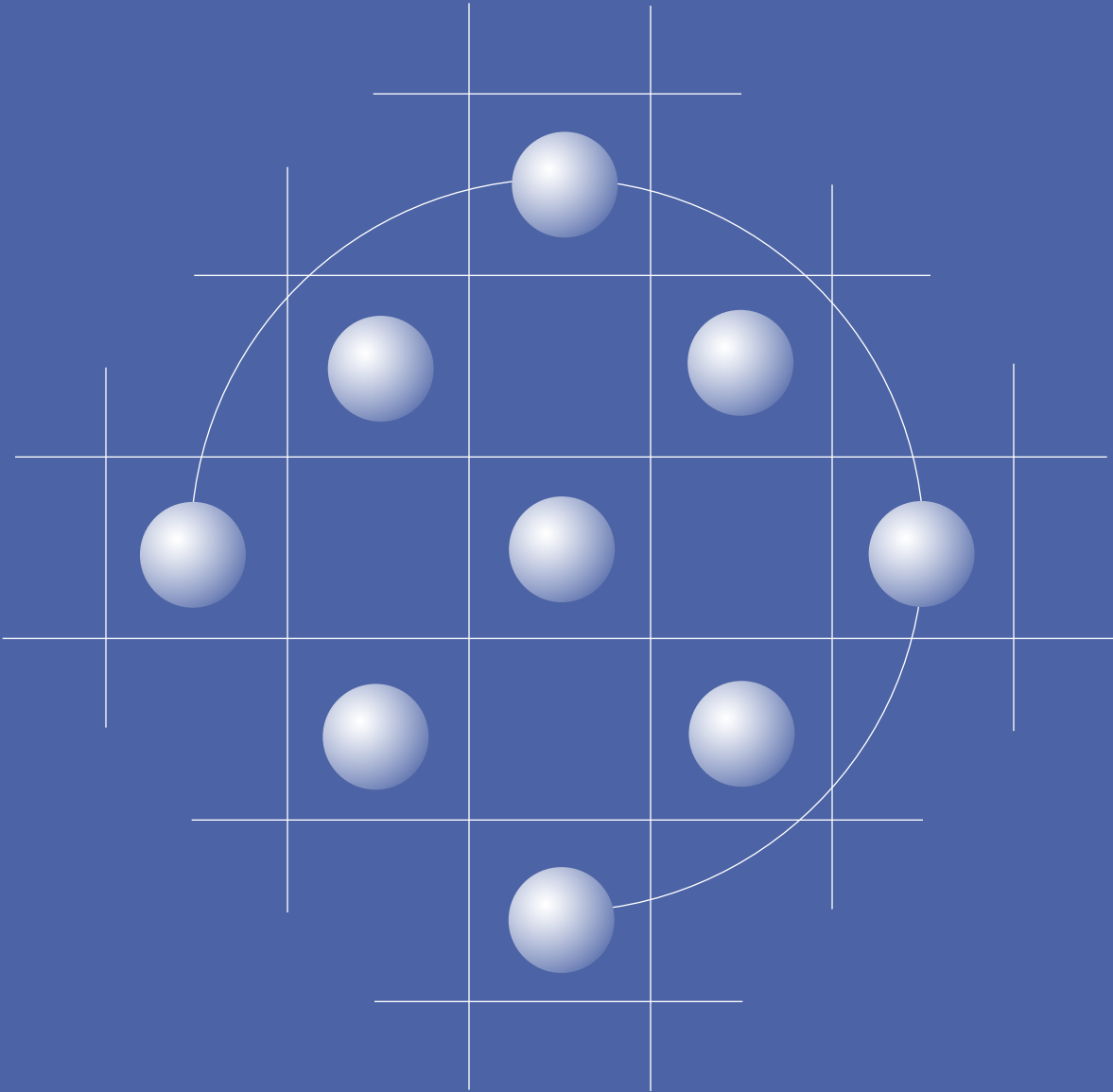


Section 4

Participant Handouts



Direct Experience

Participation

(Trainer introduces the activity/exercise and explains how to do it)

Trainees participate in:

Brainstorming
Role play and story-telling
Small-group discussion
Case studies
Games and drawing pictures



Application

Next Steps

(Trainer gives suggestions)

Trainees discuss:

How the knowledge/skills
can be useful in their lives
How to overcome difficulties
in using knowledge/skills
Plan follow-up to use
the knowledge/skills



Generalization

Lessons Learned

(Trainer gives information, draws out similarities and differences, summarizes)

Trainees participate in:

Presenting their results and drawing
general conclusions



Reflection

Thoughts/Feelings

(Trainer guides discussion)

Trainees participate in:

Answering questions
Sharing reactions to activity
Identifying key results



The theory of reasoned action

This theory states that the intention of a person to adopt a recommended behaviour is determined by:

- The person's attitudes towards this behaviour (his or her beliefs about the consequences of the behaviour)
- The person's perception of the social norms towards a certain behaviour in a group or culture

In the context of peer education, this concept is relevant because:

- Young people's attitudes are highly influenced by their perception of what their peers do and think
- Young people may be highly motivated by the expectations of respected peer educators

The social learning theory

According to this theory, individuals can increase their ability to take control of their lives (called self-efficacy) by acquiring new knowledge and skills that teach them how to better handle situations. This learning can occur:

- Through direct experience
- Indirectly, by observing and modelling the behaviour of others with whom the person identifies
- Through training in skills that lead to confidence in carrying out a behaviour

In the context of peer education, this means that the inclusion of interactive experimental learning activities is extremely important and that peer educators can act as influential teachers and role models.

The diffusion of innovations theory

This theory argues that social influence plays an important role in behaviour change. The role of opinion leaders in a community, acting as agents for behaviour change, is a key element of this theory. Their influence on group norms is predominantly seen as a result of person-to-person exchanges and discussions.

In the context of peer education, this means that the selected peer educators should be trustworthy and credible opinion leaders within the target group. Especially in outreach work, where the target audience is not reached through formally planned activities but rather through everyday social contacts, the role of opinion leaders as educators may be very important.

These three theories assert that people adopt certain behaviour not because of scientific evidence but because of the subjective judgement of close, trusted peers who act as role models for change.

The theory of participatory education

This theory states that empowerment and full participation of the people affected by a given problem is key to behaviour change. The relevance of this theory in the context of peer education is obvious: many advocates of peer education claim that the (horizontal) process of peers talking amongst themselves and determining a course of action is key to the success of a peer education programme.

The health belief model

The health belief model suggests that if a person has a desire to avoid illness or to get well (value) and the belief that a specific health action will prevent illness (expectancy), then the person will take a positive action towards that behaviour. An important aspect of the health belief model is the concept of perceived barriers, or one's opinion of the tangible and psychological costs of the advised action. Peer educators could reduce perceived barriers through reassurance, correction of misinformation, and assistance. For example, if a young person does not seek health care in the local clinic because he or she feels that confidentiality is not respected, the peer educator may provide accurate information on a youth-friendly service, thus helping to overcome the barrier to accessing proper health care.

Social ecological model for health promotion

According to this model, behaviour is determined by the following:

- Intrapersonal factors – characteristics of the individual such as knowledge, attitudes, behaviour, self-concept, and skills
- Interpersonal processes and primary groups – formal and informal social network and social support systems, including the family, work group, and friendships
- Institutional factors – social institutions with organizational characteristics and formal and informal rules and regulations for operation
- Community factors – relationships among organizations, institutions, and informal networks within defined boundaries
- Public policy – local, state, and national laws and policies

This theory acknowledges the importance of the interplay between the individual and the environment, and considers multilevel influences on unhealthy behaviour. In this manner, the importance of the individual is de-emphasized in the process of behavioral change.

IMBR model: information, motivation, behavioural skills, and resources

The IMBR model addresses health-related behaviour in a way that can be applied to and across different cultures. It focuses largely on the information (the 'what'), the motivation (the 'why'), the behavioural skills (the 'how'), and the resources (the 'where') that can be used to target at-risk behaviours. For example, if a young man knows that using condoms properly may prevent the spread of HIV, he may be motivated to use them and know how to employ them correctly, but he may not be able to purchase or find them. Thus, the concept of resources is important to this model.

In the context of peer education, this means that a programme that does not include all four IMBR concepts probably lacks essential components for reducing risk behaviour and promoting healthier lifestyles. A programme might, for example, explain to young people the need for contraception and describe contraceptive methods but omit demonstrating their proper use. Participants would then be informed about what to do but not how to do it.

Questions

1. What does AIDS stand for?
2. What does HIV stand for?
3. Can you get HIV from kissing?
4. 'You can catch AIDS from sharing infected needles'. Is there anything wrong with this statement? Answer yes, no, or I don't know. If you answer yes, explain what is wrong with the statement.
5. What does it mean if someone is diagnosed as HIV-antibody positive (HIV+)?
6. How can HIV be transmitted from mother to child?
7. In the context of testing for HIV, what do we mean by the 'window period'?
8. The HIV virus cannot survive outside the body. True or false?
9. Why does anal sex carry more risk of HIV transmission than other kinds of sex?
10. You cannot get HIV infection from giving blood with sterile syringes. True or false?

Correct answers

1. Acquired immunodeficiency syndrome
2. Human immunodeficiency virus
3. Kissing only carries a risk if there is an exchange of blood from an HIV+ person to his or her partner. This can occur when the skin or mucous membranes in or around the mouth are damaged.
4. The statement is wrong: you contract HIV (the virus), but not AIDS.
5. It means that the white blood cells have produced antibodies in reaction to the presence of HIV in the bloodstream. It proves that the person is infected with HIV. However, the antibodies cannot kill the virus!
6. During pregnancy, delivery, and breastfeeding.
7. HIV antibodies usually take between two and three months to appear in the bloodstream. This period is called the 'window period', during which an infected person will test negative, even if she or he has the virus and is infectious.
8. True.
9. The rectum bleeds easily, allowing blood to mix with semen carrying HIV.
10. True.

1. Condoms are the most effective protection against the spread of sexually transmitted infections (STIs).
FALSE
 - Abstinence from sexual intercourse is the best way to prevent the spread of STIs.
 - Condoms are the next best prevention, but only complete sexual abstinence is 100 percent effective.
2. Biologically, both men and women have an equal risk of acquiring an STI from a sexual partner.
FALSE
 - Women are more vulnerable to STIs than are men because women's mucous membranes are larger and more sensitive. Small tears are common in the vagina.
3. Women who take contraceptive pills are protected from pregnancy and STIs.
FALSE
 - Fluid exchange puts you at risk of contracting STIs. The pill is not a barrier that protects from fluid exchange.
 - When taken consistently, the pill is an effective hormonal method for preventing pregnancy.
4. Using two condoms at once ('double bagging') provides more protection against STIs.
FALSE
 - Condoms are made to be used alone – friction between two condoms can cause breakage.
 - Do not combine a male condom with a female condom.
5. Condoms are not always effective in preventing human papilloma virus (HPV), which causes genital warts.
TRUE
 - HPV can be transmitted by touching (hand to genital or genital to genital) an infected person's lesions.
 - Genital warts can be found on parts of the genitals (testicles, vulva) that are not covered or protected by a condom.
 - Genital warts are transmitted during an outbreak. However, a person may not be aware that he or she is having an outbreak, since warts are not always visible.
6. Someone infected with chlamydia usually has noticeable symptoms.
FALSE
 - Most people infected with chlamydia show no symptoms (the same is true for gonorrhoea).
 - If left untreated (with antibiotics), chlamydia (and also gonorrhoea) can cause long-term complications (infertility and pelvic inflammatory disease in women and prostatitis in men).
 - Symptoms: In women – pain or dull ache in cervix, heavy feeling in pelvic area, pain when urinating or during intercourse, heavier menstrual flow, heavy cervical discharge; in men – urethral discharge, pain when urinating, epididymitis.

7. A person with herpes can infect a partner even if he or she does not have any visible lesions.

TRUE

- Transmission is possible in the absence of lesions.
- The contagious time is at the beginning of an outbreak, during 'shedding', when the infected person feels pain or a tingling, burning, itchy sensation.
- The least contagious period is when the infection is dormant and there are no visible lesions.

8. Gonorrhoea can be cured with antibiotics.

TRUE

- There are two types of STIs: bacterial and viral. Gonorrhoea is a bacterial STI. Bacterial STIs can be cured with antibiotics. Viral STIs cannot be cured, although they sometimes go into remission (meaning you have no symptoms); antiviral drugs may help some people maintain a state of remission.
- Symptoms: In women – pain or dull ache in cervix, heavy feeling in pelvic area, pain when urinating or during intercourse, heavier menstrual flow, heavy cervical discharge; in men – urethral discharge, pain when urinating, epididymitis.

9. Only women can be tested for STIs.

FALSE

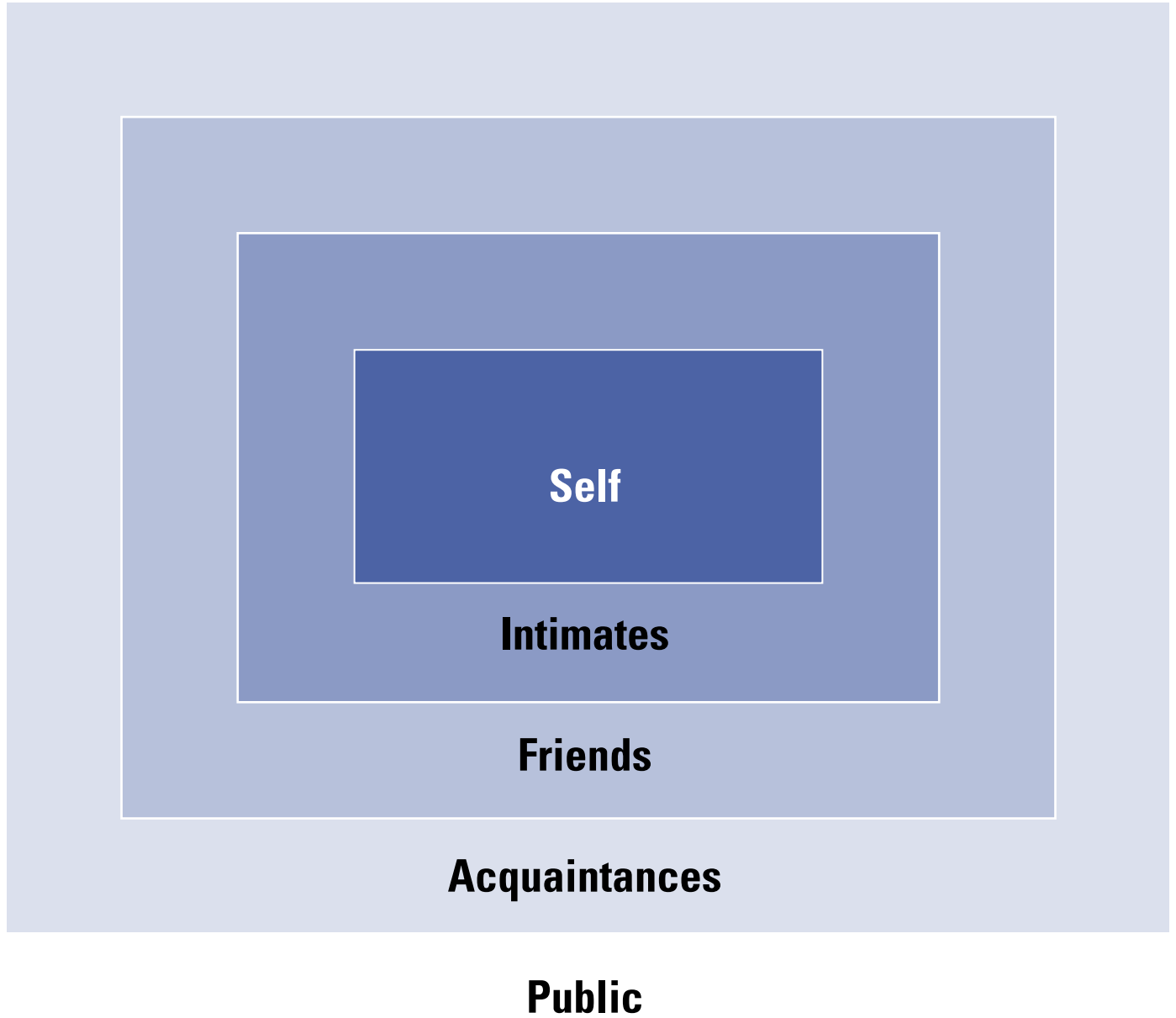
- Both men and women can be tested for most bacterial and viral STIs.
- The tests differ for men and women and depend on a person's sexual behaviours (the health-care provider may need to take oral, cervical, urethral, or anal cell cultures).
- There are three types of STI tests: blood tests (syphilis, HIV); cell cultures (chlamydia, gonorrhoea); and visual inspections (HPV, herpes).

10. Which one of the following STIs cannot be cured?

- Chlamydia Gonorrhoea Herpes

HERPES

- There are two types of STIs: bacterial and viral. Herpes is a viral STI. Bacterial STIs can be cured with antibiotics. Viral STIs stay in the human body, sometimes without symptomatic outbreaks (remission); antiviral drugs may help some people maintain a state of remission.

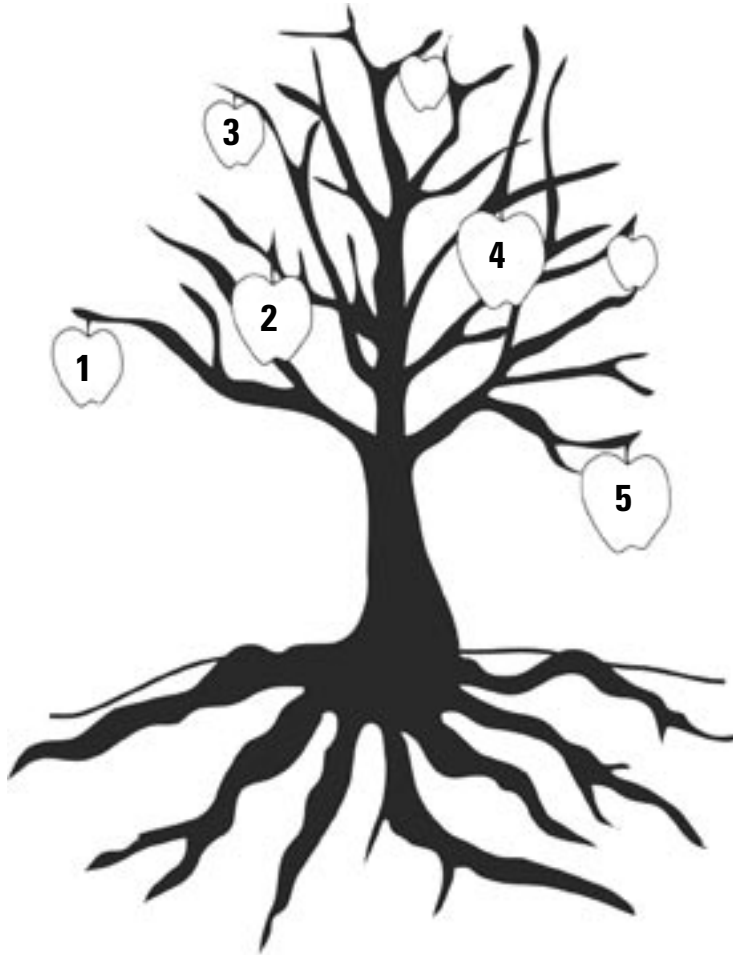


Sex refers to the biological differences between males and females. These differences are concerned with physiology and are generally permanent and universal. Sex identifies a person as male or female: type of genital organs (penis, testicles, vagina, womb); type of predominant hormones circulating in the body (estrogens, testosterone); ability to produce sperm or ova (eggs); ability to give birth and breastfeed children.

Gender refers to the socially constructed roles, responsibilities, and expectations of males and females in a given culture or society. These roles, responsibilities, and expectations are learned from family, friends, communities, opinion leaders, religious institutions, schools, the workplace, advertising, and the media. They are also influenced by custom, law, class, ethnicity, and individual or institutional bias. The definitions of what it means to be female or male are learned, vary among cultures, and change over time.

If anyone asks about dictionary definitions of sex and gender, point out that dictionary definitions tend to define sex and gender in a similar way, but that in peer education training, we use a social-science definition of the term 'gender'.

Trunk of the tree: 17-year-old girl involved in transactional sex (sexual relationships in exchange for clothes, food, and other goods)



Roots:

1. Poverty
2. Coerced sex, rape, incest
3. Lack of communication with parents
4. History of alcohol or drug abuse or other risk-taking behaviors
5. Family violence
6. Lack of education or reproductive health education
7. Unfriendly social situations
8. Early sexual debut
9. Desire to be independent

Branch 1: Dropping out of school

Apples for branch 1:

1. No education
2. Limited career possibilities

Branch 2: Guilt, fear, low self-esteem

Apples for branch 2:

1. Suicide
2. Social isolation

Branch 3: Prostitution

Apples for branch 3:

1. Involvement in crime
2. Problems with the legal system and police

Branch 4: Stigma

Apples for branch 4:

1. Limited access to services
2. No friends, lack of social support

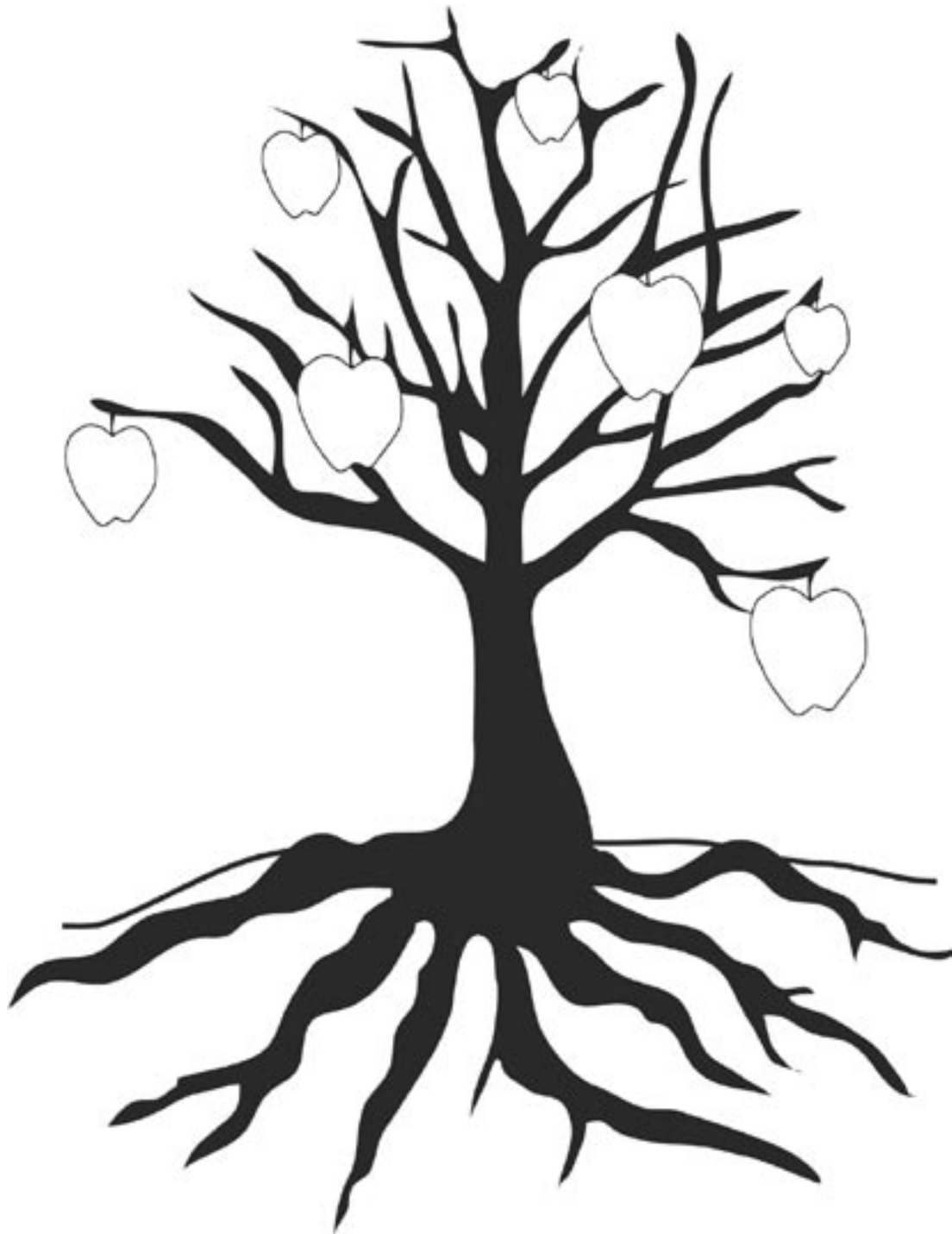
Branch 5: Violence leading to unprotected sex

Apples for branch 5:

1. STI/HIV infection
2. Unwanted pregnancy
3. Physical and mental harm

Possible measures:

1. Acknowledge the existence of transactional sex
2. Build up self-esteem and empower young women to make healthy life decisions
3. Establish drug and alcohol prevention programmes
4. Provide more educational and employment possibilities for young people
5. Rehabilitation programs for victims of violence
6. Improve young women's negotiating skills



	Educational approach	Outreach approach
Target	Primarily used to reach mainstream youth	Used to reach out-of-school youth, particularly high-risk, marginalized, harder-to-reach youth
Settings	Formal settings (i.e., school, youth centres)	Informal settings (i.e., bars, gathering points, transport stops)
Type of activities	Planned activities, often complementary to other curricular activities	Informal meetings
Methods	Participatory, interactive techniques	Various information-sharing techniques, spontaneous discussions, can include counselling
Focus	More or less structured groups, with or without adult presence or facilitation	Small groups, often one-on-one contact

Tag team versus competition style

The 'tag team' style allows one person to present, while the other person observes and supports his or her partner. Partners can divide the material in a way that lets them capitalize on their individual strengths and have their own moment in the spotlight. A competitive style puts facilitators at odds with one another as they teach the class. As such, the tag team style is the preferred method.

Preservation of energy

Presenting can be tiring both for the facilitators and the participants. Co-facilitators provide diversity in voices, presentation styles, and energy levels. Co-facilitation helps to hold the attention of the group, while giving each facilitator time to shine and time to rest.

Maximizing diverse resources

No one, no matter how well educated or skilled, has a talent for or knows about everything. Working as a team allows each person to contribute the best of his or her gifts, talents, and resources.

Extra eyes, ears, and hands

Two facilitators can manage a group better than one. The second person can help gauge participants' reactions and notice whether people seem to understand the material. The co-facilitator can also help hand out materials and can assist in monitoring discussions when participants have been separated into small groups. Finally, a co-facilitator can also handle problems with the physical environment, late-comers, and phone calls.

Support

Two facilitators in the same room should support each other rather than compete for floor space. Everyone can have an 'off' day when nothing works well: perhaps an activity did not go as planned, or you lose your place in a lecture. The co-facilitator is there to help smooth over those moments. Co-facilitators' behaviour towards one another – being supportive and respectful – should serve as a model for the way participants should behave towards each other.

Directions: Circle 'agree' or 'disagree' for each question.

1. When I am talking, I do not mind if my co-facilitator interrupts me to make an important point.

Agree

Disagree

2. When I feel that something important should be mentioned during a workshop, I need to be able to interrupt the other facilitator so that I can make my point.

Agree

Disagree

3. When my co-facilitator makes a mistake while leading a workshop, it is okay for me to correct him or her in front of the group.

Agree

Disagree

4. I want to be able to trust my co-facilitator to be able to figure out when I need help facilitating.

Agree

Disagree

5. The way to let your co-facilitator know that you have something to say is to raise your hand until you are acknowledged.

Agree

Disagree

6. I feel uncomfortable being in charge so I would prefer to have my co-facilitator run things.

Agree

Disagree

7. When my co-facilitator talks a lot, I feel like I have to say something just to remind the group that I am there.

Agree

Disagree

8. If a participant discloses upsetting information, I usually wait to see if my co-facilitator will handle it before I do.

Agree

Disagree

9. I get nervous at the beginning of each workshop because it is so hard to get started.

Agree

Disagree

10. I like to be flexible to the group's needs, so I do not like to plan out exactly what we are going to cover in a workshop.

Agree

Disagree

Incentives are things that bring about action. In peer education, incentives can help attract peer educators into a program and keep them motivated and interested in their work. Incentives can range from fairly costly to inexpensive. The following list of incentives was developed during brainstorming sessions held with Y-PEER Focal Points in Ochrid, Macedonia, in August 2004.

Higher cost

- Offer large quantities of high-quality or high-tech educational materials (electronic resources, T-shirts, notebooks, manuals)
- Sponsor attendance to conferences, meetings, or presentations that occur at the regional or international level
- Provide internships, scholarships, or job opportunities at organizations
- Invite peer educators to represent their organization at national and regional events
- Hold contests with generous prizes (such as travel or a computer)
- Sponsor a formal reception for all people involved with peer education (peer educators, trainers, staff, partners, donors)
- Provide administrative, technical equipment (computers, photocopies, software)
- Offer a salary

Lower cost

- Provide no- or low-cost access to administrative, technical equipment for peer educators (computers, fax, phones, internet)
- Find ways to make use of peer educators' creativity by letting them write and design a newsletter, website, or promotional materials
- Conduct regular monitoring visits so peer educators know supervisors are interested in their work
- Invite senior staff from non-governmental organizations (NGOs), donors, and partners to observe work at the field level
- Provide access to low-cost basic health services (family planning, counselling, and commodities such as pills or condoms)
- Continue training by providing short refresher courses or introducing new technical information
- Provide access to additional reference or resource materials
- Pay small sums of money to peer educators, such as a per diem for work days
- Provide money for local transportation or provide bicycles
- Give some promotional materials (t-shirts, pens, pamphlets)

Little or no cost

- Ask peer educators for their ideas and listen to what they have to say
- Provide verbal recognition of good work or successful completion of assignments (one-on-one, in meetings, or at events)
- Give awards (such as 'peer of the month')
- Finish some meetings with a 'fun' session with refreshments (this could also mean having a meeting and providing lunch or snacks after)
- Invite peers to present their work or knowledge at higher-level meetings or workshops
- Invite peers to attend regular staff meetings to learn more about the project

Apply these suggestions to help trainers and peer educators relax, reduce stress, and invite balance into their lives.

Breathe deeply. Have you ever noticed your breathing when you are feeling stressed or moving too fast? It is probably shallow and tight. Take a few slow, deep breaths to relax.

Take a walk. Get out. Go shopping. Play sports. Exercise not only helps burn off nervous energy but also allows you to leave the place causing you stress.

Eat well. Busy people often skip meals or eat fast food too frequently. Heavy foods, too many or too few calories, and inadequate nutrition can make you feel lethargic. Eat vegetables, fruits, grains, and lean proteins – nutritious, high-energy foods.

Drink water. Most people do not drink enough water and feel dehydrated, tired, and achy. Next time you feel dry or in need of a liquid ‘pick me up’, drink water instead of coffee, tea, or high-sugar drinks. Experts say that once you feel thirsty, you are already dehydrated, so drink up.

Slow down. Do not worry; you do not have to stop. By making sure your mind is actually where your body is, you will feel (and appear) less scattered, think more clearly, and be more effective. Time-management and delegation strategies can help avoid confused priorities and schedule conflicts.

Team up. If you are a stressed-out trainer or peer educator, you may not be letting other people help you get things done – whether delegating tasks to other peers or trainers, partnering with other groups, or simply networking for support and advice. Sharing the load with other people and staying connected to positive people can help prevent stress.

Sleep well. A good night’s sleep is not a luxury; it is a necessity for clear-thinking and mindful responsiveness. Aim to get a good night’s rest by watching what you eat before you go to bed, turning off the television and computer, and taking a few minutes to slow down and transition from ‘busy day’ to ‘restful night’ – perhaps by sipping some herbal tea and listening to soothing music.

Loosen up. Tight muscles and narrow, critical thinking exacerbate stress and propel you towards burnout. Find ways to stretch both body and mind. Take a bath. Pray. Gentle stretching loosens tight muscles, while similar ‘mind exercises’ or meditation can help lessen chronic perfectionism and criticism.

Have fun. Laughter is great medicine, so surround yourself with fun things and people. Watch your favorite funny movies, play with your kids or animals, choose to be around people who make you laugh, or just laugh at yourself when you get overly serious or unhappy.

Get away. Whether for an hour, a day, or a week, remove yourself from your work and concentrate 100 percent on someone or something else. Recharge yourself today so you are more productive and can enjoy your work tomorrow.

	Peer information	Peer education	Peer counselling
Objectives	Awareness Information Attitude change	Awareness Information Attitude change Skills building	Information Attitude change Prevention skills Problem-solving/ coping skills Self-esteem Psychosocial support
Coverage	High	Medium	Low
Intensity	Low	Medium/high	High
Confidentiality	None	Important	Essential
Focus	Community Large groups	Small groups	Individual
Training required	Brief	Structured workshops and refresher courses	Intense and long
Examples of activities	Distribution of material in public events (sports events, youth concerts) World AIDS Day	Repeated group events based on a curriculum	Counselling of young people living with AIDS Clinic-based youth counselling on reproductive health

What are monitoring and evaluation?

Monitoring is the routine and systematic process of collecting data and measuring progress towards programme objectives. Questions that monitoring activities seek to answer include: Are activities occurring as planned? Are services being provided as planned? Are the objectives being met? Monitoring supports evaluation, as the two are closely related.

Evaluation is the process of systematically assessing a project's merit, worth, or effectiveness. In this process, the relevance, performance, and achievements of a programme are assessed. The evaluation process addresses the question: Does the programme make a difference? The common types of evaluation include process evaluation, outcome evaluation, and impact evaluation.

Process evaluation consists of quantitative and qualitative assessment to provide data on the strengths and weaknesses of components of a programme. It answers questions such as: Are we implementing the programme as planned? What aspects of the programme are strong? Which ones are weak? Does the programme reach the intended target group? What can we do to strengthen the programme? Are we running into unanticipated problems? Were remedial actions developed? Were these actions implemented?

Outcome evaluation consists of quantitative and qualitative assessment of the results of the programme. Outcome evaluation addresses questions such as: Were outcomes achieved? How well were they achieved? If any outcomes were not achieved, why were they not? What factors contributed to the outcomes? How are the target groups and their community impacted by the programme? Are there any unintended consequences? What recommendations are offered for improving future implementation? What are the lessons learned?

Impact evaluation is the systematic identification of a programme's effects – positive or negative, intended or unintended – on individuals, households, institutions, and the environment. Unlike an outcome evaluation, which is focused at the programme level, impact evaluation is typically carried out at the population level and refers to longer-term effects.

Definitions of youth

Webster's Dictionary, 1998

The quality or state of being young; youthfulness; juvenility; the part of life that succeeds childhood; the period of existence preceding maturity or age; the whole early part of life, from childhood, or, sometimes, from infancy, to adulthood.

United Nations General Assembly (the basis for UN statistics on youth)

Defines youth as those ages 15 to 24. Note that by this definition, children are those under age 15. However, the United Nations Convention on the Rights of the Child defines children as up to age 18, thus theoretically providing more protection and rights to those up to age 18. There is no similar United Nations Convention on the Rights of Youth.

U.S. Agency for International Development

Youth is generally defined as the cohort between ages 15 and 24, the generation straddling childhood and adulthood, especially by researchers working with U.S. Agency for International Development funding.

United Nations Division for Social Policy and Development

Calls those ages 12 to 19 'teenagers', and those 20 to 24 'young adults'. This distinction is important since the sociological, psychological, and health issues these two groups face may differ. Some countries consider young people to have become young adults when they pass the 'age of majority', which is usually age 18, at which point they are treated as adults under the law. However, the operational definition and nuances of the term 'youth' often vary from country to country, depending on sociocultural, institutional, economic, and political factors.

Definitions of youth participation

Adolescent participation

UNICEF uses this term, defining it as 'adolescents partaking in and influencing process, decisions, and activities'.

Children's participation

Roger Hart uses this term in his essay *Children's Participation: From Tokenism to Citizenship*. In it, he describes participation as the process of sharing decisions that affect one's life and the life of one's community.

Youth-adult partnerships

As defined by Advocates for Youth, this term refers to a situation where adults work in full partnership with young people on issues facing youth and/or on programmes and policies affecting youth.

Youth involvement

This term is often used interchangeably with ‘youth participation’.

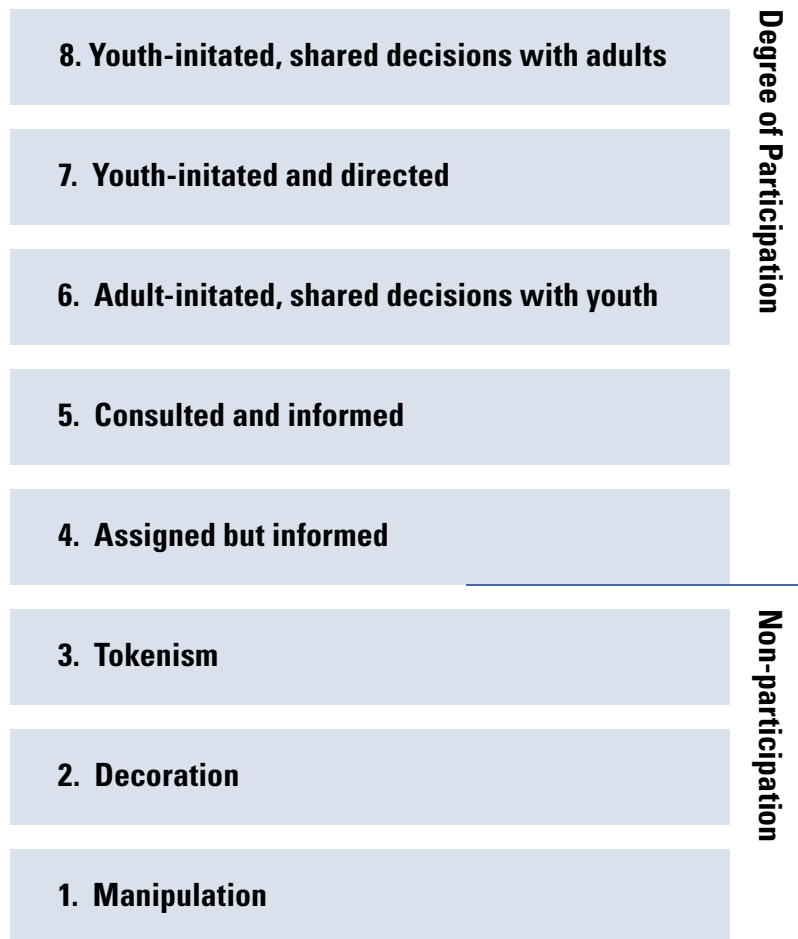
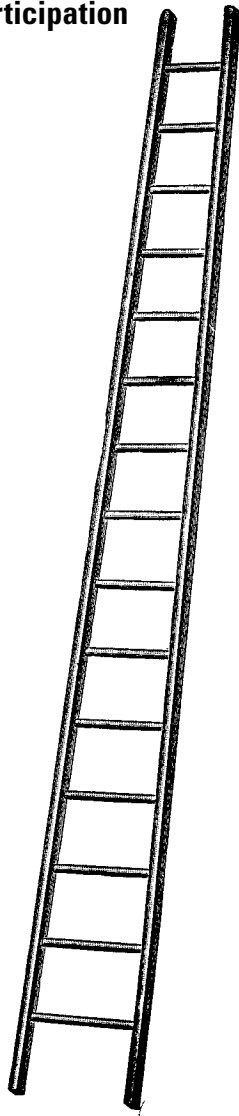
Youth participation

This is the most common term used in the fields of youth development, youth governance, and health. It follows the terminology used for the inclusion and involvement of other marginalized groups (i.e., participation of people living with HIV/AIDS). The U.S. National Commission on Resources for Youth defines youth participation as: ‘Involving youth in responsible, challenging action that meets genuine needs, with opportunity for planning and/or decision-making affecting others, in an activity whose impact or consequences extends to others – outside or beyond the youth participants themselves.’

Hart's *Ladder of Participation* depicts participation on a continuum, from manipulation and tokenism, which do not constitute real participation, to higher levels of participation in which young people initiate, direct, and share decisions with adults.

The ladder of participation highlights two important characteristics about true youth participation. First, simply having a young person present does not result in true participation. Young people must have a certain level of empowerment, responsibility, and decision-making power to participate meaningfully. Second, the quality and type of the partnership between youth and adults is important.

Ladder of Participation



An example of participation at the lower end of the ladder is involving young people on a programme discussion panel without giving them decision-making power or any role in the management of the programme. Examples of higher levels of participation include having youth serve on boards or steering committees and participate in day-to-day decision-making.

Youth-adult partnership

A true partnership between youth and adults in a professional setting has several distinguishing characteristics:

- It integrates the realistic perspectives and skills of youth with the experience and wisdom of adults.
- It offers both parties the opportunity to make suggestions and decisions.
- It recognizes and values the contributions of both young people and adults.
- It allows young people and adults to work in full partnership – envisioning, developing, implementing, and evaluating programmes.

Sharing the power to make decisions means that adults respect and have confidence in young people's judgement. It means that adults recognize the assets of youth, understand what youth can bring to the partnership, and are willing to provide additional training and support when youth need it.

Both youth and adults may need to embrace change in order for the partnership to work. For example, adults may need to modify their ideas about what will and will not work and about times and conditions under which work proceeds. Similarly, youth may need to understand the limitations and realities that affect a programme's development, operation, and evaluation.

In addressing adolescent and reproductive health issues, youth and adults can work together in a number of ways, such as conducting a needs assessment, writing a grant proposal, raising funds, designing a programme, training staff, delivering services, implementing interventions and projects, overseeing a programme, collecting data, evaluating a programme's effectiveness, improving unsuccessful aspects of a programme, and replicating successful programmes.

Safeguards should protect youth from abuse

Minors need special protection when working with people who are older than they are. Institutions should have anti-harassment policies designed to prevent abuse as well as discrimination or harassment on any basis: racial, ethnic, religious, sexual, socio-economic, or age. The policies should outline how they are to be enforced, including a clear and safe grievance procedure.

In countries where it is legal and possible, the backgrounds of all adults and older youth should be checked before they are hired. This process should also be clearly stated by organizations in its recruitment guidelines and followed for all staff.

Attitudes as challenges

Some adults still believe that the opinions of young people do not matter, that youth are not capable of contributing in a valuable way, and that adults have nothing to learn from youth. These types of attitudes about youth might be viewed from the perspective of cultural diversity, where firsthand experience can be an effective strategy for changing attitudes. For example, involving young people at high levels of responsibility and decision-making enables adults to see that youth can be thoughtful and make important contributions. When someone comes to see a formerly undifferentiated group as diverse, that person becomes more likely to value the individuals within the group and let go of stereotypes.

Power dynamics, usually rooted in cultural norms, may contribute to challenges of youth-adult partnerships. Formal instruction in school often teaches youth to expect adults to provide answers and to ignore, deride, or veto youth ideas. Adults frequently underestimate the knowledge and creativity of young people and may be accustomed to making decisions without input from youth, even when youth are directly affected by the decisions. Therefore, successful partnerships require deliberate effort on the part of both adults and youth.

Spectrum of attitudes

According to the 'spectrum of attitudes' theory, adults may have one of three types of attitudes about young people's ability to make good decisions. These attitudes also determine the extent to which adults will be willing to involve young people as significant partners in decisions about programme design, development, implementation, and evaluation.

- **Youth as objects.** Adults who have this attitude believe they know what is best for young people, attempt to control situations involving youth, and believe that young people have little to contribute. These adults seldom permit youth more than token involvement. For example, an adult might write a letter to an elected official about an issue pertinent to youth and use a young person's name and signature for impact. Adults may feel the need to protect youth from the consequences of potential mistakes.
- **Youth as recipients.** Adults who have this attitude believe they must help youth adapt to adult society. They permit young people to take part in making decisions because they think the experience will be good for them, but they also assume that youth are not yet self-sufficient and need practice to learn to think like adults. These adults usually delegate to young people responsibilities and tasks that the adults themselves do not want to undertake. The adults usually dictate the terms of youth's involvement and expect young people to adhere to those terms; the adults might deliberately retain all power and control. For example, adults who view youth as recipients might extend an invitation to one young person to join a board of directors that is otherwise comprised solely of adults. In such a setting, a young person's voice is seldom raised and little heard – adults do not expect the young person to contribute, and the young person knows it.

- **Youth as partners.** Adults who have this attitude respect young people and believe they have significant contributions to make. These adults encourage youth to become involved and firmly believe that youth involvement is critical to a programme's success. They accept youth having an equal voice in many decisions (see box on equal decision-making, page 167). They recognize that both youth and adults have abilities, strengths, and experience to contribute. These adults are as comfortable working with youth as with adults and enjoy an environment where youth and adults work together. They believe that genuine participation by young people enriches adults just as adults' participation enriches youth. For example, adults who view youth as partners might hire young people to participate at the very beginning of a programme's design.

Organizational environment

Adults who endorse the concept of youth-adult partnerships must also be willing to alter the organizational environment if institutional barriers exist that are detrimental to young people and their ability to participate. Some barriers that could make youth involvement difficult include:

- **Work hours and meeting times.** An organization's hours of operation usually coincide with times when young people are at school or work. To engage youth, programme planners must find nontraditional times at which to hold important meetings. Often, scheduling conflicts can be difficult to overcome. However, compromise is vital if an organization is to create effective youth-adult partnerships. For adults, this may mean altering schedules to hold meetings in the late afternoon, early evening, or on the weekend. For youth, this may mean gaining permission from school or other work to attend a daytime meeting.
- **Transportation.** Many young people do not have assured access to a vehicle. Programme planners should schedule meetings in easily accessible locations. They should also provide youth with travel vouchers or immediate reimbursement for the cost of travel.
- **Food.** Few young people have the income to purchase meals in business districts or dinners in restaurants. When a meeting occurs at mealtime, the organization should provide food or sufficient funds for young people to pay for the meal.
- **Equipment and support.** Organizations should provide youth with the same equipment as other employees, such as a computer workstation, mailbox, e-mail account, and business card. Failure to do so carries a powerful message that these youth – whether they are full-time or part-time volunteers, interns, or peer educators – are not as important as adult employees.
- **Procedures and policies.** With input from youth and adults, organizations should develop policies on youth-adult interactions. For example, if a programme involves overnight travel, youth and adults should be clear about their roles and responsibilities in travelling together. The policies will need to respect youth's desire for independence and, at the same time, address the legal liability of the organization, the comfort level and legal responsibilities of adult staff, and parental concerns about security. Organizations may also consider establishing policies requiring the consent of parents or

guardians for youth participation, for staff driving young people to meetings, and other policies specific to a particular institution's work.

- **Training.** In organizations that have always operated from an exclusively adult perspective, staff may need training in cultural competency. Whether working directly with youth or not, staff will need to accept young people's perspectives and ideas and change workplace rules to meet the needs of youth. Organizations and their staff must make a determined effort to let young people know that they are valued.

Equal decision-making?

The goal of equal decision-making may not be realistic or attainable if adults have financial responsibility, if youth are short-term interns, or if the work requires technical skills that youth do not have. In these cases, it is important for adults to be honest with youth about the situation and identify areas where youth can make meaningful contributions to decision-making processes.

You are the coordinator of a community-based reproductive health peer education programme for volunteer youth. Each year, you train 12 to 16 youth to be certified as peer educators. Once certified, they conduct outreach sessions in schools, community centers, and places of worship. Unfortunately, each year you have difficulty retaining members. As the year progresses, youth begin to drop out and, typically, only one to three youth actually implement the programme. What can **you** do to attract committed peer educators and retain more of them in the programme?

In the reproductive health and HIV/AIDS fields, information about the impact of youth participation and youth-adult partnerships is limited. But literature from related fields indicates that involving young people in programmes has many benefits. Programme experience and research suggest 10 elements that lead to effective youth-adult partnerships.

Clear goals for the partnership. Youth and adults should understand the reasons for and objectives of the partnership.

Shared decision-making power. If youth have no power to make decisions, their participation is not one of partnership.

Commitment from highest level. Those in the highest level of the organization should commit fully to partnerships in order for them to be feasible and meaningful.

Clear roles and responsibilities. Be clear on which youth and adults have roles in the partnership and ensure that those people understand everyone's roles and responsibilities.

Careful selection. Select the appropriate youth and adults for the partnership. Youth vary widely in their level of development and readiness to assume responsibility, and adults vary widely in their degree of commitment to work with youth.

Relevant training. Young people may need training in communication, leadership, assertiveness skills, and technical areas. Adults may also need training in working with youth as well as in technical areas.

Awareness of different communication styles. Different styles of communication do not necessarily imply disrespect, disinterest, or different goals and expectations. Asking questions and assuming the best about others can help diffuse conflicts that arise from different communication styles.

Valuing participation. Part of valuing youth involvement is to hold young people accountable for their responsibilities, just as one would with adults. The skills and commitment that adults bring to the partnership should also be valued.

Room for growth. Establish ways for youth to advance to increased levels of responsibility.

Awareness that youth have other interests. Youth may not be able to meet high levels of obligations because of other commitments and priorities. Work with youth to develop a level of responsibility that matches their time and commitment.

Impact on youth

Youth participation can:

- Help youth form higher aspirations, gain confidence, attain resources, improve skills and knowledge, change attitudes, and develop more meaningful relationships with adults
- Foster resilience by giving youth opportunities to contribute to family or community
- Enhance young people's social competence, problem-solving skills, and autonomy, and give them a sense of purpose
- Help young people be more open to learning, engaging in critical dialogue, exercising creativity, and taking initiative

Research has identified factors that seem to account for the difference between those young people who emerge from high-risk situations with positive results and those who do not. While many factors influence health behaviors, resilient youth, in particular, display some important characteristics, including:

- Social competence, including responsiveness, flexibility, empathy, caring, communication skills, a sense of humor, and other pro-social behaviors
- Problem-solving skills, including the ability to think abstractly, reflectively, and flexibly and the ability to arrive at alternative solutions to cognitive and social problems
- Autonomy, including a sense of identity and an ability to act independently and to exert control over the individual's environment
- Sense of purpose and future, including having healthy expectations, goals, an orientation towards success, motivation to achieve, educational aspirations, hopefulness, hardiness, and a sense of coherence

The findings above come primarily from literature on youth development, which is defined as the ongoing growth process in which youth attempt to meet their basic personal and social needs to be safe, feel cared for, be valued, be useful, be spiritually grounded, and build the skills and competencies that allow them to function and contribute in their daily lives. Thus, youth are more likely to develop in positive ways when they have opportunities to:

- Feel physically and emotionally safe
- Build relationships with caring, connected adults
- Acquire knowledge and information
- Engage in meaningful and purposeful activities in ways that offer both continuity and variety

Research also shows that contributing to one's community has many positive outcomes. One study found that college students who provided community service for credit significantly increased their belief that people can make a difference and that people should be involved in community service and advocacy. They became less likely to blame social services clients for their misfortunes and more likely to stress a need for equal opportunities.

Behavior change theory and research on resiliency suggest that, while the types of activities offered by successful youth development programmes vary, the emphasis lies in providing opportunities for active

participation and real challenges. Proponents of youth development programmes and of youth-adult partnerships have in common a belief that youth are caring and capable. Rather than seeing youth as problems to be managed, youth development proponents view young people as valued resources.

Proponents of youth-adult partnerships see young people as individuals with the capacity to make positive and wide-ranging contributions when they receive support and the opportunity to develop their skills. Few things can more concretely demonstrate a belief in young people's capabilities than when trusted adults share with youth the power to make decisions.

The literature leaves little doubt that youth involvement benefits those youth who participate meaningfully in programmes. By providing young people the opportunity to develop skills, competencies, leadership abilities, self-confidence, and self-esteem, youth involvement programmes contribute to building resilience, a protective factor that can help prevent negative health outcomes and risky behaviors.

Impact on adults and community

Youth involvement also has an impact on adults involved in the partnerships. A U.S. study examined organizations in which youth had decision-making roles such as advisory board members, staff members, peer educators, and programme planners. Interviews and focus group discussions with young people and adults from 31 organizations showed that adults began to view youth as competent individuals who contributed to the organizations rather than simply as receiving its services. The energy of youth also enhanced adults' commitment to the organizations and their ability to work collaboratively.

The study found that adults:

- Experienced the competence of youth firsthand and begin to perceive young people as legitimate, crucial contributors
- Found their own commitment and energy was enhanced through their work with youth
- Felt more effective and more confident in working with and relating to youth
- Understood the needs and concerns of youth, became more attuned to programming issues, and gained a stronger sense of connection to the community
- Received fresh ideas from different perspectives
- Reached a broader spectrum of people
- Developed more relevant and responsive programming and services
- Shared knowledge

The study also identified positive outcomes for the organizations:

- Young people helped clarify and bring focus to the organization's mission.
- The adults and the organization, as a whole, become more connected and responsive to youth in the community, leading to programming improvements.

- Organizations placed a greater value on inclusion and representation and saw programmes benefiting when multiple and diverse voices participated in making decisions.
- Having youth make decisions helped convince foundations and other funding agencies that the organization was truly committed to meaningful youth development and youth involvement.

Impact on reproductive health and HIV/AIDS

Programmes involve youth in various ways in the reproductive health and HIV/AIDS fields. Substantial partnerships at the local programming level include youth involvement in planning and developing programmes, peer education projects, youth-led clubs and sports teams, and youth-run newspapers. Youth involvement with advocacy, policy development, governance, and evaluation is also expanding. Below are brief summaries of the limited research that does exist on the impact of such efforts, most of which covers peer education. Adult partners typically work with these projects, encouraging youth to make decisions and providing assistance where needed.

Peer education

- In Peru, a peer programme resulted in improved youth knowledge and attitudes, a reduction in the proportion of sexually active males, and increased contraceptive use at most recent intercourse.
- In Cameroon, a community-based peer programme resulted in improved knowledge about contraception in the intervention site, with increased condom use at last sex associated with influence based on peer education.
- A Family Health International study of 21 peer programmes found that most peer educators reported changes in their own behaviors as a result of their involvement. Thirty-one percent said they were practicing safer sex, including using condoms, and 20 percent said they had reduced the number of partners.
- Some researchers have concluded that peer education interventions tend to influence only the behaviors of small numbers of peer educators, not necessarily the target populations, making these interventions not cost-effective enough to justify implementation on a large scale.

Other programme activities

- In Nigeria and Ghana, through the West African Youth Initiative, youth worked as peer educators and were involved in programme planning, design, implementation, and evaluation. Reproductive health knowledge, willingness to buy contraceptives, ability to use contraceptives, and proportion of sexually active youth reporting use of a modern contraceptive increased significantly.
- A media campaign in Zambia (called HEART) included seven youth on its design team and a youth advisory group of 35 young people from 11 youth organizations. Focus group discussions, in-depth interviews, and pre-testing of materials with young people who were the target audience helped shape the media messages. A year after the campaign, viewers were 46 percent more likely to be practicing primary or secondary abstinence and were 67 percent more likely to have used a condom at last sex, compared to non-viewers.
- In Kenya, the Mathare Youth Sports Association (MYSA) in a slum area of Nairobi offers reproductive health education while operating football teams, garbage collection, and other community projects. Youth manage MYSA, emphasizing the skills and ideas of youth as its strongest resource.

- In Uganda and Kenya, a youth-run newspaper called Straight Talk shows how a youth-led editorial board can respond to questions from youth with a candor and connection that makes the paper widely popular in school clubs in both countries.

Institutional involvement

- The International Planned Parenthood Federation now has a substantial number of youth on its board of directors.
- A growing number of organizations working globally, such as YouthNet and Advocates for Youth, have made a commitment to having young people on their permanent staff and linking interns in a two-way mentoring programme.
- Groups such as the Women's Commission for Refugee Women and Children are incorporating youth into evaluations of projects.
- Involving youth in reproductive health and HIV/AIDS programmes increases credibility, visibility, and publicity for the programme, according to several studies.
- Youth can be visible ambassadors for programmes and organizations. The Barcelona YouthForce, an alliance of some 150 youth and 50 adults from around the world, worked at the XIV International AIDS Conference in 2002 to make youth a higher international priority in HIV prevention efforts through press conferences, an on-site newsletter, and other advocacy efforts. This was expanded at the XV International AIDS Conference in Bangkok in 2004 with an emphasis on involving youth in the scientific content of the meeting.

1. AIDS (acquired immunodeficiency syndrome) is caused by HIV, the human immunodeficiency virus, which damages the body's defense (immune) system. People who have AIDS become weaker because their bodies lose the ability to fight all illnesses. They start to become sick with a variety of illnesses, and eventually many will die. There is no cure for HIV/AIDS.
2. The onset of AIDS can take up to ten years from the time of infection with HIV. Therefore, a person infected with HIV may look and feel healthy for many years, but he or she can transmit the virus to someone else. New drug therapies called antiretroviral therapy (ART) can help a person stay healthier for longer periods of time, but the person will still have HIV and be able to transmit it.
3. HIV is transmitted through the exchange of any HIV-infected body fluids. Transfer may occur during all stages of the infection. HIV is found in the following fluids: blood, semen (and pre-ejaculate fluid), vaginal secretions, and breast milk. There is no known case of getting the virus from saliva while kissing. However, if a person has a cut in the mouth, he or she could possibly get HIV from kissing an infected person who also has a cut or open sore. The virus can only survive for a short time outside the body, so it cannot be transmitted through touching an infected person or sharing ordinary objects such as plates, eating utensils, and clothes.
4. Worldwide, HIV is most frequently transmitted sexually. During sexual intercourse, body fluids mix and the virus can pass from the infected person to his or her partner, especially if there are tears in vaginal or anal tissue, wounds, or other sexually transmitted infections (STIs). Girls and young women are especially vulnerable to HIV infection because their vaginal membranes are thinner and more susceptible to infection than those of mature women.

If an HIV-positive man has sex with a woman and does not use a condom, the man's semen can carry the virus into the woman's bloodstream through a tiny cut or sore inside her body, which can be so small that she does not know it is there. If an HIV-positive woman has sexual intercourse with a man without a condom, her vaginal secretions can transmit HIV into the man's blood through a sore on his penis or through his urethra, the tube that runs down his penis.

5. People who have STIs are at greater risk of being infected with HIV/AIDS and of transmitting their infection to others. People with STIs should seek prompt treatment and avoid sexual intercourse or practise safer sex (non-penetrative sex or sex using a condom), and inform their partners. A person infected with an STI is five to ten times more likely to become infected with HIV. Additionally, people who have an STI are also at a greater risk of transmitting their infection to others.
6. The risk of sexual transmission of HIV/AIDS can be reduced if people abstain from sex, if uninfected partners have sex only with each other, or if people have safer sex, that is, sex without penetration or with a condom. The only way to be completely sure to prevent the sexual transmission of HIV is by abstaining from all sexual contact.

7. HIV can also be transmitted when the skin is cut or pierced with an unsterilized needle, syringe, razor blade, knife, or any other tool. People who inject themselves with drugs are at high risk of becoming infected with HIV/AIDS. In Eastern Europe and Central Asia, the sharing of contaminated needles among injecting drug users is currently responsible for the majority of infections. Moreover, drug use alters people's judgement and can lead to risky sexual behaviour, such as not using condoms. Intravenous (injecting) drug users should always use a clean needle and never use another person's needle or syringe. If you know or suspect your sexual partner to be injecting drugs, you should **never** have unprotected sex.
8. Anyone who suspects that he or she might have been infected with HIV should contact a health worker or an HIV/AIDS centre in order to receive confidential counselling and testing.

HIV tests can identify HIV antibodies in the blood as early as two weeks after infection, but the body may take up to six months to make a measurable amount of antibodies. This period of time is known as the 'window period'. The average time is 25 days. A positive result on an HIV test means that HIV antibodies are present in your bloodstream and that the person is HIV positive. The onset of AIDS may take up to ten or more years. Remember – it is possible to live a productive and healthy life as a person living with HIV/AIDS.

A negative result on an HIV test usually indicates that the person is not infected with HIV. However, re-test after six months is suggested if the person engaged in high-risk behaviour during the past six months, because it can take this long for the immune system to produce enough antibodies to be detected.

9. HIV is not transmitted by casual, everyday contact: hugs or handshakes; swimming pools; toilet seats; shared bed linen, eating utensils, or food; mosquito and other insect bites; or coughing or sneezing.
10. Discriminating against people who are infected with HIV/AIDS or anyone thought to be at risk of infection violates individual human rights and endangers public health. Everyone infected with and affected by HIV/AIDS deserves compassion and support.