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Reaching Out-of-School Youth with Reproductive Health and HIV/AIDS Information and Services

A. August Burns, Claudia Daileader Ruland, and William Finger
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Family Health International, YouthNet Program

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August Burns, a writer and consultant, produced a report for YouthNet based on a literature review and interviews in Uganda. She has worked with adolescents in a youth-friendly clinic setting for more than 25 years and has taught classes on adolescent reproductive health at Tulane University and the University of Vermont. YouthNet writers Claudia Daileader Ruland and William Finger contributed additional research and writing to the final paper.

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Introduction

Youth who do not attend school or who drop out prematurely miss many of the fundamentals of basic education — reading and writing skills, mathematics, and science. But they are also disadvantaged because they lose a valuable opportunity to learn about reproductive health and HIV in a stable and credible environment: the classroom. Such youth are vulnerable to misinformation from unreliable sources or possibly never learn about the issues at all. While some parents fulfill their roles as educators by openly discussing these health concerns with their children, others avoid the topic because of embarrassment or lack of knowledge or skills. In some parts of the world, a growing number of out-of-school youth have lost their parents to AIDS.

Worldwide, some 120 million school-aged children are out of school, and slightly more than half of these are girls, according to UNICEF. Fortunately, some of these young people receive health information through innovative programs. One program brings education to rural youth in conjunction with agricultural training. Another uses radio to teach youth about HIV and reproductive health. Still another integrates health information with clinical services for high-risk youth. But most youth are not so fortunate in benefiting from these pilot projects.

This Youth Issues Paper examines a topic that is not well represented in the published literature but is clearly relevant to the well-being of young people. The first chapter distinguishes between "mainstream" and "socially marginalized" out-of-school youth, providing a conceptual view for this varied population. The second chapter examines the link between schooling and safer sexual behavior, underscoring the fact that school benefits children beyond literacy and knowledge. The third chapter presents programs that work with out-of-school youth using a framework that identifies key goals and possible actions that programs can take. Following are four case studies, showing how different projects have worked with both mainstream and marginalized out-of-school youth. The last chapter summarizes the key points of the paper.

We hope that this paper will aid those who work with out-of-school youth in identifying opportunities to provide many varied groups of youth with reproductive health and HIV education and services.

— Nancy E. Williamson, YouthNet Program Director

Chapter 1. Who Are "Out-of-School" Youth?

"There was some people, a set of them, who say don't bother about school again, as you pregnant. But there was some who was supportive and say you must go back to school."

– Young woman, Jamaica

"Orphans are the order of the day here. There are many. The biggest problem they face is trying to afford school fees, including books and uniforms. So many of them don't go to school."

– Young man, Mansa, Zambia

Across the globe, out-of-school youth are a diverse group. They may have completed school, dropped out, or never started school. They may have jobs or be married, or may be girls who have been forced to quit school because they need to work in the home, are pregnant, or have babies. They work in factories, live on the street, hawk vegetables in the market, stay at home for housework or child care, or are unemployed.

Many out-of-school youth come from intact, caring families that either cannot or choose not to send their children to school. These youth may connect with alternative educational or vocational programs or with church, sports, or community groups. They may have at least some of their basic needs met and may have family support in helping them to take advantage of available opportunities. This paper will refer to young people in such circumstances as "mainstream" out-of-school youth. They include married adolescents, boys and girls in rural areas, and girls who get pregnant and have to leave school. In most developing countries, girls are more likely to be out of school than boys.

Other out-of-school youth live under the most challenging conditions and are marginalized from mainstream services and society. Street children, adolescent sex workers, orphans, child soldiers, and other such groups are generally, but not always, out of school.

Out-of-school youth have many of the same needs as other youth, including the need for food and shelter, a sense of connection or belonging, skills in problem-solving and life planning, job or vocational training, access to appropriate services, empowerment to take responsibility for their own lives, and information on sexual health issues, including contraception and HIV prevention. However, different populations of out-of-school youth have specific needs defined by their circumstances.

Terms Used in This Paper

In this paper, the terms "adolescents" and "youth" are used interchangeably to refer to the young people about whom this paper is written – generally boys and girls ages 11 to 18.

The term "out-of-school youth" is used to define several groups of young people: those who have dropped out of school, those who never attended school, or those who participate in nonformal school programs. When considering out-of-school services or programs, this paper is not referring to "after-school" programs for youth who attend school, but rather programs and services specifically geared toward youth who do not or cannot attend school.

This paper focuses on out-of-school youth ages 11 to 18, who generally would be attending the last years of primary school and secondary school. However, many programs do not distinguish by age, especially those targeting marginalized groups. Also, many programs reach both in- and out-of-school youth without distinguishing between the two.

School Enrollment

The World Bank reports a trend in declining enrollment of primary school-aged children in some countries. In Kenya, which has one of the highest levels of school enrollment in sub-Saharan Africa, the proportion of primary school-aged children attending school dropped from 91 percent in 1980 to 69 percent in 2000 (it later increased with the implementation of Universal Primary Education — see page 10). Tanzania and Zambia experienced similar, although not as sharp, declines.[1] Much of this decline may be due to the growing number of AIDS orphans. In Zambia, for example, the United Nations reports that in families where the main breadwinner died of AIDS, 21 percent of girls and 17 percent of boys subsequently dropped out of school.[2]

A recent analysis estimates that more than 37 million adolescents ages 10 to 14 in sub-Saharan Africa will not complete primary school — nearly twice the entire population of primary school children in the United States.[3] The study also found that while the educational disparity between boys and girls is declining, the gap in school attendance between children from the poorest and richest households is rising. The study is based on Demography and Health Survey (DHS) data from 26 sub-Saharan countries. Another recent study found that some 27 million children and youth affected by armed conflict, including refugees but mostly internally displaced persons, do not have access to formal education.[4]

Throughout the world, numerous barriers prevent young people from attending school, including economic disadvantage, lack of infrastructure, and national policies. For example, many young people are unable to pay the fees associated with schooling — books, uniforms, and tuition. Attending school can mean lost income for a family, not just because of the costs associated with schooling, but because many families need their children to work. In some nations, a lack of reliable roads and transportation makes it impossible for young people to get to and from school quickly or safely. And in other countries, certain national policies may prevent eligible students from attending school — for example, requiring pregnant girls to drop out of school.

Mainstream Groups

Out-of-school youth who can be considered mainstream include girls, particularly those who are married or pregnant, and young people living in rural areas.

Teenage girls often work within the home or with small family businesses, such as selling vegetables, instead of staying in school.

Girls. In most developing countries, the education of girls lags significantly behind that of boys, particularly in secondary school attendance. In 24 of 35 DHS reports, at least one-fifth of all children ages 11 to 15 are not enrolled in school, and in nearly every country, the percentage is higher for girls. Only in the Philippines and several Latin American countries are more boys not in school at this age.[5]

School enrollment for girls is lowest in sub-Saharan African countries. In Burkina Faso, Guinea, Mali, and Niger, only one in five girls ages 11 to 15 is in school. Of the 17 DHS reports in sub-Saharan Africa, nearly

half of girls this age were not enrolled; about 40 percent of boys were not enrolled.

In North Africa, the Middle East, and Asia, one-fourth to one-half of girls on average receive a basic education.[6] Girls are most likely to be kept home when there is a need for household help, especially to care for sick family members or for siblings. They may become the heads of households when they are still children themselves because of the absence of parents. If a family is poor, the parents may choose to send only their male children to school.[7]

Pregnant girls and married adolescents. Adolescent girls who are married, pregnant, or mothers represent a significant proportion of the out-of-school population. When families arrange for young girls to be married, these girls are at risk of early childbearing, without having the option or information to use contraception to delay or space children.[8] In India, about one-third of girls are married by the time they are 15, and nearly two-thirds by the age of 18. Only seven percent of these married adolescents use any contraception.[9] Often the age of marriage coincides with the age of sexual debut among girls because of strong societal pressures against premarital sexual intercourse.

Married adolescents often disappear from the social milieu of other young people and therefore present a significant challenge to outreach efforts. Young mothers become part of the adult population and may not receive the benefits of youth-friendly efforts that could provide them with needed information and services in a manner that is developmentally appropriate. While the average age of marriage for males is older than that of females in most societies, young married men are often expected to leave school and begin work immediately to support their new families.

Rural boys and girls. In all regions of the world, children in urban areas have greater access to schooling than children in rural areas. Throughout Latin America and in many African and Asian countries, the proportion of adolescent women in rural areas who have seven or more years of education is one-half to one-third that of urban areas. For instance, in Pakistan, 56 percent of urban girls have at least seven years of education, compared to nine percent in rural areas.[10]

Socially Marginalized Youth

Some out-of-school youth are especially vulnerable and socially marginalized. Their numbers include street children, orphans, migrants, child soldiers, refugee children, drug users, gang members, and adolescent sex workers. These young people often have weak or no ties to their families and are not connected to the usual community supports such as schools, faith-based organizations, or the formal workplace. They may have been abandoned by their families, lured or abducted from their families, or sold into bonded labor or brothels. Their poverty forces them to endure situations — including discrimination, exploitation, and social isolation — that put them at risk of unprotected sex and alcohol and drug use.[11]

Mainstream out-of-school youth include married adolescents, boys and girls in rural areas, and girls who get pregnant and have to leave school. In most developing countries, girls are more likely to be out of school than boys. . . . Some out-of-school youth are especially vulnerable and socially marginalized, including street children, orphans, migrants, child soldiers, refugees, drug users, gang members, and adolescent sex workers.

Street children. The United Nations estimates the worldwide population of street children at 150 million.[12] Forty percent of these children are homeless and are either orphans or can no longer rely upon their families for basic support. The other 60 percent work on the streets to help support their families. Street children live in especially difficult circumstances and typically experience enormous challenges in meeting their own basic needs for food, shelter, and safety. Street children generally depend upon peers for information, approval, and connection. They are at risk for early and unsafe sex, violence, and drug abuse.[13]

Orphans and vulnerable children in communities highly affected by HIV. By 2001, 13 million children were defined as orphans as a result of losing

one or both parents to AIDS — equivalent to the United Kingdom's entire child population.[14] This number is expected to rise to more than 25 million by 2010, according to *Children on the Brink 2002*, published jointly by the U.S. Agency for International Development (USAID), Joint United Nations Programme on HIV/AIDS (UNAIDS), and UNICEF. Children in households affected by AIDS often lack food, medical care, money for school fees, protection from neglect and abuse, economic support, and emotional care. In Kenya, 52 percent of children orphaned by AIDS were not in school and make up a significant proportion of the population of street children.[15] While the AIDS orphan crisis is centralized mainly in Africa, countries in other regions, especially the Caribbean and Asia, are expected to experience large increases in the number of children who have been orphaned by AIDS.[16]

Street children, such as these youth in Mexico, live in especially difficult circumstances and are at high risk for early and unsafe sexual activity.

Adolescents involved in commercial sex work. According to UNAIDS, one million children are forced into the sex trade every year. Children trapped in the sex industry have no rights or ability to resist sexual aggression and are often obliged to take multiple clients each day. Their young age and physical immaturity, combined with the physical trauma of aggressive or repeated intercourse, make them especially susceptible to contracting and then spreading HIV.[17] According to the United Nations Convention on the Rights of the Child, any child under the age of 18 involved in the sex trade is considered sexually exploited.

Child soldiers. Some 300,000 children are serving as soldiers in current armed conflict in more than 30 countries around the world. As conflict breaks out, civil society is destabilized, driving children from their schools and homes and often separating them from their families. They may be abducted by an army or may join voluntarily as their best hope for survival. Not only are child soldiers prey to sexual and physical abuse, but the dangers inherent in armed conflict overshadow any opportunity to build a future.[18]

Chapter 2. Protective and Risk Factors

School-based prevention programs have the advantage of a captive audience that can progress through programs and curricula. The school setting provides the opportunity to work with the same group of young people, to teach and practice skills with them, and to address their questions and concerns over a period of time. Without that daily, ongoing structure, reaching youth with comprehensive and understandable information becomes a challenge. In addition, research has found that school attendance often is associated with protective factors against sexual risk taking.

Surveys in nine Caribbean countries involving nearly 16,000 youth respondents identified risk and protective factors associated with early sexual debut, lifetime sexual partners, condom use, and pregnancy. The strongest protective factors against sexual risk taking were school-related, including feelings of school connectedness, participation in family life education courses, academic performance, number of years of education, and the degree of safety of the school environment. Connectedness to parents was also a protective factor, including parental expectations regarding school completion, age at marriage, and sexual behaviors. Consistent risk factors included being out of school and experiencing physical or sexual abuse.[19]

School attendance is associated with protective factors against sexual risk taking.

An analysis by the FOCUS on Young Adults Project of youth surveys in 10 countries found that girls in school were significantly less likely to have experienced sexual intercourse than girls who were not attending school. The study concluded that national policies and community norms that encourage education for girls may contribute to the factors that delay sexual debut. The relationship between school attendance and sexual behaviors for boys was not as strong.[20]

School attendance alone does not always constitute a protective factor; sometimes the school environment plays a role in whether school is a protective factor. In rural Kenya, for example, data from nearly 600 adolescents ages 12 to 19 suggest that girls are less likely to engage in premarital sexual intercourse if they have attended schools where female students feel they are treated equitably.[21] The school environment did not affect the rate of sexual activity for boys, however.

Risks Higher for Out-of-School Youth

Risk and protective factors exist on multiple levels — among individuals, peers and sexual partners, families, other adults in the community, and cultural institutions and norms. Without the protective factor of school, risks for certain segments of youth become more pronounced.

Girls are often at greater risk of HIV infection than boys their same age, for example, and lacking the protection of school exacerbates that risk. In some of the worst HIV-affected nations, adolescent girls are infected at a rate five to six times higher than boys, and there is growing evidence that older men are responsible for a large share of these infections. However, in some parts of the world, including Latin America and the Caribbean, boys are more prone to HIV infection. But there is also evidence that a portion of the new cases of HIV infection is related to gender-based violence in homes, schools, and the community.[22] Thus, the school environment can be a negative influence in some cases. In situations of armed conflict, young women and girls are often targeted for sexual violence.

Since girls who are out-of-school are more likely to have sexual intercourse, they are also more likely to experience the consequences, including unintended pregnancy. When pregnant, girls under the age of 15 are more likely to experience premature labor, spontaneous abortion, and stillbirths than older women, and are up to four times as likely to die from pregnancy-related causes. A large proportion of patients with vaginal fistula (up to 80 percent) are less than 20 years old.[23] Girls and young women are less likely to access prenatal care or to be attended by a qualified birth attendant. They are more likely to seek an abortion to end an unplanned pregnancy than older women, to seek later (and thus riskier) abortions, and to be hospitalized with the most severe complications when unsafe abortion is the only option.[24]

The risks to out-of-school youth go beyond health consequences. A young girl who becomes pregnant may lose her chance to receive the education and training she needs to have a dependable livelihood, relegating her and her child to a life of poverty.[25] A young father who works to support a growing family may miss educational opportunities. Very young adolescents of limited education who become parents are less able to provide for their children or prepare them for life, repeating the cycle of risk.

Many youth who are out-of-school and unemployed spend much time on the streets, where they are vulnerable to experimentation with risky behaviors such as alcohol and drug abuse. Street kids, adolescents involved in sex work, and gay and bisexual males are particularly vulnerable and are often out of school. The abuse of drugs and alcohol is associated with an increase in unsafe sexual behavior and its consequences of sexually transmitted infections (STIs)/HIV and unintended pregnancies, as well as an increased risk of violence. In Tanzania, for example, youth ages 16 to 24 who smoked tobacco and drank alcohol were four times more likely than others to have multiple sexual partners. In Kenya, the single most important predictor of sexual activity for adolescent girls was using tobacco, alcohol, or drugs. Studies from numerous other countries confirm these findings.[26]

Very young adolescents, because of their lack of skills and experience, are especially vulnerable to coercive or abusive situations and the reproductive health risks those situations engender. Very young adolescents who are not in school are more likely to be overlooked by program planners, less likely to receive skills training and reproductive health information, and at greater risk of sexual exploitation.

Chapter 3. Working with Out-of-School Youth: Goals and Actions

A key to effective reproductive health (RH) and HIV prevention programs for youth is to provide the information, education, skills, and services that young people need to make choices that keep them healthy and able to pursue their potential in life. Out-of-school youth, who are often difficult to reach, present special challenges to providing comprehensive RH information and services. This is particularly true because the information they need — on human sexuality, abstinence, RH, STIs, pregnancy prevention, HIV prevention, and skills for sexual decision-making — are difficult to address in informal settings since this information requires sensitivity and focus. In addition, messages about sexuality issues and behavior change are complex and require multiple contacts from a variety of channels to be effective.

Programs for out-of-school youth must be flexible to meet the needs of this large and varied population. Out-of-school youth may congregate in mixed-age groups with highly diverse skill and educational levels. They may be geographically scattered. They may be on the move and unable to adhere to a fixed schedule. Market children or street hawkers, for example, may take 30 minutes from their selling activities to watch a street theater performance but may not be available for a follow-up activity. As a result, curricula for these populations must be designed to allow for maximum learning in short segments or must employ strategies that bring young people back for continued contact.

Framing Program Actions

When considering how to develop an RH or HIV program to best reach out-of-school youth ages 11 to 18, programs should first conduct a needs assessment of their local community, ideally involving a participatory process with youth as well as community stakeholders. The assessment can help determine whether to target out-of-school youth specifically or develop projects that reach in-school youth as well. It can also help focus on a more segmented target audience, such as younger youth versus older youth.

RH/HIV interventions with out-of-school youth should include one or more of these three goals:

Goal 1: **Encourage youth to stay in school or return to school**

Goal 2: **Provide out-of-school youth with accurate information on RH/HIV issues and services and with communication and negotiation skills**

Goal 3: **Provide out-of-school youth with appropriate RH/HIV services**

These goals draw on a comprehensive framework for youth interventions, including creating a supportive environment; improving knowledge, attitudes, and behaviors; and increasing use of youth-friendly services. Under each goal are actions that projects have taken to achieve the goal. These actions and the case studies in the following chapters focus on projects that specifically target out-of-school youth — not projects for general populations that may reach out-of-school youth.

Goal 1 Encourage youth to stay in school or return to school

ACTION: Support policies that help keep youth in school

- Since January 2003, more than 1.3 million children entered school for the first time under Kenya's new free primary education policy. This has increased the national primary school enrollment from 5.9 million to 7.2 million pupils. Similar experiences were reported in Malawi, Tanzania, and Uganda.[27] Schools provide an established and credible venue for health information for youth. A review of 11 published and evaluated school-based HIV/AIDS risk-reduction programs for African youth reported that 10 of those increased youth knowledge about HIV/AIDS.[28]

ACTION: Provide assistance with school fees

- A program in Mansa, Zambia, supports the school fees of 47 children affected or orphaned by AIDS in grades 8 to 12. "Although we recognize that this particular activity is not sustainable in the traditional sense, we justify it by the notion that without education, these youth have no chance to contribute to their community," said Linda Lahme, cofounder of the Luapula Foundation and a U.S. Peace Corps volunteer. The organization raises funds to support its goal of promoting self-reliance and independence of HIV-affected children through the provision of social, financial, and educational support until the child becomes self-supporting.

ACTION: Use innovative curriculum design and delivery systems to bring education to rural youth who might not have accessible in-school opportunities

- In Honduras, the Sistema de Aprendizaje Tutorial (SAT) brings education to rural youth who live too far from the nearest school to be able to attend. This program focuses on providing agriculturally based education to youth and adults, but has also incorporated HIV education into the curriculum in response to the spread of HIV in the region. Further research is needed to determine if alternative schooling offers the same protection effects to young people as regular schooling. (See page 18 for a case study on this program.)

- In Zambia, 18,000 young people who lack access to traditional schools listen daily to a radio program that integrates life skills and HIV prevention messages with lessons on literacy and mathematics. The program includes curricula targeted toward traditional grade levels 1 through 5, with students from seven to 17 years old. (See page 15 for a case study on this program.)

ACTION: Empower pregnant girls to return to school

- In Jamaica, teenage girls who participated in a program for pregnant adolescent girls were more likely to return to school and delay a second pregnancy than girls who did not participate in the program.[29] The program offers counseling, education, and services to young women. Among participants at the Women's Center of Jamaica Foundation's (WCJF) program, 55 percent of pregnant girls returned to school after their pregnancies, compared to 15 percent of nonparticipants. In the study, reported use of modern contraceptive methods was about the same between the two groups, but the WCJF graduates had markedly fewer subsequent pregnancies, suggesting they used contraception more consistently. About 15 percent of the WCJF graduates had a subsequent pregnancy compared to 39 percent of those who had not participated in the program. The evaluators interviewed 88 graduates of the WCJF program under age 17 and a comparison group of 111 mothers who did not participate in the program.[30]

Goal 2 Provide out-of-school youth with accurate information on RH/HIV issues and services and with communication and negotiation skills

ACTION: Involve youth in creating credible messages

- Homies Unidos in El Salvador engaged out-of-school gang members familiar with the lifestyle, slang, and codes of conduct of the gangs to reach their peers. The gang members translated medical terminology into street slang to transmit reproductive health information.[31]

- In Brazil, incarcerated male adolescents became involved in an HIV prevention program when the adult staff quit using traditional approaches and began using music, hip-hops arts, and graffiti, as the youth suggested. Before involving the young male prisoners in program design, researchers had first examined their existing knowledge, attitudes, and practices about HIV/AIDS. Ninety-eight percent were sexually experienced, and they had other risk factors common to socially marginalized youth, including drug use, exchanging sex for money, and a lack of condom use. Many said that their lives included other risks more important than AIDS, such as surviving everyday crime.[32]

ACTION: Involve youth in disseminating health information by using approaches that appeal to youth

- In Belize, a successful strategy combined arts and entertainment to communicate important RH information by training 28 peer counselors to perform drama and dance for out-of-school youth audiences. The greatest effect was noted in the peer counselors themselves; of the 28 trained peer counselors, 15 started using contraception following their involvement in the project. Results also indicated a 10 percent increase in out-of-school youth using a local clinic after the project was initiated.[33]

- Magnet Theater in Nairobi, Kenya, pulls audiences to weekly performances at fixed locations and times in order to educate young people about HIV. Because information alone is not enough to change behaviors, Magnet Theater also involves its audience — young people who may be in- or out-of-school — in its performances through dialogue, questioning, and reflection. Each performance has several "dilemma points" in which the actors freeze in a dramatic moment where they are faced with multiple behavior options. The audience is asked to choose the best decision, and the story proceeds on the chosen option. The Magnet Theater is part of a multicomponent behavior change communication intervention in Kenya that includes a radio soap opera, a talk show, and peer education.[34]

Using Media to Reach In- and Out-of-School Youth

Health information programs can reach both in- and out-of-school youth without singling out one group. The following programs use media interventions to reach youth with RH and HIV information. Many who benefit are out-of-school. Other programs reaching both groups include Boy Scouts and Girl Scouts and community-based sports programs.

- Zambian youth established the newspaper *Trendsetters* in 1995 to provide sexual and RH information to youth, thus helping them adopt safer sexual practices.[43] The monthly newspaper is free, written and edited by youth, and distributed to all secondary schools and many retail outlets throughout the country.
- In Uganda, the daily government newspaper reaching some 150,000 inserts a supplement called *Straight Talk*, which provides frank information and advice to youth about sexuality, self-esteem, HIV/AIDS, and the rights of children to avoid exploitive relationships.[44]
- In South Africa, the popular television and radio drama *Soul City* has developed specific story lines for 12- to 18-year-olds promoting the sexual and reproductive health of young people.[45] A separate program, *Soul Buddyz*, is designed to meet the needs of pre-sexual debut 8- to 12-year-olds and covers such topics as sexual intercourse, puberty, HIV/AIDS, and violence.[46] The *Soul City* series reached more than 26 million people, and three out of four viewers were ages 16 to 24.
- More than one million young people in Nicaragua ages 13 to 24 have watched one or more episodes of *Sexto Sentido*, a weekly television show that introduces intimate and complicated topics, such as emergency contraception, through acceptable ways. Puntos de Encuentro, a Nicaraguan nongovernmental organization that works with women's and youth groups, found that 45 percent of young people who were frequent viewers had heard of emergency contraception, compared to only 28 percent of young people who had never seen *Sexto Sentido*.

- The Youth Activist Organization (YAO) in Zambia involves peer educators in its Youth Football and Sexual Reproductive Health Camp for boys (beginning at age 14) and their parents. This program combines sports with education on male responsibility in RH, HIV prevention, family planning, and child health. The camps last about a week, and out-of-school youth participate alongside in-school youth. The peer educators report that they often correct misconceptions held by the youth, such as the idea that if a woman has had an abortion and a man has sexual intercourse with her, he will contract HIV. Six months after a YAO football camp in 2000, the local health clinic noted a reduction in the number of unplanned pregnancies and a greater awareness among the community about the transmission and prevention of HIV.[35]

ACTION: Involve community leaders to add social credibility to RH and STI/HIV information

- A research project in Northern India used classes and other approaches in a community-based STI-prevention program that provided youth with the information they need to stay healthy and act responsibly while also being acceptable to the community.[36] More than 700 youth participated in the prevention program (about half in both the intervention and the control groups). Statistically significant results from the intervention included an increase in the number of young men in the slums who recognized that STIs can be asymptomatic. After the intervention, the percentage of young men who reported that STIs are not always symptomatic in women increased from 61 percent to 87 percent. According to the researchers, community acceptance of educational programs that target STIs will vary at onset, but may be increased if the programs are introduced in a sensitive manner by educators who address cultural as well as medical concerns.

- In 1999, as part of a multicomponent intervention and research project in Bangladesh, out-of-school youth ages 13 to 19 were offered a 20-session life skills curriculum that included RH and HIV information.[37] Trained peer educators organized community events with reproductive health themes that drew

These girls in Nepal, ages 10 to 14, had never been to school before enrolling in a nine-month literacy program by World Education and the Centre for Development and Population Activities (CEDPA). The program included reproductive health information and warnings of girls being trafficked to India. Many of these girls knew of others who had been taken to India. This group recently completed the literacy training, and most are now enrolled in school or plan to enroll (as indicated by the show of hands). Others may choose vocational education.

These boys in Nepal are part of a "savings group" for ages 10 to 19. They each try to save five rupees (about U.S. $0.07) per month, which they can lend out for interest, including lending to their parents. They receive reproductive health information through the program, organized by a local nongovernmental organization.

out-of-school youth, as well as parents and community leaders. The project took place as part of a community intervention, which involved sensitization and outreach to community stakeholders, as well as youth. More than 6,000 out-of-school adolescents attended classes, organized by community facilitators, while another 2,000 obtained RH information from peer educators. Despite community involvement, reaching out-of-school boys was challenging, as many were working and could not attend the educational sessions.

ACTION: Bring health information to youth where they work and spend free time

- In an effort to reach female factory workers, Conrado de Cruz, a nongovernmental organization in Guatemala City, provides RH education at assembly plants at the edge of the city. Many of the young women have recently moved from rural areas, making them vulnerable to sexual exploitation, STIs, and pregnancy. Attempts to reach these young women individually with RH information would be time-consuming and impractical; however, integrating this education into their workday maximizes the number of young women reached.[38]

- In Chiang Mai, Thailand, Lifenet reaches young migrant construction workers by implementing programs in bars and clubs where these youth spend their time. A study of youth social networks revealed that these risk behaviors occur most often within small groups of friends and that friendship groups significantly influence other risk behaviors.[39] Lifenet aims to build networks of support among young people at risk so that peers can promote healthy behaviors rather than risky ones. Within the first year, Lifenet reached more than 175 youth, helping them realize they are not "bad people" for spending time in entertainment establishments, and providing them with RH and HIV education.

A computer-assisted learning center for at-risk youth at an Opportunities Industrialization Center in Ethiopia.

Goal 3 Provide out-of-school youth with appropriate RH/HIV services

ACTION: Work in conjunction with local health clinics to provide youth-friendly health services

- A project in Uganda targets 2,400 adolescents, including street children and youth involved in commercial sex work, with health services. In conjunction with local clinics, health organizations, and the Ugandan Ministry of Health, the project supplies medication to treat STIs and offers HIV voluntary counseling and testing. (See page 22 for a case study on this program.)

- A collaborative effort among social services agencies in Manila, the Philippines, has been working for more than a decade to provide RH and STI services to street children, many of them without families who survive by selling themselves for sexual activity, picking pockets, shining shoes, and other means. The project includes referrals to health clinics that treat STIs, distribute condoms, and

offer other basic information. Sexuality education and RH/HIV services are often not a strong component of programs for street children, although some programs are trying to make them a higher priority. This and other projects have found that child-to-child and youth-to-youth education activities are often the most successful in getting street children to seek and use health services.[40]

ACTION: Integrate RH/HIV services into programs to develop youth livelihood skills

- High-risk adolescent boys and girls living in extreme conditions in Zambia received training in business and life skills as well as small loans to begin their own businesses, such as tailoring or selling dried goods.[41] Many of these young people previously begged, stole, or sold sex to earn income for themselves and their families. After their basic income needs were met, the young people then received HIV and RH information. (See page 24 for a case study on this program.)

ACTION: Bring RH/HIV services to places where young people work

- In Cambodia, about 200 formal and informal health facilities are located near 15 garment factories where young people work. The Sewing a Healthy Future initiative aims to build the capacity of health professionals to provide quality services to young people and to strengthen referral networks among service providers and between service providers and youth. Approximately 35,000 factory workers, beginning at age 16, have benefited.[42]

Chapter 4. Interactive Radio Instruction Program

In Zambia, the Ministry of Education (MOE) hopes to provide all children with basic education (grades 1 through 9) by the year 2015. One project helping to reach that goal is the Interactive Radio Instruction (IRI) Program, administered by the Ministry of Education's Educational Broadcasting Services Department (MOE/EBS) with assistance from the U.S.-based Education Development Center, YouthNet, and USAID. The program targets youth living in squatter compounds and rural areas throughout Zambia that are not easily served by the traditional educational system.

With some 750,000 children not attending school in 2000, the MOE conducted a needs assessment to determine why. Some of the reasons included having to walk long distances between home and school, being unable to pay for school fees and books, and being an AIDS orphan. Because radios are an inexpensive method for reaching youth, the Ministry decided to create the IRI program.

With some 750,000 children not attending school in the year 2000, the Ministry of Education decided to create the Interactive Radio Instruction Program. Radios are an inexpensive method for reaching large numbers of youth, especially in rural areas and urban squatter compounds.

Out-of-school children ages seven to 17 receive information on HIV/AIDS and RH, in addition to reading, arithmetic, and other subjects for grades 1 through 5. Volunteer mentors guide the lessons, which are delivered by radio to groups of 40 to 50 youth in homes, backyards, churches, or simple cement-block classrooms.

The program began in 2000 in Lusaka, the capital, with 15 centers and has grown to more than 450 localities serving some 18,000 children throughout the country. The program airs Monday through Friday from 9:30 AM to 4:30 PM and includes continuous 30-minute sessions. Because it uses a national broadcasting service to air its program, short breaks for news are interspersed throughout the day. The IRI program also encourages use of community-based radio stations, such as those run by faith-based organizations.

The average session includes three lessons, one each on literacy, numbers, and life skills. Every session begins with an introduction and welcome, reviews the previous day's lessons, and then focuses on that day's specific lessons, which are often introduced through a drama, song, or participatory activity.

A broadcast schedule arranged by grade levels guides the program. For example, sessions for grades 1 through 3 may be broadcast in the morning, and sessions for grades 4 and 5 may be broadcast in the afternoon. The sessions are taught in English, and the mentor translates the information into a local language. The students who participate in the IRI program are registered for statistical, management, and support purposes.

To have an IRI program, a community must identify a community mentor and a meeting place for children to sit (community building, social hall, church center, home, garage, etc.). Radios are usually supplied by the MOE, but, where possible, communities purchase their own. Last year, the program itself bought 300 radios, and a donor gave another 200 radios. The MOE also pays for chalkboards, pencils,

What Do They Learn?

At a grade 4 IRI class at a center just outside of Lusaka, 17 students ages nine to 12 discussed a variety of topics, from dysentery and cholera to malaria, mosquito bites, dirty water, and HIV. Asked what they learned during their sessions, the students said:

- "We learn about life skills, such as washing plates, sweeping the floor, HIV/AIDS, TB."
- "We learn about traditional subjects such as English, math, science, and social studies."
- "We discuss what we like about being part of a family."
- "We learn about HIV/AIDS."

Asked what HIV was, one small boy answered, "It is a disease, a virus that causes AIDS." Asked how HIV is transmitted, studends responded: through sex, sharing of razor blades, through blood transmission, between lovers, and from a mother to child.

The lesson includes a discussion about a young girl going to the market. She meets an older man who promises her sweets if she would go to the bush with him. The question posed to the students is, what should she do? "The girl should refuse," answered a student. "The girl should not go, because she could be killed."

exercise books, and texts. The MOE covers the cost of airtime, along with salary and training for the radio program's writers and producers.

Training and Community Mentors

The MOE/EBS has trained the writers, producers, and mentors to sensitize them to youth RH, HIV/AIDS, and life skills issues. In 2003, the project integrated life skills and HIV prevention messages, including objectives and storylines for 200 life skills segments, into the grade 4 core academic curriculum.

YouthNet provided training to enhance the skills and confidence of the radio program curriculum writers so that they could produce age-appropriate life skills materials, use participatory methodologies, and comfortably discuss issues related to RH, HIV/AIDS, and sexuality. YouthNet also led a training of trainers for 51 staff from the EBS and other branches of the MOE. The newly trained MOE staff members, in collaboration with master trainers and under the supervision of YouthNet facilitators, then trained 400 community mentors in nine provinces.

The MOE/EBS is working to ensure that youth involved in the IRI program are as well equipped with important HIV information and life skills as those from conventional schools. As a result, the Ministry continually assesses the progress of students in the program to ensure that they are performing as well as conventional school students.

The mentors are the heart of the IRI program. Communities identify their own mentors and support them through small payments of money or in-kind contributions (food, assistance with tending gardens, etc.). Some mentors are retired teachers, but most are young men and women. Mentors must be literate (i.e., completed at least grade 9) and undergo IRI training to understand how IRI works and what makes a good mentor.

Mentor training is a key part of the IRI program because some of the life skills topics the mentors are supposed to teach are sensitive. Since the training by YouthNet, the MOE/EBS says it has seen changes in the ability of community mentors to teach the more challenging topics, such as incest and rape. The mentors have been taught to be direct with youth yet strike a balance. Mentors are also taught resourcefulness and encouraged to make not to make their own charts using local materials and create a "mentor's kit," rather than wait for supplies from the MOE/EBS.

"The function of a mentor does not just end at the close of the radio broadcast," says Foster Lubinda, acting controller for MOE/EBS. Community mentors are often involved in post-broadcasting activities, such as helping children with their homework after hours or providing counseling. The mentors are often role models for their communities, respected by adults and youth alike.

Findings and Observations

Because the program addresses the needs of the poorest and most vulnerable youth, parents, community leaders, and other local stakeholders generally approve of the program. Even so, the program faces several major challenges.

1. *Mentor motivation and retention*. Because the mentor's participation is voluntary, the turnover rate is high, and there is a constant need to train, which can ultimately drain the resources of a community.

2. *Broadcasting expenses*. The IRI program is provided only a limited budget from the government, and financial sustainability is an important issue.

3. *Expansion to higher grades*. The IRI program is discussing whether the program should expand to higher grades to afford youth an opportunity to sit for national exams for secondary school. For now, the MOE would like to focus on primary school children, but the question remains as to what will happen when youth reach grade 5: Will the IRI program just abandon them? Will the children return to the streets after finishing the IRI program? The MOE believes that the IRI program is doing what it can by at least providing children with more options at an earlier stage in life.

Radio has proven to be a useful tool to reach out-of-school youth. Here, youth learn about how a radio studio works.

According to Lubinda, the three best features of the IRI program include:

1. *Effective teaching methodology*. Because the program promotes great interactivity and engages children in a variety of activities such as drama, singing, and participatory drills, it is teaching youth about life skills in a unique and practical manner.

2. *Ability to reach both adults and children*. The IRI program enables both community mentors and students to learn essential life skills that are needed to overcome the many challenges of life, especially those faced by vulnerable children. With life skills development as one of the pillars of the IRI program, mentors and students spend much time on becoming more assertive and capable of leading positive, healthy lives.

3. *Capacity to reach a wider audience*. Through radio, the program is able to reach a wider audience than most conventional schools.

Chapter 5. Sistema de Aprendizaje Tutorial

In some rural areas of Latin America, students regularly visit their neighbors to ask what they know about HIV. Based upon their neighbors' answers, students share what they have learned about the virus from a unique educational system. The Sistema de Aprendizaje Tutorial (SAT), or Tutorial Learning System program, targets rural youth in Colombia, Honduras, Guatemala, Costa Rica, and Ecuador with contextually appropriate education. SAT brings education to rural youth rather than having them travel many miles daily or move to an urban area to continue their studies.

Students go beyond the classroom and share what they are learning by teaching families in their community about HIV/AIDS and many other topics. This is part of the SAT philosophy: The student becomes a resource for the community and an impetus for social and economic development. The goal of the lesson on HIV/AIDS is to provide students with factual information and encourage them to start a dialogue about issues of sexual responsibility, abstinence, and the social pressures facing adolescents.

The primary purpose of SAT is to provide students with skills that can be applied to their future livelihoods, which are typically agricultural. As one of SAT's creators, Farzam Arbab, explained, "The skills and disciplines of traditional education systems are not directly applicable to the conditions of most rural people: they address the reality of other societies . . . with careers and professions being chosen on the basis of academic tradition rather than an emphasis of social needs and development options."[47]

SAT attempts to meet the educational needs of rural youth through a mixture of formal curriculum and applied practical activities in health, agriculture, and microenterprise. With a trained tutor, a group of 10 to 30 students study a set of 70 interdisciplinary textbooks over a period of six years. Students graduate from the program with a diploma in rural well-being, equivalent to a high school diploma.

Administrators create ever-evolving textbooks based on their work with the students, not based on their own schooling experiences, through a process referred to as action research. Through their daily activities with the students, these tutors examine the effectiveness and weaknesses of the textbooks. They report the results to Fundación para la Aplicación y Enseñanza de las Ciencias (FUNDAEC), or Foundation for the Application and Teaching of the Sciences, which then updates the texts accordingly.

FUNDAEC designed the SAT program in Colombia in the early 1980s. Currently both the Ministries of Education in Colombia and Honduras recognize SAT as a secondary education program spanning grades 7 through 12. SAT enrolls many students who previously were not attending school, including young mothers. Without the SAT program, the majority of these students would still be out of school, since the students live in rural areas and the distance to the nearest school is too far for them to travel.

"If it weren't for SAT, I never would have even passed through the doors of a high school . . . my family is poor," said one young woman from Honduras. "I know I wouldn't have been able to [attend school]."

In addition to geographical distance from school, rural SAT students have numerous responsibilities outside of their studies, including working on their family's farm or

caring for younger siblings. Recognizing these other pressures on students' time, the SAT students and tutors work together to customize a schedule for learning. All groups must meet for at least 15 hours of classroom work each week. Some groups meet in the evening, others over the weekend, and others follow the more traditional morning schedule, depending on the needs of the participating students.

SAT programmers reached more than 75,000 rural youth in Colombia during more than 20 years of operation. Today there are more than 25,000 youth enrolled in the program in 18 of the 32 departments (provinces) in the country. Some 40 institutions collaborate with FUNDAEC in program implementation and management, including PLAN International, the Dioceses of the Catholic Church, and Cooperación Ceiba.

In Honduras, SAT was launched in 1996 in one department (Gracias a Dios) as a pilot project funded by the U.K. Department for International Development (DFID) and the Canadian International Development Association (CIDA). The program is jointly sponsored by a Honduran nongovernmental organization called Asociación Bayán and the Honduran Ministry of Education. SAT now serves approximately 1,000 students in three Honduran departments and is scheduled to expand to three more.

The SAT program includes a flexible schedule to accommodate rural youth with farm chores.

Findings and Observations

The findings and observations described below are based on visits to SAT groups in Honduras and Colombia, program documents, program evaluations, and interviews with SAT students, tutors, and parents, as well as staff at FUNDAEC and Asociación Bayán.[48]

1. *Self-confidence and communication skills have increased.* Almost all SAT students identified self-confidence as the most important way the program had helped them. This newfound sense of pride, dignity, and trust enables them to speak out in public, to join new community organizations, and to feel that they hold a higher status in their families and their communities.

"I've spent my adolescence there [in SAT], and it has helped me in a variety of ways," said Juana, a 17-year-old SAT student in her fifth year of study. "One is what I like the most, to be able to talk in public, to not be afraid of anyone, to say whatever I feel. To not be shy and to speak in a way that doesn't go against any individual person. It's helped me improve my participation, and thanks to SAT, I have visited other communities, they have invited me to visit, and they say it is because I like to talk." It is plausible that increased self-esteem could enable students to make responsible choices about their sexual behavior, although more research is needed. Communication and negotiation skills are necessary for adolescents to make informed and responsible choices about their sexual health.

2. *Knowledge has increased and spiritual principles deepened*. Students reported gaining knowledge in community health and HIV prevention. In one coastal community in Honduras, several SAT students started a community apothecary. Another adolescent mentioned that one of the things he liked learning about the most in his first year of study was HIV/AIDS. Many people in his community didn't know what HIV/AIDS was, he said, and he has shared what he learned in SAT with his family and community. Another student, Sonia, explained that she felt more capable after studying in SAT because she is now able to start a project by herself; she knows how to make money in a project, and even to get a loan to start a project. SAT "opens your mind."

The SAT curriculum also integrates a spiritual component. In creating the textbooks, FUNDAEC draws from both science and religion, which it sees as complementary systems of knowledge. Spirituality is a protective factor that decreases the likelihood of early sexual initiation; therefore, the inclusion of spiritual content by SAT may also play a role in the prevention of HIV/AIDS and RH problems. Further research is needed to determine whether this is so.

3. *The SAT design can be transferable to other countries because of*:

- **Strong partnerships**. FUNDAEC, as the parent organization of the SAT program, works closely with other institutions to provide training to program coordinators (who then train tutors) and to maintain copyright of the SAT textbooks. However, the day-to-day management of the SAT groups rests with collaborating institutions. FUNDAEC's close ties with these institutions provide an important quality-control mechanism. SAT's successful expansion in Colombia and into Honduras relied on these strong partnerships.

- **Local involvement**. The program's success hinges upon the involvement of nongovernmental organizations at the local level. While FUNDAEC plays a critical role in

Youth in the SAT program receive agriculturally based schooling that includes an HIV education component.

training local-level institutions to manage SAT groups, these local institutions are responsible for tutor-training and general oversight of the SAT groups.

- **Flexible core curriculum**. The core curriculum can be supplemented with locally appropriate materials. Local institutions have developed additional textbooks, practical activities, and field trips to enhance the core curriculum. This aspect of the SAT program ensures that, at a minimum, SAT students complete the core curriculum and the core practical activities. However, the program is flexible enough to ensure that it remains relevant to the students' environment.

4. *The program has the tools and framework to include more RH information in the curriculum*. Other than the lesson on HIV/AIDS, the SAT curriculum currently includes little on RH, but FUNDAEC in Colombia is updating and revising two textbooks to include substantially more RH content. The program might consider these strategies and activities:

- **Continue the action research strategy**. Writers shaped the SAT texts through action research, investigating the needs of the target population and creating the curriculum in response to these needs. Content on reproductive health should be written in a way that relates to students' daily lives and is not abstract.

- **Investigate and evaluate how institutions independently supplement the SAT curriculum with RH and HIV information**. Several institutions that manage SAT groups (such as Corporacion La Ceiba in the Department of Antioquia) have already added an RH component to the existing core curriculum. An evaluation of their work might inform the permanent integration of RH into the core curriculum.

Pablo and Dr. Roberto

The first community-service textbook that students study includes a lesson on HIV/AIDS. It presents a narrative that students can relate to as an introduction to information about HIV/AIDS.

In the story, the mother of a young boy, Doña Marina, is worried because her son, Pablo, has been staying out late at night. Pablo's parents decide to hold a family meeting, and they invite their friends Roberto (a doctor) and Carlos (a farmer). Carlos tells the story of a boy who worked on his farm and died of AIDS. He asks Roberto to tell them more about the disease, how it is spread, and why it is fatal. The lesson continues with a discussion between those present at the family meeting, who raise questions such as, "Is it true that a mother can transmit the disease to her child?"

Dr. Roberto explains the symptoms of HIV, and also the fact that a person can be infected and not show any symptoms for many years. The students are then asked to answer a variety of factual questions on HIV/AIDS based on the information presented in the story; for example: "True or False: AIDS is a disease exclusive to prostitutes and homosexuals." After finishing these questions, the students discuss ways to prevent the spread of HIV.

- **Maintain the pedagogical philosophy of the program**. One of the challenges of incorporating RH content into the curriculum will be its seamless integration into the existing textbooks. The RH content, like other areas of knowledge, should be continually reinforced throughout the students' years of study. Including factual information on RH is only one component of integrated content; other components include addressing other protective factors, including self-esteem, mentorships between the tutor and students, and spiritual values.

Chapter 6. The Health Matters Project for Vulnerable Adolescents

A dozen young dancers stand waiting for the drummers behind them to begin. About 50 to 75 out-of-school teenagers rest under the few bushes in the yard or jostle for prime positioning on a small porch at the Kawempe Teenage Center, part of the Health Matters Project for Vulnerable Adolescents. The teenagers in the crowd are waiting to take part in an education and counseling session, to see the doctor who staffs the youth-friendly health services, to get some food, or to join a soccer game. About 15 street girls are living here for a while. The young people chat and laugh with each other, keeping a watchful eye on the dancers and drummers.

The Health Matters Project for Vulnerable Adolescents seeks to reduce HIV/STI transmission and the incidence of unintended pregnancies among adolescents involved in commercial sex work and street children in the slums of Kampala, Uganda.[49] It is working to increase access to youth-friendly services for vulnerable adolescents through outreach arrangements, peer-provided services, and drop-in centers. Their target population includes 1,800 youth involved in commercial sex work and 600 street children in Uganda's capital city. The Uganda Youth Development Link (UYDEL), part of the African Youth Alliance, coordinates the two-year project.

In order to reach their target population, UYDEL sought the participation of 60 community leaders and 66 owners of bars, video halls, restaurants, and brothels frequented by young people. These adults identified vulnerable adolescents needing assistance and referred youth to the project's services. The businesses also suggested appropriate places within the community for youth-friendly drop-in centers and provided their own premises as outposts for mobile clinical sessions.

Through a series of focus group meetings with the youth, UYDEL determined that the young people needed access to contraception and other RH materials. From these sessions, administrators selected 40 peer educators and trained them to provide youth-friendly outreach services, including distribution of socially marketed, nonprescription contraceptives and STI kits, at bars, brothels, and similar places.

Next, the project organized training and ongoing technical assistance on youth-friendly services for service providers from each of the five drop-in health centers. The goal was to ensure that adolescent RH and STI health services offered by the project were responsive to the needs identified by the young people.

In the first year of the project, providers treated and counseled 5,000 adolescents, distributing almost 90,000 condoms. In addition, over 4,500 young people attended the center's weekly health talks, enhanced by drama, dance, drumming, and video shows. Most adolescents request services because of STIs, HIV/AIDS issues, early pregnancies, aftereffects from abortions, drug and alcohol abuse, and a desire for accurate information on RH rights. The number of vulnerable adolescents seeking services continues to rise significantly.

The project works in conjunction with local clinics, local health organizations, and the Ugandan Ministry of Health. Together, these organizations supply medication to treat certain STIs, conduct voluntary counseling and testing (VCT) services at drop-in centers, train UYDEL's team members in STI management, and provide education materials.

Findings and Observations

Program evaluations and a site visit for this paper yielded these findings and observations.

1. *Use peer educators with vulnerable youth*. The use of former and current youth sex workers as peer educators can help locate and provide other young people with health services and education. Adolescents doing sex work are nomadic, making regular follow-up difficult. However, inclusion of these youth in the project itself can help solve this challenge.

2. *Livelihood skills are critical for young sex workers and street children*. Programs need to offer a broad range of support, including livelihood skills, to help young people change their behaviors. Many of the youth in the project saw prostitution as their only income generating skill. These youth require new employment skills to replace that income; they may also need support for their children and drug treatment.

3. *Youth-friendly services for vulnerable youth need to be accessible*. If youth know when they should arrive at a health center for services geared towards their needs, they may be more likely to come. Youth will be less likely to seek services if the youth-friendly hours are infrequent or unscheduled. In the case of illegal sex work, providers need to be particularly sensitive to the issue of stigma and privacy. Some youth may prefer not to be identified by name, place, or label.

4. *Community involvement contributes to the success of projects for vulnerable children*. Local leaders and community-based organizations should be involved. In some areas, involving the police can be beneficial as well. These leaders can refer adolescents to health care centers, and sometimes do so in Kampala, according to UYDEL.

Young people practice dancing at the Kawempe Teenage Center in Uganda.

Chapter 7. Youth Skills Enterprise Initiative

On the streets of Lusaka, Zambia, many unemployed and out-of-school young people lounge on street corners. Skinny boys beg for spare coins outside shops and markets. Big, uncertain glances define a new street kid, while hardened stares give away those who have been doing this for years. Some street youth spend their nights stripping passersby and selling the clothes at the second-hand market. Other youth sell themselves for sex. The money they make buys food and basic needs for them, and sometimes for their families.

These youth are susceptible to a number of risks including HIV infection and other STIs. To address this vulnerability, a joint venture by the Zambia Red Cross Society, the YWCA Council of Zambia, and Street Kids International (SKI) created the Youth Skills Enterprise Initiative (YSEI). The program targets boys and girls beginning at age 14 who have minimal education, sub-standard living conditions, and little or no previous working experience.

While youth workers share information about HIV/AIDS, nutrition, and hygiene with these street kids, they have found that only when the kids had safely earned a profit would they act on this knowledge and take better care of themselves. Since it began in 1996, the program has sought to provide street youth in Lusaka with an opportunity to earn increased daily income while learning useful business and life skills.

Trainers identify youth who are interested in the responsibility of starting a business; help the youth examine viable business ideas; begin skills training; and offer credits, loans, and ongoing guidance.

Community members pass information about the program to young people they think would benefit. YSEI interviews interested participants to confirm their commitment and eligibility. Participants then enter a six-stage training process, beginning with a needs and opportunity assessment. Next, the young people attend information and recruitment meetings. There, trainers introduce young people to the concept of self-employment and the details of the YSEI program.

Trainers identify youth who are interested in the responsibility of starting a business and help the youth examine viable business ideas. Youth need to set realistic goals while considering the demand and competition in their community. Some youth choose tailoring, while others want to sell dried goods or vegetables. Once a business is identified, the youth and YSEI leaders begin skills training, relying on a Street Business Toolkit to enforce those skills. With supervision, the youth develop a basic business plan during approximately 25 hours of classroom time. Three additional three-hour sessions closely examine their financial plans and a loan component.

Street youth have indispensable knowledge, different from anything one could learn from years of schooling. They have learned to address poverty and hunger and to cope with minimal resources. The business plans build upon these skills but also emphasize problem solving, communication, and goal setting.

A business plan without capital, however, is not enough. The YSEI program offers credit, loans, and training to a population otherwise considered hard to serve and too risky for loans. After successfully completing the training, participants are given a loan in the form of the assets needed to start their business, such as a table and baskets for a vegetable stand or a sewing machine for a tailoring business.

To ensure that each participant receives direct attention from the trainer, the optimal size for each training group is 12 to 15 youth. The entire training program, from recruitment to the start of a new business, takes three to four months, and approximately 45 youth can be trained each year.

Each participant then has a three-month repayment period, during which the program provides business guidance, personal support, and education on health and social issues. After repayment of their first loan, participants are eligible for larger second and third loans to encourage business growth and diversification. Ideally, after their third loan, participants will have the skills and experience necessary to access the loans that larger lending organizations offer.

During the weeks of training and business guidance, participants gain basic business and life skills that impact not only the success of their businesses but also their capacity to make healthy and safe decisions. Economic security saves some from participating in the sex trade; others use their money to buy healthy food and basic hygiene products. Through training, participants also build a support network of youth workers and peers. They learn to take on new challenges with confidence, knowing they have friends and mentors to turn to if needed. Above all, participants learn to set and strive for personal goals.

"Before this program," said one girl, "I couldn't afford basic things." She described how she rinsed her baby's diapers out in water and used soap only once a week. She proudly explained that with the profit from her business she could now buy toiletries and clothes.

Street children projects, such as the one in Zambia, have found that developing regular, gainful employment helps to make information sharing on HIV/AIDS, nutrition, and other health areas more effective.

Chapter 8. Observations and Conclusions

Research on, and evaluation of, projects targeting out-of-school youth for RH/HIV education and services are limited. Often projects focus on youth in general, serving both in- and out-of-school. Or, projects focus on a delivery approach such as training providers in youth-friendly services, using peer educators, or using a media campaign to reach youth. Looking at the lives of the young person rather than thinking of the delivery system first may lead programs to design more holistic projects or put RH/HIV services into a broader policy and programmatic context.

Three observations can help program planners conceptualize this issue and consider how to develop programs.

1. *By identifying out-of-school populations as mainstream or socially marginalized, programs can target the services that particular youth most need.* Out-of-school youth vary extensively in their circumstances. Community needs assessments can help identify the situations involved and the types of services that can be most useful to fill the gaps of information and services for groups of youth. By distinguishing especially between mainstream and socially marginalized groups who are not in school, programs can be more focused in the services they provide. The mainstream groups include married, rural, and pregnant youth. Socially marginalized groups include street children, orphans, and adolescents who resort to commercial sex to survive.

2. *Mainstream out-of-school youth are generally harder to reach with RH/HIV services than in-school youth.* Mainstream out-of-school youth have less access to information and services than those in school. Adolescent girls in arranged marriages are at risk of early childbearing, without having the option or information to use contraception to delay or space children. Married adolescents are likely to be out of the social milieu of other young people and therefore present a significant challenge to outreach efforts. Rural youth face barriers in education in general, including RH/HIV information.

3. *Socially marginalized groups of out-of-school youth need a broad range of basic services, including food, shelter, and marketable skills, as well as RH/HIV services.* Interventions for AIDS orphans, youth forced into prostitution, or those living on the street may first need to focus on new employment skills and basic survival services before emphasizing RH/HIV services. This approach may require programs to think more broadly, developing coalitions with multiple community partners.

The four recommendations below summarize major themes that can apply to both mainstream and marginalized groups. The recommendations are designed to serve as guidance for future efforts in this field.

1. *A wide range of approaches should be used to encourage youth to stay in or return to school.* Research consistently finds a strong correlation between increased schooling and safer sexual behavior, including delay in sexual debut, increased knowledge of reproductive and sexual health, increased use of contraception, and increased condom use. To reinforce this positive relationship with schools, a number of approaches

can be used, including: changing restrictive national policies by making education universal and reducing school fees; implementing national level programs such as radio-based distance learning curricula to rural areas; encouraging parents to keep their children in school; and developing innovative community-based projects, such as supporting pregnant teenagers so they can return to school. All of these actions contribute to reinforcing the protective factor of connections with school, and thus contribute to improving RH/HIV outcomes for the general population.

2. *Community leaders should be involved to add social credibility, support, and sustainability to RH and HIV programs*. With community support, programs can gain the support of parents, religious institutions, and the youth themselves. Such community endorsement can enhance the prospects for implementation and sustainability of programs. Examples of such involvement of the community include: using community mentors as teachers, having students interact with community members, incorporating local materials into a core curriculum, and using local sponsors to help sustain rural education.

3. *Programs need to involve youth in developing messages and designing delivery systems to reach out-of-school youth with accurate RH/HIV information and communication skills*. Many out-of-school youth are most receptive to information about RH/HIV from their peers and from materials in the vernacular they use. Using artistic approaches such as theater, music, and dance often involve youth more easily in discussing RH/HIV issues than more traditional educational materials. Peer educators can be particularly useful in taking information to out-of-school youth, who do not have access to teachers.

4. *Reaching out-of-school youth with RH/HIV services requires training providers, making services more accessible to youth, and educating youth about the need for services*. Providers need training in working with youth, especially in being sensitive to the particular needs of youth. Accessibility to services (such as flexible hours and locations) can be particularly important for out-of-school youth. Many youth are reluctant to go to a traditional clinic, so services need to go to them where possible, such as the workplace, social venues, and sports settings.

These observations and recommendations — together with the background, goals, actions, and case studies presented in this paper — describe the challenges and opportunities in addressing the needs of out-of-school youth regarding RH and HIV information and skills. Thinking about this large topic in terms of more discrete groups is essential in developing programs. The program examples provided in the paper illustrate how different interventions can successfully address the needs of various types of out-of-school youth. The case summaries provide in-depth examples of innovative programs for different groups of out-of-school youth.

Looking at the lives of the young person rather than thinking of the delivery system first may lead programs to design more holistic projects.

All youth need community and policy support; opportunities to improve knowledge, attitudes, and behaviors related to RH/HIV; and ready access to youth-friendly services. The needs of out-of-school youth are often more pronounced and require greater creativity and effort. Without these efforts, millions of youth who have left school prematurely or never attended school will face greater reproductive health and HIV risks in the future.

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