old, with an HIV/AIDS information booklet. The booklet has been developed through contact with students, parents and teachers. Since November 1991, 80,000 booklets have been distributed. Their impact is being evaluated.

Project	**Project AIDS Prevention – Schools**
Project representative	Simpara Mariam Ongoiba
Country	Mali

Begun in January 1996 and due to run for another three years, this programme aims to develop and distribute a booklet to educate all seventh year students about HIV/AIDS and STDs in order to reduce infection. The programme has involved close cooperation between the Department of Health, the Department of Education and a number of different agencies.

Project	**Schools HIV/AIDS and Population Education programme (SHAPE)**
Project representatives	Nomajoni Ntombela and Thandi Shongwe
Country	Swaziland

Initiated in 1991, this project works to reduce the incidence of HIV/AIDS, STDs and early pregnancies. It has provided communication, education and information about responsible sexual behaviour to young people at school aged nine to 24 and has included counselling for students and parents, peer education and teacher training. The project has worked in partnership with the Ministry of Health, the Ministry of Education and a number of national and international NGOs.

Project	**Soul City's Lifeskills Education Package**
Project representative	Lebogang Ramafoko
Country	South Africa

This national project seeks to model positive role playing while engaging young people at school, aged 11 and upwards, in discussions. Taking a multi-media approach, it has been developed from a television series and has used various theme-based activities. The development process has been largely informed by young people themselves. The project also involves advocacy, lobbying and research.

Asia

Project	**AIDS Education among School Youth and their Families**
Project representative	Prof Nguyen Vo Ky Anh
Country	Vietnam

This project looks to reduce STD and HIV/AIDS infections by targeting all seventh- and eighth-grade (lower secondary school) students in the national educational system. This has involved producing booklets designed to meet the needs of such students and, since July 1995, distributing 2,400,000 booklets. A secondary benefit of these has been the dissemination of the information to the students' families and peer group.

Project	**STD/AIDS Curricula Development Project**
Project representatives	Associate Prof Nipa Manunapichu and Patchaneporn Samarnmit
Country	Thailand

This curricular development project aims to:

- improve students' knowledge of HIV/AIDS and STDs
- assist them with their perceptions of risky behaviours
- help them develop negotiation and decision-making skills.

For the last three years, this project has applied three different curriculum models to three high schools in Thailand. The first model has integrated sex education into a student club; the second has combined sex education with boy scout activities; the third has applied sex education across the curriculum.

Latin America

Project	**Antonio Restrepo Foundation**
Project representative	Maria Claudia Carrassquilla
Country	Colombia

This project produces and distributes materials for health personnel and young people. It also undertakes mass media campaigns.

Project	**Centre for the prevention of AIDS in schools**
Project representative	Marie-Francoise Sprungli
Country	Peru

This project reinforces positive attitudes and social skills to help prevent adolescent pregnancies, HIV/AIDS and STDs. Since November 1995, it has included six project activities covering counselling, management, material development, research, schools-based and community-based activities and training for parents, students and teachers. It has worked with secondary students, their parents and teachers and health professionals in various districts of Lima.

Project	**National Peer Education Programme on HIV/AIDS and STIs**
Project representative	Dr Gisela Herrera
Country	Costa Rica

This project involves a table game about HIV/AIDS. Those involved in the project have developed a curriculum, adapted and validated the game material, trained adolescents and supervised the work of peer educators, who have used the game. This project has taken place in the marginal areas of the cities of San Jose, Limon and Puntarenas and has involved 12 to 18 year olds of both sexes.

Project	**Project Prevention of STD/HIV/AIDS**
Project representative	Javier Medieta
Country	Bolivia

Begun in February 1996, this project seeks to increase young people's sexual health knowledge through the inclusion of reproductive health education in the curriculum.

It is concerned with developing and validating authorised curricula – particularly for use in Santa Cruz high schools. Those involved have worked with 1500 students, 200 parents and 100 teachers, and have trained adolescents, parents and teachers. Their work has included mass media communication and research into the understanding of sexuality and sexual and reproductive health.

Appendix 2: Bibliography

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WORLD HEALTH ORGANIZATION, *School health education to prevent AIDS and sexually transmitted diseases,* 1992; AIDS series no 10.

Education is the key to reducing the impact of the HIV/AIDS epidemic in the developing world. This book examines a variety of different educational interventions in schools and outlines how they can help to reduce not only HIV/AIDS but also unwanted pregnancy, sexual coercion and drug use.

This book will be of interest to head teachers, educational policymakers and NGOs working in the developing world.

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