Responding to what Young People really want to know

Developing Question-Answer Booklets on Sexuality, HIV and AIDS with Young People
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The GTZ HIV Practice Collection

The German HIV Practice Collection is edited by the German HIV Peer Review Group (PRG), an initiative launched in September 2004 by AIDS experts working in German and international development cooperation. The aim of this group is to collaboratively manage knowledge about good practice and lessons learnt in German contributions to AIDS responses in developing countries.

Based on a set of jointly defined criteria for ‘good practice’ (see text box), PRG members assess different ways of responding to AIDS that have been submitted to them for peer review. Approaches that meet the majority of the criteria will be documented, published and widely disseminated as part of this Practice Collection. While some of the documented practices cannot fully meet, as yet, the criteria for ‘good practice’ (i.e. several external evaluations and multiple replications in different countries), all of them represent examples of ‘promising practice’ that may inform and inspire other actors in the complex and dynamic fields of HIV prevention, AIDS treatment, impact mitigation, support and care.

Selection Criteria

- Effectiveness
- Transferability
- Participatory and empowering approach
- Gender awareness
- Quality of monitoring and evaluation
- Innovation
- Comparative cost-effectiveness
- Sustainability

PRG members believe that collaborative knowledge management means ‘getting the right people, at the right moment, to discuss the right thing’. Through the peer review, discussion and dissemination of innovative approaches, German development cooperation supports essential principles of capacity development:

- The process is organised as a transparent and mutual learning experience involving AIDS experts of German organisations, their partner institutions in developing countries and AIDS experts working for multilateral organisations.
- It provides planners and practitioners with a range of practical, evidence-based programming models.
- It focuses on the results of the reviewed approaches, looking at their achievements, challenges and lessons learnt.

PRG membership is open to AIDS experts and development cooperation planners and practitioners with an interest in German contributions to the AIDS response in developing countries. For more information, contact the Secretary of the Peer Review Group at aidsprg@gtz.de or go to http://hiv.prg.googlepages.com/home
Young people are among the most important target groups for HIV prevention programmes because they are many, and they tend to take risks. The number of young people is increasing globally, both in absolute terms and in relation to other age groups.

In sub-Saharan Africa, about 30% of the total population are between 10 and 24 years old. An important proportion of these young people are sexually active, often with changing partners, and thereby exposed to the risk of falling pregnant unwantedly, contracting sexually transmitted infections (STIs), or infecting themselves with HIV. Yet, the HIV epidemic can only be halted when we succeed in changing young peoples’ behaviour by providing them with the knowledge, skills and attitudes they need in order to be able to protect themselves. Equally, all eight millennium development goals, though they are not explicitly stating an overarching reproductive health goal, can not be achieved without directing attention to the reproductive health of youth.

Basic knowledge on HIV transmission and prevention is nowadays widespread. HIV and AIDS information material produced for young people often takes a purely educational, knowledge-oriented and biomedical perspective. Interestingly, it looks amazingly uniform in different countries. The kind of questions that are in young people’s minds as they grow up are mostly ignored: questions on puberty, relationships, love and sexuality, the opposite sex, pregnancy and how to prevent it, sexually transmitted infections, HIV and AIDS.

In this report, an experience is presented of developing sex education material that meets the needs of young people. The concept was first developed in Tanzania and has in recent years been adapted in various other contexts in Africa and Asia. There is little doubt among youth experts that active involvement of young people in designing information and education approaches is a prerequisite for successfully meeting their informational needs (WHO: 2004). To date, this has not often been translated into practice.

Adolescents have many questions...

Consecutive steps, involving young people and youth experts throughout the production process. This systematic approach lends itself to replication and adaptation in different socio-cultural settings. The outcome of the process is a set of question-answer-style booklets. So far this approach has been replicated or adapted in 17 countries in Africa and Asia. Reactions and evaluation results have shown high appreciation and further demand by young people, educators and parents alike.

Lessons learnt are that it is essential and rewarding to involve young people throughout in the production of education material for them, that the material should take a broader perspective of young people’s concerns related to reproductive health and sexuality instead of an HIV perspective only; that particularly in the beginning a lead role by government structures is not necessarily appropriate and helpful, as they tend to avoid controversial issues such as youths’ sexuality. Instead, creating alliances with non-government and international organisations often contributes to making the process viable.
The Context

Why young people matter
Young people\(^2\) are among the most important target groups for HIV prevention programmes because they are many, they are likely to be sexually active, and they are prepared to take risks. Among unmarried 20 year old females, 51\% are sexually active in Africa and 45\% in Latin America and the Caribbean. For males the respective figures are 90-95\%. In sub-Saharan Africa, about 30\% of the total population are between 10 and 24 years old. The number of young people is increasing globally, both in absolute terms and in relation to other age groups (except for the old industrialised countries) (UNFPA:2003). An important proportion of these young people are sexually active, often with changing partners, and thereby exposed to the risk of contracting sexually transmitted infections (STIs), including HIV, and of unintended pregnancies. It is estimated that half of the current HIV infections worldwide were acquired by people below 25 years of age (UNAIDS:2005).

An increasing time period between first sexual experience and first stable union (or marriage) is typical for rapidly changing societies. In Morocco, for example, the average age of marriage has increased in the past 40 years from 17 to 29 years for young women and from 21 to 32 years for young men. These same societies consider sexual experience before marriage unacceptable, so that young people do not receive appropriate sex education and information on preventing unwanted pregnancies and sexually transmitted infections.

At the same time, there is proof that the HIV epidemic can only be halted when we succeed in changing young people’s behaviour by providing them with the knowledge they need in order to be able to protect themselves\(^3\).

Some observations regarding existing HIV educational material
In the last 20 years, more information about HIV and AIDS has become available. Today, basic knowledge on HIV transmission and prevention is widespread. However, the link to young people’s questions about their own behaviour and their choices in life is often not made.

HIV and AIDS information material produced for young people often takes a purely educational, knowledge-oriented or biomedical perspective. Interestingly, it looks quite uniform in different countries, explaining disease causes and warning against risky behaviour that could result in sexually transmitted infections (STI) or unwanted pregnancies.

The reason behind this uniformity appears to be that experts who have studied the health risks of young people regarding STIs, HIV and unwanted pregnancy believe that these risks can be minimised by simply providing information and advice. In addition, this tends to be done from an experts’ perspective instead of looking at the kind of questions that young people might ask themselves. In the worst cases, the material is boring and moralising, and does not address real life issues and the many emotional aspects related to questions of relationship and sexuality in young people’s language.

In fact, adolescents have many questions and doubts about what happens to them when they grow up and mature, about their sexual feelings and their sexual life. Prevention of HIV infection might be one area of interest, but it is neither the only nor the most important one. Perceptions about puberty and physical development, about sexual relationships, about fertility and pregnancy, about contraception and disease prevention, about normality and abnormality, all influence how girls and boys perceive their roles and their options, and they all determine how they will behave.

WHO (2004) therefore considers it a priority for such programmes to involve young people in Adolescent Sexual and Reproductive Health Programmes, to give them a voice, and to respond to their expressed needs. None of the eight millennium development goals can be achieved without sufficient attention to the reproductive health needs of youth (Global Health Council, 2004).

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\(^2\) WHO has categorized young age groups as follows: adolescents = 10-19, youth = 15-24, and young people = 10-24 years. In reality, these terms are used interchangeably (e.g. ‘youth friendly services’, ‘adolescent reproductive health’) and often, pupils of different categories are found in one class.

For operational reasons the WHO terminology will not strictly be adhered to in this paper.

\(^3\) See the case of Uganda, Tanzania and Zambia, countries where AIDS prevalence in young people declined in the nineties, see Alan Guttmacher Institute (2003); and GTZ (2002).
The report presents an experience of developing sex education material that meets the needs of young people. The concept was first developed in Tanzania and has in recent years been adapted to various other contexts in Africa and Asia (see Table 3, page 26).

A commonly accepted working hypothesis is that young people themselves know most about their information and communication needs. Social learning theory (Bandura: 1977, 1997) and peer education strategies show that peer groups and role models play an important role in influencing knowledge and attitude, as well as in shaping behaviour (e.g. UNFPA: 2005).

There is little doubt among youth experts that active involvement of young people in designing information and education approaches is a prerequisite for successfully meeting their informational needs. This has, however, not often been translated into practice.

The approach described in the following is neither revolutionary nor brand-new. It is based on widely accepted theories of health behaviour (e.g. social learning theory) and health education (UNFPA/UNAIDS: 2005).

It is new in so far as it follows in a rigorous and systematic manner a number of consecutive steps, involving young people and youth experts throughout the production process. This includes needs assessment, planning, and development of the materials. This systematic approach allows for replication of the process in different continents and cultural settings. The outcome of the process is a set of question-answer-style booklets that use simple language and humorous illustrations for emphasizing and illustrating the messages. The questions were posed in just this way by young people, and the answers were formulated together with them. The questions relate to topics such as growing up, love, partner relations, sexual relationships and sexual behaviour. The resulting set of booklets looks quite different depending on the socio-cultural setting in which it was developed (based on the respective different questions, different language, different illustrations, etc.).

How young people in Morocco perceive their sexuality and sexual life

The advantages of using simple booklets for sex education are manifold: They
• can be read everywhere, also in secret
• do not require technical equipment (VCR or DVD player, computer etc)
• can be shared with many others
• can be read when talking about sexual issues is difficult or even impossible
• can be locally produced, and
• may even help to improve their users’ reading skills.

There is no doubt however, that for successful behaviour change additional enabling factors are required other than just accurate information. They include access to services such as youth-friendly clinics and condoms, the existence and implementation of youth-friendly policy and legislation, a supportive immediate environment, the existence of positive role models, e.g. of responsible partnership, and more. In this sense, the booklets are no more (yet also no less) than one effective instrument in the orchestra that constitutes a comprehensive behaviour change strategy for youths.
The Approach

Objective and target group

The approach aims to provide young people with correct, youth-friendly information on their reproductive health and sexuality in a process that involves them at all stages in order to enable them to make healthy decisions with regard to their own sexuality. The booklets target adolescents between 12-20 years of age\(^4\) with basic reading skills.

The following steps describe the approach in detail. For better illustration, reference is made to its implementation particularly in Tanzania - the country of “origin” of the practice, Kyrgyzstan - a rapidly westernising Asian Republic - and in Morocco, a rather conservative, though changing Arabic-Islamic setting. In these countries the process has been accompanied by the authors of this paper.

Step 1: Baseline research (KAPB and focus groups)

The first step, the baseline or situation analysis on adolescents’ knowledge, attitudes and behaviour regarding sexual and reproductive health, is in many settings already available because other partners studied and documented it. Where no adequate studies are available, it is important to invest in such a baseline study, either in form of a KAPB survey or a qualitative study such as for example focus group discussions with young people, health workers and other relevant groups (or both).

Baseline surveys should contain questions that can be used for monitoring the booklets’ impact at a later stage\(^5\). The findings of a baseline study serve to assess young people’s pre-intervention level of knowledge and behavioural intentions. In addition, they will highlight areas of uncertainty, ignorance and concern that should be addressed by the question-answer-booklets.

Step 2: Collect and compile questions asked by adolescents\(^6\)

Collection: The collection of anonymous questions is a simple way of getting a wealth of information on young people’s language, their main interests and their information needs.

The collection of questions can be conducted in and out of school, yet implementing this step in schools is certainly easier and cheaper\(^7\).

In most settings, it is advisable to conduct this step with boys and girls separately. Otherwise there is a risk that peers disturb each other, or boast and joke instead of taking the questions seriously. Feelings of embarrassment can also prevent young people from expressing their questions where boys and girls sit together in crowded sitting arrangements – which is often the case in poor schools in developing countries.

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

\(^4\) Though this does not precisely match the WHO defined categories, in practice this age group turned out to be the most appropriate and acceptable one.


\(^7\) In Tanzania an attempt was made with out of school youth, using literate peers to collect and note down questions from friends in the neighborhood (GTZ/repro project).
A sheet with a short introductory text is distributed, inviting pupils to write down all their questions on partnership, sex, reproduction and sexually transmitted diseases. Students are asked to indicate their sex and age. It is of utmost importance to explain and consequently ensure the anonymity of the process. Also, teachers are asked to leave the classroom so that pupils do not feel observed or judged whilst coming up with their questions. One hour should be allocated for writing down questions. The filled-in forms are then collected in a ballot box.

Youth also pose questions on the lack of understanding between themselves and adults.

Coding and analysis: All questions are entered into a data base and categorised according to the content of a question. The categories are developed inductively, i.e. by reading through the questions: There tend to be biomedical questions on issues like conception, pregnancy, contraception, STIs, HIV and AIDS etc., questions on sexual practice, such as sexual desire, sexual intercourse, ‘normality’ and ‘abnormality’ of practices etc., but also questions on cultural norms and values, on gender roles, on parent-child communication, and on cultural and religious taboos. The data base will allow for grouping of similar statements and for their qualitative and quantitative analysis. Programmes that can be used include Access, Epi-Info and, to a lesser extent, Excel.

It is important to enter all questions, even though many will be similar or even identical, and to always specify the age and the sex of the respondent in order to allow for an analysis by sex and age. This can be done by a well-instructed research assistant. The research team leader – preferably with team members who work with young people – is in charge of guiding the next step.

Young people have many questions

The cut-off point of the age groups to be included in this part of the process depends on the students’ literacy level: all those who are able to write down their questions can be included. In some countries this can be at the age of 10 to 12 years, in others it is 13 years and above. In addition to literacy levels, the cut-off point will also depend on the acceptability of this type of study to the educational authorities. In more restrictive cultural contexts, one might only get permission for older adolescents.
Step 3: Screen and categorise questions with young people

From the complete pool of questions – which may amount to several thousand, the most frequent ones are selected. Frequency is however, not the only criterion. Questions should also be included when they are regarded as particularly relevant for expressing or shaping the attitude and behaviour of young people, even if they are only asked a few times. Here the information from baseline studies and the knowledge about the epidemiological and socio-cultural situation helps to prioritise questions. If, for example, gonorrhoea is known to be highly prevalent in the target group, different aspects of prevention and treatment have to be addressed. If female genital cutting is a common practice, this is also an important topic to be included, as is the case in Guinea. Some questions may touch on a particularly burning issue, e.g. the dread of not being able to present the “drop of blood” in the wedding night, or serious misconceptions, such as sanitary towels destroying girls’ virginity (Morocco). Given that these issues are unlikely to be addressed anywhere else, and that they have implications on hygiene practices and school attendance, the opportunity must be seized to address them in the booklets. Roughly 150 to 250 questions should be selected.

The resulting list is screened by a group of young people (e.g. peer counsellors) who assess each question on whether it is understandable and relevant for adolescents. If necessary, they reformulate questions to make them easier to understand. As a next step, the selected questions are grouped. The following categories have proven useful for such a categorisation:

- Growing up, Puberty
- Male-female relationships among adolescents
- Sexual relationships
- Pregnancy
- Safer sex and contraception
- HIV and AIDS

However, depending on the particular issues the youths bring up, other or additional categories can be appropriate (e.g. drugs, alcohol and smoking).

Step 4: Develop answers in a multi-disciplinary team including young people

A multi-disciplinary team of experts in the fields of social science, health and education works on a first draft of booklets containing simple, scientifically correct answers. The scientific correctness is crucial as it is a major argument against attempts of censoring sensitive issues (see the example on masturbation below). The responsibility of professionals is to make sure that sex education is not confounded with moral or religious instruction. The guiding principle for this step is: Not everything which is true has to be said, but all that is said must be true.
The resulting drafts should be proof-read by a group of young people to make sure that the answers are understandable and relevant to them. This means not only that the information should be correct, but also that the recommended behaviour can realistically be adapted by young people in their particular social environment. Such an assessment can be done in a workshop where small groups read and edit questions and answers by category. On this basis, young people (e.g. again trained peer counsellors) and other experts modify the first draft as necessary.

In Morocco, the elaboration of answers to adolescents’ genuine questions in a culturally acceptable way, i.e. compatible with the Koran, posed a great challenge. And yet, finding the “right” formulations was of utmost importance to the participants from the Ministries of Health and Education as well as youth organisations who were struggling for the proper responses in a number of workshops.

The example of the issue of “masturbation” shows this vividly: Many, in particular, male adolescents had posed questions on how masturbation is viewed by Islam and its potential detrimental effects on physical and mental health. These questions point at the state of inner turmoil they experience in relation to this issue. According to the Koran, sexual activity that does not involve a partner of the opposite sex is not acceptable. Health science however, can not support detrimental effects of masturbation on health; from a preventive, public health point of view it is even a good option to prevent HIV infection.

The essential criteria for the formulation of responses to adolescents’ questions are as follows:

- They must be based on scientific evidence and factually correct.
- In terms of content and language, they must correspond to adolescents’ lifestyle.
- They should not be moralising.
- They should be acceptable in terms of cultural and religious norms.

In Morocco, the controversial issue of masturbation has been resolved in a way that the response clearly rules out detrimental effects on physical health but also mentions that this practice is not well-perceived in the religious context.

The case of Kyrgyzstan

Thanks to the existence of a national HIV prevention strategy, there is a good framework for action in Kyrgyzstan and considerable efforts for its implementation have been undertaken. Efforts of different governmental agencies and donors had however been badly coordinated. Many different agencies have produced their information material, mostly targeted at risk groups such as intravenous drug users, homosexuals, commercial sex workers, military and migrants. However, despite the definition of youth as one of the most vulnerable groups by the national HIV prevention strategy, no information material was available to youth, nor did the school curriculum include any form of sex education. The fact that the little information available was in Russian only, aggravated the situation for youth with Kyrgyz mother tongue.

In response to this gap, GTZ together with UNICEF allocated funds to the development of youth friendly information material on sexuality, HIV prevention and drug abuse, both in Russian and Kyrgyz, and the question-and-answer-booklets were considered an appropriate format. The entire process from collecting questions, up to compiling and illustrating the final information booklets was carried out with the involvement of youth at all stages of the process.

Three aspects stand out when looking at the Kyrgyz experience, namely the strong collaboration with local NGOs and UN bodies, the production of versions in four languages and the illustrations not only agreed upon, but made by two adolescents.
After careful consideration, it was decided not to involve Muslim dignitaries and religious structures directly in the development of the booklets because it was feared that their particular attitudes and the way in which these would impact on the process, might jeopardise this sensitive undertaking from the start.

**Step 5: Brainstorm on illustrations and work with cartoonist and photographer**

Once the content has been developed, the multi-disciplinary team suggests appropriate illustrations. A mix of scientific illustrations, photos and cartoons is best. Ideally, a cartoonist is contracted (and he or she, too, should ideally be young). Cartoons can often better convey the essence of a problem or a situation than words can. In addition, they make a text more attractive to the reader.

Photographs are useful as illustrations of everyday scenes, creating a sense of familiarity and personal involvement in the sense of "This could be me". The same group of young people that has edited the draft texts can comment on the illustrations, suggest changes and alternatives, as well as additional images.

It might not be possible to take photographs showing typical scenes from real life situations (such as hugging or kissing) because people might perceive this as a private affair. If real life situations are photographed, the people photographed should always be asked for permission to use their photo in the publication. In Tanzania, the photos were made by a local photographer involving students of the drama department of the Bagamoyo College of Arts. These students staged scenes including hugging, quarrelling and kissing because it would have been inappropriate to photograph such situations in daily life in Tanzania. In Morocco, the use of photographs of people was felt not to be appropriate at all. Here, a "creativity workshop" was organised with a number of adolescents and a young cartoonist from a youth magazine. The adolescents suggested scenarios derived from the booklet questions that were then developed with the artist. Some cartoons were drawn by adolescents themselves.

In Kyrgyzstan, the illustrations were not only discussed and pre-tested among adolescents, but two girls were the main illustrators for the booklets. One of them drew cartoons, whereas the other one took photographs. The young people were asked to portray all social sub-groups of society (Russians and Kyrgyz people, rural and urban environments) to ensure optimal identification with the illustrations. However, one word of caution must be added here: whenever people are photographed in real life situations in order to use their pictures in a publication, they must be asked for their consent, ideally in writing. In Kyrgyzstan, one lady was offended by the fact that her son’s picture was in one of the booklets. The fact that he had given his verbal consent helped to avoid a lawsuit.
Step 6: Review answers and illustrations in a multidisciplinary team and field test with groups of young people

After the compilation of a final illustrated draft, a group of experts, including some of the adolescents who worked on it before, should review it once more.

Field testing should take place in an environment in which young people are relaxed, have time to read the booklets and to comment on them. In many settings, this can only be done in a sort of workshop setting, where young people come together as a group for some days, read the booklets individually or in small groups and then comment on them, in individual or group interviews, and/or in writing. It is also important to pre-test the material with different age groups of the final target population.

Step 7: Compile the final draft for printing

Based on the young people’s final comments, the laid out version for printing is prepared.8

At this stage, one crucial question must have been answered: Who is the final “owner” of the product and who should take the responsibility for the content and the distribution? This has proven to be an important issue, as the publication and distribution of the booklet series can lead to further inquiries and sometimes controversies; it needs to be clear from the start which authority will respond to these motions. It is often suggested that this should be the Government through the Ministry of Education or the Ministry of Health. The experience in different contexts and countries has demonstrated that it may be more effective to look for a project or an NGO as partners and responsible editors because they are less dependent on the political forces in a society. Opting for government ownership tends to lead to lengthy approval procedures and may result in a cropped version, excluding important, yet taboo issues, such as e.g. homosexuality or masturbation (for more details see: lessons learnt).

Another important question concerns the language/s in which the booklets will be published. In Tanzania, the booklets were produced in the local language Kiswahili and then translated into English. The English version was mainly needed to communicate with other projects and donors in order to find partners willing to pay for reprinting. The English version was also needed for sharing with projects and other interested parties internationally, e.g. through putting it onto the website.

In Tanzania, the secondary schools where interested in an English version, so that English beginners could improve their language skills by reading the booklets. Versions in other languages should also be edited together with young people to make sure that the language chosen is theirs.

In Morrocco, where currently a French version of question-answer booklets is being translated into Arabic, this proves to be a challenge as the Arabic language is so closely associated with religious connotations. Great care has to be taken to avoid the creeping in of a conservative and moralising attitude.

In Kyrgyzstan, the booklets are available in four languages, namely Russian, Kyrgyz, Uzbek and Tajik. Even though only Russian and Kyrgyz are official national languages, it was decided to translate the booklets also into two other languages in order to serve the already marginalized minority populations. Questions were collected in three languages (Ru, Kg, Uz); then all of them were translated into Russian. The working language during the development process was Russian; thereafter the booklets were translated into the respective languages. Especially the translation into Kyrgyz proved to be very cumbersome, as the language lacks many of the more technical terms (e.g. terms for contraceptive methods) and in many instances it is difficult to find terms that are understandable to youth, i.e. non-technical, but also not perceived as rude. Several skilled translators developed a first version that was pre-tested among different age groups and both in the north and the south of the country, where different dialects and levels of con-

8 Clarify beforehand whether the print house can do the layout for you or whether layout has to be provided by a third party.
servatism prevail. Having a multitude of language versions to choose from allows access to the information to all social sub-groups in the country. The existence of a Russian version opens up potential for spread and exchange with other Russian speaking countries, whereas the existence of an Uzbek and Tajik version allows spread of the materials into the neighbouring countries Uzbekistan and Tajikistan. Nevertheless, it also poses a challenge, as any modification (e.g. as a result of feedback from readers) has to be carried out in all four blueprints, increasing production and printing costs.

The titles of the eight Russian booklets

1. I am not a child and not yet an adult – Questions about growing up and their answers
2. To become a woman and a man – Questions about virginity and marriage and their answers
3. The other sex– Questions about relations between boys and girls and their answers
4. More than just friends – Questions about sexual relationships and their answers
5. Where do children come from? – Questions about pregnancy and their answers
6. Having a child or not? – What does it depend on? – Questions about contraceptives and infertility and their answers
7. Forbidden fruits are sweet - Questions about smoking, alcohol and drugs and their answers
8. For the young generation to stay healthy - Questions about HIV/AIDS/STIs and their answers

Step 8: Print and start the dissemination process

The costs for the printing of the booklets are high compared to the cost of their development. Often, projects working on adolescent reproductive health do not have a budget for the production of the quantity of booklets needed to reach all youth in a region or a whole country. In Tanzania, the project opted for a first edition of 5000 sets per language. Afterwards, efforts were made to find partners willing to fund the printing of further editions.

Printing in colour is particularly attractive but has to be weighed against the option to print a bigger number in black and white. A viable compromise is to have a colourful and attractive cover and to print the booklet itself in black and white. As the target group is so large - in some countries up to 20% of the population – it may be better to

9 They are available for download at: http://www.unicef.org/magic/bank/youthhealth.html.
10 In Tanzania, the cost for development of the series of 6 booklets was about 5000 US $. The price for printing one set was one US $.
compromise on visual attractiveness in favour of the quantity. Also, the quality and weight of the paper will have an impact on the number of copies that can be printed with a given budget.

The first edition should be distributed in such a way that it creates the demand for more copies. Therefore copies should be given to all partners, organisations, and institutions working with young people in sexual and reproductive health issues. In Tanzania, we offered organisations up to five sets at no charge but then requested them to contribute to the printing costs for additional copies. To those interested in greater quantities for use in their own programmes it was suggested to finance a reprint for which they would become co-editor.

If individuals (teachers, social workers, priests, and young people) asked for an individual copy – either in writing or by passing the project office – they received one set free of charge. With this approach, it was easy to find several partners, non-governmental and governmental, who either ordered or reprinted copies.

Step 9: Monitor and evaluate

Monitoring and evaluation should involve looking at the quality of information provided, the quality of the distribution process and the booklets’ effects on their readers’ knowledge, attitude and behaviour.

Quality of the information provided

The quality of the information provided depends to a large extent on the process of the development of the booklets. If experts, young people and good illustrators have been involved, and if the steps described above are followed, the product is likely to be of high quality.

And yet, it can be argued that those who finally read the product in remote and poor areas have another perception and understanding of the issues addressed than those who were involved in the production process. Some of the readers will also be younger than those who participated in the production.

Therefore different methods and tools for checking the quality of the product are needed. One is to collect all comments that come in from partner organisations as well as from individual readers. In Tanzania, all letters – and they were many – were evaluated. In the same way, phone calls from readers who give comments and/or ask for additional copies should be registered.

In addition, a reader survey can be organised. This is especially feasible if in a given area or institution many young people received the booklets and can be traced for an interview. Such a reader survey can also collect information for other indicators (see description of the reader survey in Tanzania below).

Quality of the distribution process

There is a wealth of anecdotal evidence that IEC material produced with technical and financial assistance of donor agencies is distributed to peripheral offices where it remains undistributed and unread until it is outdated (or even eaten by termites).

However, if partners have to pay for the product, the chances that the product is used are much higher. Where individuals write a letter or spend time and money on transport for collecting copies, the chances that they use the product are quite high. Therefore detailed records on who requested, who received, and who paid for sets of booklets are a good way to monitor the distribution process. When a larger quantity of copies is provided to an institution, e.g. a regional or district education office, it is recommended to analyse together with the given institution how and if the product reached the target group. This too can be part of a reader survey (see the example of Tanzania below).
Impact on knowledge, attitudes and behavioural intention

The impact on knowledge, attitudes and behavioural intentions can only be evaluated by a survey before and after the introduction of the booklets, or by a study that also looks at a control group that has not had access to the booklets. A survey can repeat the questions that were asked by the baseline survey and assess whether there are significant differences in knowledge, attitudes and behavioural intentions between the two surveys. In order to eliminate confounding factors such as other sources of information on reproductive health and sexuality, a well-designed survey should include a control group that resembles the target group in all other aspects, yet has not had access to the booklets. Whether the costs of such a survey is justified has to be assessed with care. However, monitoring and evaluation of the quality of the booklets and of the quality of the distribution process should be a routine component of all programmes using them.

The case of Morocco

The situation

The growing prevalence of HIV and the urgent need of an appropriate response in Arab Muslim countries are increasingly acknowledged. The Moroccan government meets the challenge of the latent, yet growing problem of HIV and AIDS with a comprehensive multisectoral strategy (PNLS) whose implementation is however faced with limitations in the given socio-cultural context. This is particularly true for adolescents who are considered an important target group in the PNLS. The target group, young unmarried people in Morocco faces societal changes in a particularly unprepared and unprotected way. Young people live in a situation of enormous tension between strict patriarchal Arab traditions and Muslim values, implying strong familial control of girls, unbroken norms of e.g. “virginity till marriage”, and on the other side strong expectations and the pressure of being “modern” by boys and young men who have a respective orientation through their access to satellite TV and internet. This confrontation between Western and local values and life styles is particularly pointed in Taza, Al Hoceima and Taounate (TAT), a region supported by the German Technical Cooperation (GTZ). It is partly attributed to the high number of labour migrants returning from Europe for their summer vacation with their adolescent children - who are often perceived and labelled as Europeanised and loose.

There is no opportunity to practise appropriate behaviours such as, for example interaction among girls and boys in a relaxed way. At the same time there is a complete lack of competent, empathetic and confidential sources of information. Existing offers of information are conservative and purely biomedical. Therefore, there is an enormous need for competent technical information and counselling as well as for youthfriendly appropriate services and health promotion.

Situation analysis and baseline study

As hardly any reliable data on adolescents' knowledge and behaviour (KAP) regarding sexual and reproductive health were available, a study was conducted in the province of Taza in 2003, not least in view of developing appropriate IEC materials.

The collection of adolescents' questions carried out at the same occasion and following the procedure described here, gave adolescents an opportunity to pose their questions on puberty, sexuality, marriage, pregnancy, sexually transmitted diseases and HIV in an open, yet anonymous way. They utilised this chance to an extent that had not been anticipated, giving evidence of their enormous lack of knowledge and thirst for information. A total of 3582 questions have been posed, whereby the average number of questions per girl was 12, 6 and 8, 4 per boy.
The Results

The impact the booklets have had on adolescents has systematically been documented and analysed in Tanzania. In other countries, information on impact is still rather anecdotal, yet it appears to point into the same direction.

Requests and reactions from readers

The first condition for a print product to have any impact is that it is read. An easy way to evaluate this is to analyse letters sent to the editors (in all the different editions of the booklets, the back cover contained a contact address).

In Tanzania these letters were filed, answered and analysed. Three types of letters were received:

a) Requests from young people for more copies
b) Requests from educators and youth leaders for copies to be used in their professional activities
c) Letters of thanks: Hundreds of young people and youth educators requested booklets or sent comments. The majority came from primary and secondary school students and from youth clubs and institutions working with youth.

1,251 letters were received within the first 18 months after print in 2001/2002, i.e. about 20 letters per week: 824 from young people, 96 from institutions, and 332 from educators, teachers, and youth leaders. Some quotations from these letters give a good impression of the impact of the booklet:

**Educators, teachers**

“I have found these series of books to be a very effective tool in my service and also to students.”
(Pastor from Tanzania Assemblies of God)

“I found them very useful especially to our youths who are living in this world of uncertainty. They are educative and relevant to what our youth want to know.”
(Headmaster from school in Tarime)

“As a teacher, the material will help me carry out my plans to form anti-AIDS clubs in the school to help students understand the magnitude of the epidemic and how to protect themselves against it.”
(Teacher from Iringa, Tanzania)

**Partner organisation**

“I considered them so good that they can support community-based health activities in family planning, maternal and child health, and HIV/AIDS/STD”
(UNFPA, Dar-es-salaam).

**Young people**

“Thanks for the books, they helped a lot. These books explain how and what real life is”
(Fatma, 15 years, Moshi, Tanzania)

“I am so happy with these books and they helped me to avoid many problems which we young people encountered.”
(Jeremia, 17 years old student from Ngudu, Mwanza).
Readers' survey
A reader survey was organised in Lindi region in the South of Tanzania12 in order to assess:
• the actual distribution and utilisation of the booklets
• the comprehensibility of the images and cartoons
• the effect on young people’s knowledge, and
• the effect on their behavioural intentions.

In Lindi region, the distribution process was ideal for a reader survey. In cooperation with the regional educational authorities, booklets had been distributed to all primary schools of the region. This allowed for random sampling of students at schools in rural and urban settings who were individually interviewed. The survey was conducted in the form of individual face-to-face interviews by male and female interviewers trained for this purpose. In 46 schools, five girls and five boys of Standard VI were randomly selected. Boys were interviewed by male interviewers, and girls by female interviewers in a confidential setting where nobody else could listen.

Distribution and utilisation
Out of 415 potential readers in the sample, 89% had already seen the booklets, yet only 70% had received their own copy. In some schools, the headmaster prohibited the distribution. In others, only selected booklets, e.g. the one on HIV and AIDS, were given to the students. In one school, the booklets were kept in the science teacher's cabinet for borrowing only.

Not all students had read the booklets they had received. The vast majority read booklet Number one “Growing up” (94%). A smaller percentage read the remaining ones (51%-65%).

The booklet on “Growing up” was not only the one the students tended to read most, but also the one they liked best. The main reason given was that it explains what happens in their bodies, that they now understand the bodily changes they are going through and feel better able to cope with these.

Sharing of booklets and parents’ views
From those adolescents holding their individual copies, 30 % shared these with friends, 22% with siblings and 11% with relatives. 51% of the adolescents had shown the booklets to their parents.

31% of the parents encouraged their children to read the booklets thoroughly. 27% checked the booklets and gave them back without any comment. 31% could not read them because they were illiterate. 9% of the parents found the booklets not appropriate for kids, because according to them they were too frank about touchy issues.

Readers’ knowledge and behavioural intention
An important message of the booklets is that young people should know about condoms, not only because they can prevent HIV infection and STDs, but also because they protect against unwanted pregnancies. This is particularly relevant because in Tanzania, for example, a condom is mainly seen as a means of preventing HIV infection.
The survey results show that girls had understood this message: 78% of them correctly mention all three purposes of condom use. In contrast, the boys see condoms mainly as a means for disease prevention and only 47% of them mention all three purposes.

Another message that is included in different editions of the booklets is that in case of sexual desire, penetrative sex is not the only option. Other options given are engaging in sports, meeting with friends, reading, etc. in order to forget about this desire, or, masturbation. If the desire to have sex with a partner persists, then the use of a condom is strongly recommended. The booklets discourage having sex without considering the consequences.

The following survey question was asked to assess the readers’ behavioural intention:
“What will you do if you feel sexual desire?”

291 holders of personal copies answered as shown in the table below:

For boys, masturbation is a common option. Condom use comes to the mind of only 7%. Some explained that condoms are not at all available or accessible in the villages.

Although the majority of girls suggested using a condom, one may wonder about the feasibility of this option given that so few boys expressed the intention to use one. Nearly a third of the girls say that they do not yet feel any sexual desire, and therefore cannot explain how they would deal with it. A high percentage still intends to “just do it”. Given the stigma normally attached to masturbation particularly in girls, it is quite surprising that 15% of the girls mention this practice, describing that they rub the clitoris with soap and warm water until the feeling disappears.

<table>
<thead>
<tr>
<th>Table 1 Knowledge on usefulness of condoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom prevents …</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Unwanted pregnancy</td>
</tr>
<tr>
<td>STDs</td>
</tr>
<tr>
<td>AIDS</td>
</tr>
<tr>
<td>Do not know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2 Behavioural intention in case of sexual desire among readers of booklets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
</tr>
<tr>
<td>N=291</td>
</tr>
<tr>
<td>Masturbation</td>
</tr>
<tr>
<td>Sex with a condom</td>
</tr>
<tr>
<td>Other activity</td>
</tr>
<tr>
<td>Just do it</td>
</tr>
<tr>
<td>Others</td>
</tr>
</tbody>
</table>

Several options possible: “Others” mainly referred to: I did not yet feel sexual desire, and females mainly expressed this.
Comprehensibility of the cartoons

The readers’ understanding of the cartoons was assessed by interviewing them about their comprehension of the two examples depicted on this page. Evidently, young people had no problem understanding their message. All girls saw the blood and correctly interpreted it as menstrual blood. They explained that the girl cries because she realises that she has got her first menstruation. Some said she cries because she has to report this now at home.

Regarding the cartoon displayed to boys, nearly all said that the boy has an erection. The most common interpretation was that ‘he dreamt of having sex’, ‘he thinks of having sex’, ‘he would like to have sex’. Only few said that this is the morning erection due to blood in the vessels of the penis.
Lessons learnt

Young people should be involved in the development of educational material
Involving young people as key collaborators in the development of youth-oriented education material is a feasible and cost effective way to reach young people’s minds and hearts, a prerequisite for having an impact on their attitudes and behaviour.

Short and simple, easy to read material is read even in a non-reading culture
Several small booklets are more appropriate than one book, especially if people are not skilled readers. There is also less association with school books, when the booklets are in a brochure format. An attractive layout is needed to catch the reader’s interest. A big font size and many illustrations facilitate reading.

Protect authenticity of the questions and answers formulated by young people
Experts have a tendency to put things right’, which means to reformulate in correct technical terms what had been said by pupils. If the objective is to write a technical book, this may be necessary and useful. If we want to communicate effectively to young people it is much better to make use of the expressions they suggest, under condition that these are understood by their peers. For example, “chaude pisse” which literally means ‘hot urine’ can be a much better term to use than ‘gonorrhoea’, even if we know that the young people actually mean gonorrhoea. It should still be said that the medical term for this infection is “gonorrhoea”.

It is also advisable to include questions that at first view seem to be “stupid” or commonly known. Young people don’t ask a question without a good reason. Try to find out what was meant when the question was formulated.

Another important aspect for the questions is their “inside perspective”. “What should I do about my sexual feelings?” should not be reformulated as “How can adolescents cope with sexual desire?” The more genuine the questions and answers, the more young people feel that these are their expressed concerns. In the field of public health, there is an “expert culture” of describing what other people do and feel that creates a distance by conveying that we are talking about others and not about ourselves. Often, professionals don’t even realise that they are modifying messages because they are so used to their professional jargon: examples of such terminology are: ‘adolescents’ risk taking behaviour’, ‘peer pressure’ and ‘transactional sex’.

Look with a broader angle, and not with an HIV and AIDS perspective only
Friendship, sex and love are for young people among the most exciting areas to explore. At a certain age, they are the primary topics of their discussions. In contrast, disease and disease prevention are disturbing factors in this discovery of a new world. Young people have many questions, hopes and worries in their minds regarding love and friendship. Such worries circle around issues of being accepted by others, being attractive or not, being normal or cool, being fertile or barren. Only through providing answers to all questions they consider relevant, young people will be reached in such a way that information on disease and pregnancy prevention is well-received.
Among the recent evidence are assessments of the impact of "abstinence only" messages on behaviour. It has been shown that the risk of STD infection is higher in pledgers; see Brückner & Bearman (2005), pp 271-78.

The broader angle also implies a positive view on young people’s feelings and desires, a crucial issue when defending young people's rights. Educators and decision makers tend to overemphasize the potentially harmful sides of sex and love with the good intention to protect young people from risky behaviour.

One of the main criticisms of the approach and the product described here is that “It is too positive and thereby encourages young unmarried people to have sex.” However, there is evidence that an approach of overemphasis on warning and threatening leads to unprotected behaviour, firstly because young people simply disregard the information provided and secondly, because sexual activity is not associated with having to be aware of means for protection. If young people are informed and able to prepare themselves mentally and practically they are more likely to opt for safe sexual behaviour.

**Government ownership is not necessarily appropriate**

Leading decision makers are often conservative and not keen to take risks. If we look back in the history of family planning and sex education for youth in Europe, we realize that government institutions came on board late, and that they took over when the innovation process had already gone far. In the beginning, government institutions, especially the ministries for education and culture shielded away from innovative approaches and defended traditional values. This is partly due to an inherent conservatism in those ministries, and partly an avoidance of conflicts with parents, religious leaders etc. The first German “Sexualkunde-Atlas” published in 1969 after a long debate about issues which nowadays seem to be absurd in the German context (e.g. whether it is acceptable to show the drawing of a naked adolescent body) is a good example. When it was finally accepted, it had undergone so many alterations that there was not much that was interesting and new in it. At the same time, teachers who wanted to teach sexeducation referred to books from Sweden or to provocative German publications like the “Sexfront”

Question and answer booklets from young people for young people easily put ministry officials into a controversial position. Even if they, as private persons, might agree that this kind of information is needed, and even if they might be willing to give this information to their own kids, they will be reluctant to take ownership for such materials in public. This can be due to their fear of negative reactions from conservative powers within ministries and the society at large.

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13 Among the recent evidence are assessments of the impact of “abstinence only” messages on behaviour. It has been shown that the risk of STD infection is higher in pledgers; see Brückner & Bearman (2005), pp 271-78.

14 By Günter Amendt.
A professional approach should take these constraints into consideration when designing a distribution strategy and not try to force government institutions into a role they can and/or do not want to play. They can always be pulled on board, once the materials have gained enough public support due to a large demand from target groups.

In Kyrgyzstan, the information materials were developed in close collaboration with local NGOs, namely the Reproductive Health Alliance of Kyrgyzstan (RHAK) and the Info-Centre Rainbow. Both organizations were involved at all stages of the production process by providing their network. Especially RHAK proved to be a very powerful partner, since the organization has a network of volunteers in all regions of Kyrgyzstan. This is an issue in a country, where North and South are culturally different (the south is much more conservative), where languages are an issue (bi-lingual environment with strong preference of one language in each region), and where governmental youth networks are undeveloped. In addition, the process and the final product were already in local ownership and did not need to be handed over once the donor-funding would come to an end.

In Kyrgyzstan co-funding was provided by UNICEF. This happened coincidentally, but had far reaching implications. First of all, it was a good example of donor coordination and synergy, and it made the project financially feasible. Secondly, it opened the doors to the UN HIV theme group in Kyrgyzstan where other agencies committed themselves to print further copies. However, there were also certain drawbacks, such as a long debate within UNICEF whether or not abortion and contraception are to be part of the informational package – as in theory UNICEF has no mandate to advocate or provide information about those issues. The situation could finally be resolved by a compromise, whereby UNICEF provided funding for the development of the materials, yet removed its logo from the booklets’ cover.

Giving other partners permission to reprint the booklets allows for large-scale distribution far beyond a single project’s capacity.

While an organisation may fear to miss out on full recognition for its efforts invested into product development if it permits other partners to reprint the booklets, a win-win situation can be created if it is clear that both parties (and both logos) need to appear on each new edition. In resource poor settings, sex education material is unlikely to generate income for its producers. More and more organisations have realized this and only request to be mentioned in case of a reprint. In addition, organisations should be mature enough to understand that they are producing something for the sake of their target group and not for the sake of their own prestige.

Culturally sensitive products will result if all steps described above are followed

Many of the questions that young people pose are the same all over the world. But there is also a part (we estimate 20-40 %) that is specific to their respective socio-cultural contexts. These questions mainly relate to traditional educational messages, gender roles, parents’ expectations, experiences in the community, religious teaching etc. It is important to answer these questions because they stem from a certain value system, and the answers will shape attitudes, beliefs and eventually behaviours. It is therefore important that the selection of questions should be done at each new location, instead of opting for a “quick and dirty” adaptation of existing materials.

To answer culture-specific questions properly, medical professionals are not the best suited. Rather, local social scientists should be involved in this part of the process.
Lessons learnt in Kyrgyzstan

1. Time frame for production
The full production process is likely to take one to one and a half years, if done carefully and with full collaboration of youth and local organizations. This seems to be long, considering how straightforward the materials are in their final form. However, it is this simplicity and adequacy for local circumstances that take time to achieve. Even if there is a pressing need to provide sex education materials quickly, it is better to take the time needed to produce something meaningful than to rush the process and have the final product fall prey to justified criticism.

2. Contact addresses
It has proven useful to mention the address of a local organization on the back side of the booklets. Young people will turn to these contacts to request more booklets, to ask for further information or even as a contact address for young people in crisis. In Kyrgyzstan, the address of the national branch of RHAK was printed on the booklets and each regional branch obtained stickers to place the address of the local branch on an empty space on the back page.

Lessons learnt in Morocco: Developing booklets in traditional and religious contexts

It is important to base information for adolescents on context-specific and recent scientific data. In more traditional contexts like Morocco, public declarations on the importance of “adolescent sexual and reproductive health” are likely to create suspicion and resistance.

In a small inner circle of officials and experts study findings could be safely discussed. Here, the question how to handle young people’s thirst for information appealed to participants’ responsibility as parents, professionals and decision-makers and stimulated productive discussions.

The discrete background role of the German advisor to the Moroccan team was of utmost importance. The impression that non-Muslim professionals would bring in their outside values into such a sensitive realm was to be avoided at any stage.

Creating broad strategic alliances involving different departments of the ministries of health and education, the state secretariat for youth, local UN partners (UNFPA; UNESCO, UNAIDS) as well as NGOs engaged in youth promotion and/or thematically relevant areas (e.g. HIV) has been essential for the process. This culminated in a joint conference where sexual and reproductive health issues were discussed in an openness never experienced before.

A similar approach was chosen more recently in Yemen: Results of the collection of questions were first shared in defined “closed circles” within the Ministry of Health. Together with the National Population Council and under the patronage of the ‘Shura Council’, an important body representing all Yemeni clans, the collection of questions was presented in a national youth conference in April 2006. The process of booklet development in Yemen is ongoing.
Why this is a ‘Good Practice’

Effectiveness and transferability
During the last six years, the booklet-approach spread to 17 countries (see table 3). It has been implemented in a range of different cultural and social contexts. In all settings it was a success story as far as acceptance of and demand for the booklets by young people are concerned. Letters from young people requesting additional copies, letters of thanks, and letters from educators and parents were received everywhere. The demand for more booklets wherever they were distributed points at an unmet need for information and advice on sexuality for young people, in spite of the multitude of existing media and information channels.

Table 3 Spread 2000-2005

<table>
<thead>
<tr>
<th>Country</th>
<th>Language</th>
<th>Actual state of development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cap Verde</td>
<td>Portuguese</td>
<td>Baseline KAP and collection of questions conducted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adaptation of Tanzanian booklets on HIV and Condoms</td>
</tr>
<tr>
<td>Guinea</td>
<td>French</td>
<td>Guinean version developed with a local youth NGO, and printed</td>
</tr>
<tr>
<td>Kenya</td>
<td>English</td>
<td>English Tanzanian version used through community based lay health workers (CBDs) and youth centres</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>Kyrgyz</td>
<td>Series of booklets developed and printed</td>
</tr>
<tr>
<td></td>
<td>Russian</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tajik</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uzbek</td>
<td></td>
</tr>
<tr>
<td></td>
<td>English</td>
<td></td>
</tr>
<tr>
<td>Madagascar</td>
<td>Malgache</td>
<td>Translation and adaptation of the complete Tanzanian series</td>
</tr>
<tr>
<td>Malawi</td>
<td>Chichewa</td>
<td>Adaptation process finished, printed and distributed through youth centres</td>
</tr>
<tr>
<td></td>
<td>English</td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td>French</td>
<td>Adaptation process ongoing</td>
</tr>
<tr>
<td>Morocco</td>
<td>French</td>
<td>Baseline KAP and collection of questions conducted</td>
</tr>
<tr>
<td></td>
<td>Arabic</td>
<td>Series of booklets developed in French language. Currently being illustrated and translated into Arabic</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Portuguese</td>
<td>3 booklets on ‘HIV’, ‘Growing up’ and ‘Pregnancy’ adapted from Tanzanian version, and printed</td>
</tr>
<tr>
<td>Namibia</td>
<td>English</td>
<td>Tanzanian booklets reprinted with a Namibian Cover</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>Spanish</td>
<td>Went through all steps of the development process. Published with Ministry of Health</td>
</tr>
<tr>
<td>Ruanda</td>
<td>Kinyarwanda</td>
<td>3 booklets: ‘Growing up’, ‘Healthy relationships’ and ‘HIV’ adapted from Tanzanian version, and translated into Kinyarwanda; ready for print</td>
</tr>
<tr>
<td>South Africa</td>
<td>English</td>
<td>First test-run of Tanzanian version with peer educators of VW in work place intervention</td>
</tr>
<tr>
<td>Tanzania</td>
<td>English</td>
<td>Several reprints with various organisations, Kiswaheli version in Braille Script in preparation</td>
</tr>
<tr>
<td></td>
<td>Kiswaheli</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>Luganda</td>
<td>Local reprint of Tanzanian version in collaboration with KfW, in English and Luganda, first training of peer educators conducted by a local NGO</td>
</tr>
<tr>
<td>Yemen</td>
<td>Arabic</td>
<td>Questions collected and analysed</td>
</tr>
<tr>
<td>Zambia</td>
<td>English</td>
<td>Translation of HIV booklet in Tonga</td>
</tr>
<tr>
<td></td>
<td>Tonga</td>
<td></td>
</tr>
</tbody>
</table>
In some countries, the Tanzanian version was adopted, with minor changes translated into the local language, and the layout adapted to the specific context.

In other countries, the Tanzanian version was used as a first draft when working with young people on an appropriate local version (eliminating questions and adding others). However, the layout was always adapted to the country-specific context.

Where the socio-cultural setting differed significantly from the situation in Tanzania, the entire process described above was followed, resulting in quite different products, such as for example in Kyrgyzstan and in Morocco.

The overall amount of copies printed and distributed so far is about one million, with the biggest number printed and published in the country of origin, Tanzania. Here, the Tanzania Commission for AIDS reprinted copies for all primary school leavers and distributed the booklets through teacher training resource centres. The process of reprinting and adaptation is still ongoing. The English and French versions of the booklets can be downloaded from the internet.\textsuperscript{15}

\textsuperscript{15} \url{www.evaplan.org/website/evaplan/publications.html}

Different covers in different countries on booklet “Growing up”: Left in Mozambique, top in Kirgistan and below in Guinea
Participatory and empowering approach
The development of the sex education material is based on young people’s expressed concerns and questions. Together with them, responses have been developed, tested, and illustrated. Many of the young people said how much they appreciated having a chance to express their needs and to take part in the production of their own health communication materials.

Gender awareness
The present approach encourages girls and boys to express their specific needs and constraints, and they used this opportunity extensively. This is evidenced by questions related to the pressure of the norm ‘virginity up to marriage’, on the positioning of girls in the family and society, on menstruation, adverse affects of masturbation, etc., i.e. questions that young people can not pose anywhere else.

Innovation
The common approach to the often stated problem of young people’s lack of access to information on sexual and reproductive health issues is the development of “behaviour change” material by experts for the target group. The approach described here is in sharp contrast to such an educational top-down approach, in that it starts – bottom-up – with the target group’s questions and involves them throughout.

Comparative Cost-Effectiveness
In comparison with other approaches to IEC and behaviour change, the practice has been shown to be cost-effective and affordable both in terms of financial and human resources. In Tanzania, after an initial investment into the development of the set of booklets, cost sharing through re-print by other agencies led to an affordable broad dissemination process. In countries, where the existing set of booklets was adapted or even replicated, cost effectiveness is even better.

Sustainability
Again, no statement on the extent of sustainability of the practice in terms of ownership, commitment, capacity and funding over the long term can be made for all countries where this approach was implemented. In various countries, however, e.g. Tanzania and Morocco, the development and/or dissemination process has been taken on by national structures that appear to be committed to sustain the process at a broad level. Also, the involvement of and active demand by other organisations (NGOs, international, etc) contribute to the sustainability.

Many girls expressed concern about the constant control they are exposed to in their society (Morocco) (text in draft version)
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Sex education Booklets in Russian www.unicef.org/magic/bank/youthhealth.html or: www.unv.org.kg/eng/publ.htm

The booklets in the Internet

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Sex education Booklets in Russian www.unicef.org/magic/bank/youthhealth.html
Tools

The following tools and materials were developed in the course of this project and can be downloaded at

http://hiv.prp.googlepages.com/respondingtowhyoungpeoplereallywanttok

Samples of question-answer booklets on sexuality, HIV and AIDS in

- English
- French
- Spanisch
- Portuguese
- Russian
- Kyrgyz
- Uzbek
- Malgache
Abbreviations

AIDS  Acquired Immuno Deficiency Syndrome
CBD  Community Based Distributor (of Contraceptives)
GTZ  Deutsche Gesellschaft für Technische Zusammenarbeit GmbH
HIV  Human Immune-deficiency Virus
IEC  Information, Education, and Communication
KAP(B)  Knowledge, Attitude, Practice (Beliefs)
NGO  Non Governmental Organisation
PRG  Peer Review Group

STD  Sexually Transmitted Disease
STI  Sexually Transmitted Infection
UN  United Nations
UNESCO  United Nations Educational, Scientific and Cultural Organisation
UNFPA  United Nations Population Fund
UNICEF  United Nations Children Fund
WHO  World Health Organization

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