Tearfund Good Practice Guidelines
Niche Area Five
Behaviour change among children and young persons

1. INTRODUCTION AND DEFINITIONS

An estimated 2.7 million people became infected with HIV in 2008, of which 430,000 were children under 15 years. Data from Africa and Asia show that better educated people have less risk of contracting HIV. There is often a higher prevalence of HIV in poor populations. Why is this? Higher levels of education are associated with later age of sexual debut, fewer partners and more frequent condom use. Knowledge about HIV is usually greater in the more educated. Education has been described as ‘the best tool for cutting the infection’ and for ‘chipping away at the ignorance and fear, attitudes and practices’ that perpetuate the epidemic. However neither education on its own nor knowledge about HIV on its own prevents HIV. Knowledge plus commitment to safe sexual behaviour and life skills to enable effective negotiation out of unsafe sexual practices are necessary together.

There is no evidence that HIV prevention programmes using a single focus of either condom use or abstinence prevent HIV infection. A recent review of the effect of sex education and education about HIV on sexual practices shows very variable responses. Programmes that focus on individual behaviours (for example the ABC of Abstinence, Be faithful, use a Condom) fail to take account of the pressures that children and young people face. These include pressure on girls and women to engage in relationships with older, richer men who often have multiple partners, street vulnerability for young boys, and sexual coercion. Confidence and skills in negotiating to say “No” need to be developed if knowledge about HIV is to be put into effective practice. Fidelity requires agreement of both partners and does not take into account previous experience or HIV status of the individuals involved. The review shows that there are enough examples of programmes that work effectively to change behaviour that this can and should be a key part of any programme supported by Tearfund. The issue is to recognise that multiple interventions are needed at the same time before change can occur. Just encouraging knowledge gain is not enough.

Intravenous drug use (IDU) drives the HIV epidemic in Eastern Europe (Russia for instance has 5 million IDUs) and significant parts of Asia. Infection through unclean needles is then transmitted to sexual partners and to the newborn child.

The acronym SAVE has been developed by the African Network of Religious Leaders living with, or personally affected by HIV and AIDS (ANERELA+). Safer practices cover the range of measures necessary to prevent HIV transmission. A theology of harm reduction has been developed, which provides a biblical understanding to the adoption of this approach. Available medications, Voluntary counselling and testing and Empowerment emphasise the need for an integrated approach to prevention.

Tearfund’s strategic response has an integrated approach to the prevention of HIV. Linked themes are covered in the documents on Access to treatment (niche area 3), Stigma and discrimination (niche area 4), Impact mitigation (niche area 2), and prevention of transmission from parent to child (niche area 1).

2. NGO CODE OF GOOD PRACTICE IN HIV

The NGO Code of good practice, which Tearfund subscribes to, calls for communities to gain knowledge about aspects of HIV which include:

- Method of transmission, risk of HIV infection and means of prevention
- Risk reduction methods – what they are and how to access them, including commodities for prevention (condoms and sterile injecting equipment).
- Access to voluntary testing and counselling, care and support.
- Consequences of HIV infection and the consequences of discrimination
Methods of passing on this knowledge include:

- Social marketing (using advertising and marketing techniques to achieve specific behavioural goals) of male and female condoms and community education programmes to influence communal norms for safer behaviour.
- Use of culturally acceptable methods such as drama.
- Use of opinion formers such as youth leaders, sports stars, singers.
- Individual counselling, discussion groups and peer support.
- Communication to national or international agencies for advocacy relating to HIV risk – economic, social, legal and cultural.

Underpinning all of these is the importance of the participation of people living with HIV and AIDS (PLHA), under the movement of ‘Greater Involvement PLHA’ (GIPA) in all aspects of programming (planning, policy and implementation).

3. GUIDELINES FOR PRACTICE

3.1 What would this mean for the person living with HIV (PLHA)?
- Young people with HIV will understand the risk they pose to others and how to minimise that risk.
- Intravenous drugs users will have the opportunity to access a range of services to enable them to protect themselves, their fellow drug users and their sexual partners.
- There will be a decrease in stigma and discrimination towards people, in particular children, living with HIV and AIDS in the community.

3.1.1 What would this mean for young people who are HIV negative?
- There will be an understanding of the benefit of abstaining from sexual activity until marriage and of then remaining faithful to one partner. There will be an understanding of the dangers of intravenous drug use and the benefits of abstinence.
- Young men and women will develop self-confidence and skills in negotiating demands for sex in order to say “No” in order to control their sexual behaviour.
- Those who are unable to abstain from sexual activity or drug use, including those who are at risk of HIV infection from their regular sexual partner, will understand that risk and how best to minimise it.

3.2 What should Tearfund-supported projects implemented by partners cover?

3.2.1 Define the target group of youth that the education is aimed at. Specific messages that are suitable for specific ages, genders and cultures need to be developed. There is a need to include youth who are most at risk, and who will be often hardest to reach. Education alone is insufficient. There needs to be a series of interventions which enhance respect and confidence building.

3.2.2 The methodology and content of the education should be designed to address the needs of the particular target group, with input into this by youth belonging to the target group, PLHA and community leaders. Factors to be considered may include:
- Reviewing evidence-based existing materials developed by other agencies to consider using rather than designing new materials – in particular, consult with National Aids Committees, WHO and UNICEF in country.
- Age of commencing education. Bear in mind that children in poor communities are often at high risk of HIV and often do not go to school.
- Particular local risk factors needing to be addressed; Female Genital Mutilation is likely to increase HIV risk.
- How best to link HIV related messages to local interests of children and young people.
- Opposition to education, condom use and other harm reduction strategies. Tearfund partners should assess potential difficulties caused by local church and community leaders, school governors and parents groups to assess the reasons for opposition and challenge these attitudes.

Programmes that involve educating youths at school have the potential to reach large numbers, and provide an opportunity to work with the same group of youth in a formal, structured setting. Without this, providing broad and understandable information is difficult. The Life skills programme, designed by UNICEF, instructs teachers in designing lesson content and in participatory methods of
teaching. The aim is for school-based education about HIV to become an integral part of the curriculum. Minimum content is basic facts about HIV, but also necessary are skills in critical thinking, decision-making, communication and interpersonal skills. Discussion on gender roles and responsibilities may help students set and maintain personal boundaries. Preliminary evaluations show that Life Skills Programmes delay the age of sexual debut and reduce adolescent pregnancies.

Recommendations for the life skills approach to maximise effectiveness include:

- Take into account realities of pressure in classroom teaching, including the death of teachers and parents from AIDS, and consider how to support the school as a whole.
- Provide adequate teacher training and support, as many are regularly using didactic teaching methods and lack comfort and experience with participatory methods.
- Ensure the involvement of parents and community leaders prior to implementation.
- Start before youth are sexually active.
- Focus on HIV and AIDS. Do not make the content so broad that the messages are lost, or sexually sensitive topics not even mentioned.
- Ensure that girls in the school are not being sexually harassed.
- Decide on when to use single sex groups and when to integrate boys and girls in the same session.

Out-of-school youth can be divided into two groups and require different approaches. Mainstream – those who are part of a stable and supportive family or community and often have contact with church, community groups or other services. They may be from rural areas, be too poor to attend school or they may have left school due to pregnancy.

Other out-of-school youth are marginalised. They include youth living on the street, child soldiers, child sex workers and orphans in child headed households. They have weak or no ties to families or religious and community supports.

For marginalised youth in particular, curricula need to be designed for maximum learning in short sessions and have strategies that bring children back for repeated contact. Innovative approaches are to be encouraged. Food, shelter and skills training are often specific needs to address, in addition to providing education regarding HIV and AIDS and reproductive health.

Intravenous drug users:

- The most effective way to reduce risk of HIV transmission is to stop drug use. However, this is influenced by individual and social factors and may not be possible.
- Drug dependence treatment with psychotherapy and pharmacological replacement can be part of a programme addressing behaviour change.
- Sterile needle and syringe access, which is combined with education, condom distribution, bleach distribution for disinfection and referrals for treatment or other services.
- Outreach and education rely on peers and local health workers to identify IDUs.
- The risk of HIV infection from unsafe sex needs to be specifically addressed in addition to information about prevention due to drug use.
- Regular networking with police, government and agencies doing similar work is essential.

"Rounding up" IDUs and putting them in “Correction Centres” rarely produces any long term change in behaviour.

3.3 How can people living with HIV be involved?

- Youth living with HIV are a valuable resource in designing and implementing educational programmes, knowing first hand of the causes and implications.
- If confident to disclose their status, the testimony of PLHA can be particularly powerful.
- Effective treatment of intravenous drug users can rely on having former drug users as field workers, to make the contact with users and to follow-up for treatment and rehabilitation.
- Participation of PLHA should be encouraged at all levels of the organisation and programmes.

3.4 Understanding the gender dimensions within the area

Women are three times more likely to be infected during intercourse than men, and this is worse if the woman is young with an immature genital tract or if she is subjected to forced sex with trauma. Poor women are less likely to receive education and health care than men and likely to be socially and
economically dependent upon men, which can limit their power in negotiating sexual activity. Girls involved in child marriage to older men are particularly isolated and at risk of infection. Gender norms and taboos often keep women uninformed about their bodies and sexual health. Poor young women may exchange sex for money or gifts with older men.

It can be difficult to design programmes to overcome these challenges. It requires active participation of women in programme design, management and implementation and is crucial if the spread of HIV to young women is to be averted.

3.5 Relationship to homecare

- Home based care givers can link the local community, in particular marginalised and other high risk youth, with prevention programmes.
- They can assist in discussion with parents regarding education for youth.
- Caring skills provided for families with HIV can be extended to support basic needs provision for youth on the streets.
- Where intravenous drug use exists, home carers may already be in contact with other drug users living with HIV, and so be able to link up family members, neighbours or other friends who are addicts with social services, treatment and prevention programmes.

4 KEY INDICATORS

Baseline measurement of these indicators will be part of project planning and be included in the initial proposal submitted to Tearfund. This may be carried out by the partner organisation or rely on information gathered by other agencies within the target community.

- Percentage of couples approaching local churches for marriage preparation who choose to have HIV testing prior to marriage.
- Rate of Adolescent Pregnancies.
- Attitudes of youth to people with HIV and AIDS. There are specific questionnaires to assess this – referred to in Niche 4 – Ending stigma
- Correct knowledge of youth to five standard questions about HIV transmission:
  1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
  2. Can the risk of HIV transmission be reduced by using condoms?
  3. Can a healthy-looking person have HIV?
  4. Can a person get HIV from mosquito bites?
  5. Can a person get HIV by sharing a meal with someone who is infected?
- Age at sexual debut.
- Number of sexual partners in the previous 12 months.
- Both the above indicators can be assessed using standardised questionnaires which are filled in anonymously by adolescents. These provide an indication of activity but are always subject to bias. It is advisable to add a questionnaire assessing the reasons for taking unsafe behaviour.
- For high risk youth:
  o condom use with last partner
  o clean needle with last injection
- Both these indicators can be assessed using standardised questionnaires which are filled in anonymously. It is advisable to add a questionnaire assessing the reasons for taking unsafe behaviour.
REFERENCES

13. Guardians of our Children’s Health – to be launched by Tearfund.