

**Does peer education
work in Europe?**



Entre Nous

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EDITORIAL

By Gunta Lazdane and Jeffrey V. Lazarus

Does peer education work in Europe?

Dr Gunta Lazdane



Photo: Jeffrey Lazarus

Jeffrey V. Lazarus



Young age has always been the time in one's life when many choices must be made. Some of them are mysterious and attractive, perhaps based on the experience of a friend or the image of a movie star. But how to make the choice with no harm to yourself, your parents and society is something young people often cannot figure out, as evidenced by this being the age of the highest rates of unwanted pregnancies, sexually transmitted infections (STIs) and HIV/AIDS. This is where peer education can play a role.

More effective means than just teachers or physicians are needed for reaching young people and initiatives promoting peer education are now spreading across Europe, led by the UNFPA, UNICEF, IPPF and WHO. Throughout this issue of *Entre Nous* the argument for peer education is reinforced, with examples of how peer education works.

The first article, on pages 4 to 6, explains the main theories and models employed in peer education, which focus on behaviour change, and concludes with an exercise to help understand the application of theoretical and other methodological approaches to behaviour change in practice. The importance of peer education in a time of increasing incidence of STIs/HIV/AIDS is the topic of the next three articles, looking at different experiences throughout Europe, from Denmark to the Russian Federation.

On page 13, the use of theatre in peer education is highlighted. The authors of the article co-facilitated an advanced peer education training of trainers held in Estonia, early this year, in which young people from throughout central and eastern Europe and the former Soviet Union learned how to run peer education sessions. Icebreakers to get participants comfortable with one another and a review of the theory were combined with role-playing and other interactive activities that can be adapted to work with most groups of young people. A forthcoming manual and CD-ROM on this will be presented in *Entre Nous* upon completion.

While peer education is key, proper medical training for physicians attending adolescents is also crucial. More than 500 professionals from across Europe have already used a new training curriculum in adolescent medicine and health, focusing on professionals working in the field of sexual and reproductive health. While physicians are the focus of the article on pages 14 to 16, the following article looks at Hungary's experiences with sex education through the decades. Unfortunately, after nearly 30 years since "education for family life" was made compulsory in schools, adequate conditions for its success are still absent.

The final two articles look at the role of medical students in peer education. Although often older, they are still not

yet authority figures out of touch with young people. Both articles report the enormous success of programmes in which medical students work to reduce HIV incidence. Moreover, the International Federation of Medical Student's Associations is working together with WHO to jointly scale up education, empowerment and training on HIV/AIDS for medical students.

This issue of *Entre Nous* comes on the heels of World Population Day, celebrated on 11 July. This year the theme was "One billion adolescents: the right to health, information and services", which highlights the need to support young people in their efforts to lead safe, rewarding lives and contribute to the well-being of their families and communities. United Nations Secretary-General Kofi Annan put the situation best when he stated: "...If the world is to achieve the Millennium Development Goals and implement the programme of action adopted at the International Conference on Population and Development in Cairo in 1994, the most effective interventions will involve young people themselves. It is they who can best identify their needs, and who must help design the programmes that address them".

Entre Nous will further review progress on implementation in Europe on the International Conference on Population and Development Programme of Action in upcoming issues, as well as look at the Millennium Development Goals.

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PEER EDUCATION WITHIN A FRAME OF THEORI

Srdjan Stakic, Robert Zielony, Aleksandar Bodiroza and Greta Kimzeke

What is peer education?

Peer education in youth is the process whereby well trained and motivated young people undertake informal or organized educational activities with their peers (as defined by age, background or interests) over a period of time, aimed at developing their knowledge, attitudes, beliefs and skills and enabling them to protect and be responsible for their own health.

Peer education can take place in small groups or through individual contact and can take place in a variety of settings: in schools, clubs, religious settings, workplaces, on the street or in a shelter, or wherever young people gather.

Examples of youth peer education activities are:

- Sessions with students using interactive techniques such as group brainstorming, role plays or personal stories;
- A theatre play in a youth club, followed by group discussions; and
- Informal conversations with young people at a disco about risky health behaviours and referrals to service providers.

Peer education can be used with many populations and age groups for various goals. In the past decades, peer education has been used extensively in HIV/AIDS prevention and reproductive health programmes around the world. Moreover, it advocates the right of young people to participate in processes which affect them and to access the information and services they need to protect their health.

Why peer education?

Peer education has several advantages over other health education and promotion methods. One important advantage of peer education is the perceived credibility of peer educators in the eyes of their target group. Youth exposed to peer education often praise this approach because it is eased through a shared background between the educator and his/her audience in areas such as themes of interest, tastes in music and popular celebrities, use of the language, family themes (brother and sister issues, struggle for independence, etc.), and role

demands (student, team member, etc.). Another advantage of peer education is that youth peer educators are less likely to be seen as authority figures “preaching” about how others should behave. Rather, the process of peer education is perceived more like receiving advice from a friend “who is in the know”. A successful peer educator is viewed by his or her peers as someone who has similar concerns, is trying to help out, and has an understanding of what it is like to be a young person.

Peer

refers to a person who belongs to the same social group as some other people based on age, sex, sexual orientation, occupation, socio-economic and/or health status, etc.

Education

refers to the development of a person's knowledge, attitudes, beliefs or behavior resulting from the learning process.

Theories and models of behaviour change are essential parts of peer education programme proposals and development. Their inclusion alleviates the possibility of missing an essential component of the intervention. In addition, peer educators with this theoretical background are more likely to achieve their desired results through a peer education effort. This article is a brief review of peer education and some relevant theories and models of behaviour change. It concludes with an exercise on helping peer educators' transition from theory to practice.

Behaviour change theory and models

When undertaking a peer education programme, our overall goal is to develop a recommended behaviour or to change (risky) behaviour in a target group. In this context it is important to know why and how people adapt new behaviours. The fields of health psychology, health education and public health provide relevant behavioural theories and models which explain this process. They provide a rationale for why peer education is beneficial and they can guide us in planning and designing peer education interventions.

The following theories and models are of particular relevance for peer education:

1. IMBR model: Information, motivation, behavioural skills and resources
2. Health belief model
3. Theory of reasoned action
4. Social cognitive theory
5. Trans-theoretical/stages of change model

IMBR model: Information, motivation, behavioural skills and resources

The IMBR model addresses health-related behaviour in a comprehensive, clear manner applicable across many cultures. It focuses on information (the what), motivation (the why), behavioural skills (the how) and resources (the where, when and whom) that can be used to target risky behaviours. As an example, if a young person knows that proper use of condoms may prevent the spread of HIV, s/he might still need to be motivated to use them, need the skills involved in using them correctly, and need to know where, when and from whom to acquire them.

A peer education programme that does not have a comprehensive approach including the above-mentioned dimensions probably lacks essential components for reducing risk behaviour and promoting healthier lifestyles. For example, a programme might be strong on teaching information but lack adequate emphasis on skills training. Such a programme might explain to young people the need for contraceptive use and describe contraceptive methods, but might omit demonstrating their proper use. Participants would then be informed about what to do but not how to do it.

Other programmes may be strong on both information and skills, but fail to truly "reach" their audience because they lack appropriate motivational components. These programmes could leave participants with knowledge of what to do and how to do it, but without strong emotional or intellectual reasons as to why they would want to practise certain healthy behaviours. Although resources can be considered part of "information", it is worthwhile to highlight the importance of providing youth who are being trained with information about how to access appropriate resources or services beyond the scope of peer education sessions. Such resources might include youth friendly clinics, counselling services, HIV/STI and pregnancy testing and care programmes, and commodities such as condoms and contraceptives.

Health belief model

The Health belief model was developed in the early 1950s and is used to explain and predict health related behaviour,

mainly through a person's perceived susceptibility to a health threat, perceived seriousness of the possible illness, perceived barriers or costs of changing behaviour, and perceived benefits of changing the behaviour.

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 available to a person would prevent illness (expectancy), then a positive behavioural action would be taken towards that behaviour.

The most salient relevance to peer education in the Health belief model is the concept of perceived barriers, or one's opinion of the tangible and psychological costs of the advised action. A peer educator identifies and reduces perceived barriers through reassurance, correction of misinformation, incentives and assistance. For example, if a gay man does not get tested for the fear of being stigmatised at the local health clinic for his sexual behaviour, the peer educator may provide him with information on a gay-friendly health centre.

However, the Health belief model of behaviour change does not account well for habits, attitudes and emotions/mood (1). Although good to use, when implementing the Health belief model into our work, we must consider the effects of the following factors on behaviour such as culture, social influence, socio-economic status and personal experiences.

Theory of reasoned action

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

1. The person's attitudes towards this behaviour: his/her beliefs about the consequences of the behaviour. For example, a young woman who thinks that using contraception will have positive outcomes for her will have positive attitudes towards contraception use;
2. The person's subjective normative beliefs about what others think he/she should do and whether important referent individuals approve or disapprove of the behaviour. For example: a young man whose male friends engage in promiscuous sexual relations may accept that behaviour more easily.

In the context of peer education this con-

cept is relevant considering:

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

Social cognitive theory

Social cognitive theory is largely based upon the work of Albert Bandura. He states that people learn:

- Indirectly, by observing and modelling



of others with whom the person identifies (for example, how young people see their peers behaving); and

- Through training in skills that lead to confidence in being able to carry out a particular behaviour. This specific condition is called self-efficacy, which includes the ability to overcome any barriers to performing the behaviour. For example, practising correct condom use in a condom demonstration is an important activity leading to self-confidence when talking about safer sex methods with a partner.

In the context of peer education it means that the inclusion of interactive experiential learning activities are extremely important, and peer educators may act as important role models.

Trans-theoretical/stages of change model (2,3)

This model describes a sequence of stages in changing health-related behaviour. It uses the stages of change from across major theories of intervention, hence its name: trans-theoretical. This model is a preferred design for assessing and targeting the behaviour of an individual rather than a group, since people may be at enormously varying places with respect to their attitudes, behavioural experience and intentions. These are the six stages through which a person may go in the process of changing a behaviour:

1. Pre-contemplation (Has no intention to take action within the next 6 months);
2. Contemplation (Intends to take action within the next 6 months);
3. Preparation (Intends to take action within the next 30 days and has taken some behavioural steps in this direction);
4. Action (Has changed overt behaviour for less than 6 months);
5. Maintenance (Has changed overt behaviour for more than 6 months); and
6. Termination (Has no temptation and has 100% self-efficacy (in addictive behaviour).

Summary

Inclusion of behaviour change theories and models in programme design is essential to a successful peer education effort. Moreover, theories and models of behaviour change provide a framework in which to measure and evaluate programme accomplishments and downfalls. Funding, sustainability and the overall success of peer education initiatives thus depend on the successful use and application of behaviour change theories in practice by administrators and peer educators alike.

Exercise: Theory – Practise it

Objective

To help participants understand the application of theoretical and other methodological approaches to behaviour change in practice.

Time

30 minutes

Materials

Large sheets of flipchart, markers and tape.

Preparation

After the presentation of theories and models relevant to peer education, the participants are instructed to separate into three groups, each with a sheet of flipchart paper and markers.

Process

Ask participants to choose one programme in which one of their group members is involved and to analyse all aspects of it: what, where, and how. Then ask them to outline it on the sheet of paper and identify the theories and models (or parts of theories and models) that are being used in this programme. Explain to them that multiple theories and models may be used in the same programme and that only some aspects of theories and models may be used. Ask the group to present their views to the larger group.

Closure

Point to the fact that we are all already using theories and models of behaviour change in our everyday work, yet that we are often not aware of it. Initiate a discussion on the topic of why there is a need for the inclusion of organized theoretical and methodological approaches to behaviour change. Emphasize once more that a theory or a model does not have to be used in its entirety, and that different segments from different theories and models can be used in the same programme.

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PEER EDUCATION AND HIV/AIDS: HOW CAN NGOS ACHIEVE GREATER YOUTH INVOLVEMENT?

Lise Rosendal Østergaard

The Danish Family Planning Association has compiled experiences from young people and representatives of NGOs from Europe, Africa, Asia and Latin America on how peer educators can be used at the forefront of HIV/AIDS prevention. In particular how projects and programmes can be open to youth participation at all levels of the project cycle. The message from the young people was that it takes participation to make a peer-education project meaningful. The lessons learned from the participants has been published in a catalogue of ideas and now informs the work of the newly established Danish network of NGOs and research institutions working with HIV/AIDS.

Peer education is not only an approach that for a long time had been a key element in the activities of many NGO and community-based organizations, it has also been acknowledged as an efficient strategy by the international community and the public sector. At the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, specific targets and timeframes were set. It was noted that "By 2005, to ensure that at least 90%, and by 2010 at least 95% of young men and women aged 15-24 have access to the information, education including peer-education and youth-specific HIV education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection in full partnership with young persons, parents, families, educators and health-care providers".

Peer education in the wordings of the UNGASS declaration is concerned with young people. In reality a peer can be of any age. It is a person of equal standing as the target groups or someone 'who walks in the same shoes'. It is a person who belongs to the same societal group especially with regards to age, status and locality. Total identification is, however, rare. People who are likely to invest their time and energy in a project, often on a voluntary basis, are often those with a relative high amount of resources. Peer education can be young-to-young, when the educators match the age of the target group, or young-to-younger when they are a bit older. Practical application of peer education varies from one country to another but most often includes advo-

cacy, counselling, facilitation of group discussions, drama, lecturing, distribution of information materials and referrals to services.

But why has peer education in particular become so popular over the past years in relation to HIV/AIDS prevention, care and support? It is obvious that the multi-dimensional nature of the HIV epidemic and the many challenges that it puts on the communication and behaviour change programmes call for initiatives that are not only health related but also societal related. As peer education typically involves the use of members of a given community that is affected by HIV/AIDS, they are more likely to be able to induce changes among members of the same group by negotiation, example and discussions. They can attempt to modify the sexual risk-taking practices by



In May 2003, the Danish Family Planning Association (Sex & Samfund) published a handy guide to improve peer education. "Dialogue in Prevention/Expert in Being Young" addresses the needs of programme managers on how to organize a peer education project as well as the needs of peer educators themselves. It provides practical advice on how to recruit, train, retain, bid farewell and phase out the individual peer educator in order to give the volunteers as much of a professional competency as possible. It also prepares the peer educators for the many challenges ahead, including how to safeguard integrity. Many peer educators use personal experiences on sexual debut as an icebreaker, but they must be aware of their own limits and use their skills to tell only as much as they feel comfortable with. The booklet is being distributed by the health authorities in the Danish counties.

a certain group by working on their knowledge, attitudes, beliefs and behaviours.

The theoretical base of peer education is behavioural theory, assuming that people make change based on progressive steps of understanding and interiorising the relevance to their own situation. People do not make change in their personal life because of scientific evidence (in that case there would be very few smokers left!). They are much more likely to modify their practices because of the subjective judgement of a person that they have confidence in who has adopted the same changes and who can serve a credible role model.

At the international Mahler Forum 2001, organised by the Danish IPPF affiliate: the Danish Family Planning Organization, the participants all agreed on the fact that peer education projects were critical to the level of activities in their respective organisations. As a matter of fact, many of the organizations would be unable to maintain the high level of out-reach activities if it were not for the peer educators. That is not only for obvious financial reasons: peer educators often work on a voluntary basis where they receive a limited compensation for their work, but also because of the unique access that the peer educators hold to the intended audience. Young peer educators do not only know the whereabouts of the targets groups much better than policy-makers and programme managers, they also know how to catch their attention and how to initiate a dialogue with them.

That is in particular important in relation to such sensitive issues as sexual and reproductive health, including HIV/AIDS. As a Finnish Mahler Forum participant from the Finnish Family Planning Organization noted: "It can be very embarrassing to talk openly about sexuality in general and teenage sexuality in particular. Talking about young people's sexuality is often automatically related to irresponsible and experimental 'running around' – how can we, the adults, understand young people's sexuality in a broader sense that also includes feelings and love?" The obvious answer to that question was given by many of the young participants, namely to use peers, as they are closer to the context of the

young people at risk and can frame the message in a way that resonates with a young audience.

There has been a moral-based tendency to judge teenage sexuality as promiscuous. That attitude has been detrimental to proper information. Poor negotiation and communication skills of adults, be they health care professionals, teachers or others, who do not share a common language with young people, can become a barrier to HIV prevention. For adults it is often a question of which words to use in order to pass a message to young people. Experiences gained through a peer education project by the Ukrainian Family Planning Association called 'Be Safe, Be Careful, Be Happy' points at the necessity of adopting a frank language. The importance of being careful and paying attention to the needs of young people by responding to their expectations with their own language was underlined by one of the participating peer educators.

It is obvious that peer education is a window of opportunity for face-to-face communication because of the peer educators' critical access to young people. Yet, new information technologies provide a whole other variety of entry points for HIV-information. Several participants at the Mahler Forum had already gained experience with the use of new technologies to reach a bigger audience with sexual and reproductive health information. IPPF in the Balkans has set up a regional youth website to overcome barriers to young people's access to confidential information in Bosnia, Herzegovina, Croatia, Kosovo, The former Yugoslav Republic of Macedonia, and Serbia and Montenegro. In Denmark, the Danish Family Planning Association supports an AIDS telephone hotline as well as youth sex telephone hotlines, internet-based counselling services for young people and class-room-based education services for school learners. The diversity of channels of information has been massively promoted through advertisements, hand-outs, posters and streamers in order to make people use them. A number of youth counsellors, peer educators, have been trained, many of them medical students and all volunteers. They receive regular supervision and refresher training

including factual knowledge on sexual health topics but also on issues related to lover relationships and gender norms and values to overcome the tendency to focus solely on technical issues. One of the Danish counsellors pointed out that although they try to adopt what he calls "an unbiased approach to condom promotion" it has proven to be a rather poor approach to talk about condoms as an isolated subject, so they prefer to address issues of sexuality in a broader context.

What are the features of successful peer education programmes? First of all, the effective youth participation and involvement at all steps of the project cycle seems to be critical. It has for a long time been recognized that participation is a means to achieve greater project efficiency and is an end in itself to improve human development. It is, however, not always easy for programme managers to "hand over the baton" and to share power and resources with the young peer educators. Youth participation can be defined as young peoples' partaking in and influencing processes, decisions and activities. For that to happen they must be fully included at all steps of the project cycle. If that is the case, peer educators can become not only empowered but

also partners in the project - partners that might raise criticism of certain procedures and practices. In that respect it is important that the organization is prepared for that.

Second, the selection of peer educators is crucial. There has been a tendency to accept almost anybody who is ready to do voluntary work, but to have an efficient programme there must be certain criteria for selection including age, skills and attitudes.

Third, training and supervision must be consistent and regular. It is demotivating for peer educators to lack technical information and up-dated knowledge and a two-week initial course will not be sufficient. Resources must be allocated to conduct supervision of the peer educa-



The Danish Family Planning Association (Sex & Samfund) is the leading association in Denmark in the field of sexual and reproductive health and rights. It works for a society with sexual wellbeing, wanted children and no sexually transmitted infections. The mission of Sex & Samfund is the creation of the highest attainable physical, psychological and social conditions for reproduction, to ensure easy access to safe, affordable contraceptives and safe abortion. It advocates the right to sexual education, sexual wellbeing and reproductive health, including family planning as human rights both in Denmark and internationally.

Confronting HIV/AIDS through Youth Involvement



The Danish NGO Aids Network is a newly established alliance of 18 international and national NGOs working with HIV/AIDS prevention, care, support and treatment and Nordic research institutions. The aim is to build a bridge between international project work and research in order to strengthen the capacity of the NGOs to undertake evidence-based interventions, to build a platform for knowledge sharing and to document the policies, strategies and use of evidence by the NGOs. The Danish Ministry of Foreign Affairs has funded the network for an initial three-year period.

THE WORK ON YOUNG PEOPLE IN THE WHO REGIONAL OFFICE FOR EUROPE

David Rivett

In recent years, the work of the WHO Regional Office in supporting countries in building programmes focused on young people (ages 10 to 24) has extended. The major programme for this age group has been the European Network of Health Promoting Schools, now active in 43 of the 52 countries in the Region.

This programme assists countries in creating the conditions for all schools to be able to adopt and sustain health promoting school approaches. Evidence is beginning to show that schools adopting these approaches are creating safe and supportive living and learning environments which assist young people in making informed choices about their health.

Following the creation of the programme for the Promotion of Young People's Health in 2000, collaboration with other United Nations partners on activities such as peer education was initiated in order to maximize the advantages each agency possessed in specific fields. The agencies are building a consensus on best methods and approaches in designing and implementing peer education programmes. Participation of young people in the learning process is clearly an effective way of building knowledge. Peer education is now being used more frequently as a means of informing young people and building their skills in areas such as HIV/AIDS, drug use and conflict resolution.

A further programme being developed jointly is one on life skills-based education. Currently, this programme is school based and uses the health promoting school as the most effective vehicle for its implementation. However, the agencies are looking to build programmes for out of school and peer education is one of the approaches to be used in this context. Life skills-based education builds knowledge, attitudes and skills into the learning process. The programme makes links with Ministries of Education and advocates for life skills-based education's inclusion in curriculum planning and teaching and learning methodologies, especially in health education.

The most recent joint programme is one addressing the development of youth friendly health services. This programme

began in February 2002 when the agencies held an inter-country consultation with senior health policy-makers and planners, and representatives of young people and NGOs from Bulgaria, Estonia, Latvia, Lithuania and the Russian Federation (Kaliningrad and Saint Petersburg). Following the consultation, a youth friendly health service (YFHS) mapping exercise in 18 countries was undertaken. This provided immensely rich data on YFHS provision and has prompted another consultation meeting, this time in south-eastern Europe: Albania, Bosnia and Herzegovina, Bulgaria, the Former Yugoslav Republic of Macedonia, Kosovo, Moldova, Romania, and Serbia and Montenegro. This consultation, to be held in September, in Sofia, Bulgaria, aims to sensitise key policy-makers and advisers, programme managers and young people to the concept of youth friendly services and to share examples of best practice, to apply the criteria of youth friendly services to existing service provision, to introduce participants to the notions of mapping, monitoring and evaluation of services, to identify steps for the introduction of quality in youth friendly services provision and to review the lessons learned and identify strategies for scaling up best practice in south-eastern Europe.

Information and reports about all these activities are available from the team in the Young People's Health Programme: bdm@euro.who.int

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tors. Not only to ensure that they disseminate correct information but also to support them and create a sense of team spirit.

Finally, the programme must acknowledge that young peer educators are a very diverse group. The programme must be adapted to the fact that they might be in-school and cannot be expected to work at certain hours. Furthermore, they must at least be compensated for their out-of-pocket expenses.

For further information about the catalogue of ideas "Confronting HIV/AIDS through Youth Involvement: A Catalogue of Ideas for NGOs" please contact the Danish Family Planning Association at danish-fpa@sexogsamfund.dk

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SEXUAL HEALTH PEER EDUCATION AMONG YOUTH IN SAMARA, THE RUSSIAN FEDERATION

Jenny Bluhm, Mikhail Volik and Nicola Morgan

The Russian Federation, Ukraine and Estonia are facing the fastest growing rates of HIV infection in the world.



“We can’t cure AIDS, but we can easily prevent it. Let’s do it together!” is the PSI/Samara moto.

Surveys conducted by Population Services International (PSI) in many Russian cities and regions all yield the same alarming results – while 99% of youth have heard about HIV, and most (80%) consider HIV a problem for Russia, very few consider themselves at risk, believing HIV is a disease which only affects gay men or injecting drug users. Though this has been historically true in Russia, data collected in recent years has revealed a significant increase in HIV infection through sexual transmission, particularly among youth aged 15–25.

Programme background

PSI/Samara has 25 active volunteers, and to date eight have qualified as peer educators able to provide education without supervision. The remaining volunteers work at organized activities held at nightclubs, sports clubs, and street events where they distribute materials and answer questions posed to them. With time and training many of the volunteers go on to become qualified peer educators.

The volunteers are predominantly 15–24-year-old students, and though their reasons for becoming involved vary greatly, they all share the same desire to educate other youth about how to protect themselves from STIs/HIV/AIDS.

PSI/Samara has no need to advertise these positions rather volunteers come of their own initiative, often after reading an article in the newspaper, observing the current volunteers in their bright yellow shirts at youth events and in schools, or having had a first-hand experience as a recipient of peer education sessions, which have inspired them to become involved themselves.

Masha (age 15), a new recruit, took part in four peer education sessions held by PSI/Samara at a local government family centre. She gained extensive knowledge about HIV/AIDS and safer sexual behaviour that enabled her to talk more openly with her friends and family. “Without any problems I can now talk about different problems of sexual life”.

Becoming a volunteer

Upon arriving at the PSI office for the first time, each volunteer is welcomed warmly and made to feel included and

valuable. The PSI/Samara peer education coordinator, Doctor Mikhail Volik, gives new recruits individual attention and helps identify their motivations for joining, their expectations of PSI/Samara, and their personal needs and resources. An experienced volunteer is then matched to the new recruit to provide guidance and support. Dr Volik also invites volunteers’ parents to the office to reassure them that their children are in safe hands and are not promoting sex, but educating others in STI/HIV prevention.

Week after week the volunteers return not only for the scheduled training afternoons but also to attend several activities in HIV prevention held during the week at sports clubs, nightclubs or on the streets. “Very interesting people are working at PSI/Samara and I am making a lot of new friends here.” (Nastja, age 17, volunteer). When asked “Why did you come here today?” replies inevitably include “to meet my friends”, “to feel better after a stressful day at school” and of course “to get to know more information about HIV/AIDS”.

“It is a good feeling to know that you personally, with your knowledge and engagement, can do something against the spread of HIV: among your friends, in your school and in your town” (Jenny, age 22, peer educator).

Peer education training

The training itself is made up of a database of modules, where one module logically follows another. Usually, the first modules help participants feel comfortable together and open to discussing sexual health. The peer educator at times will separate the groups into male and female, or older and younger participants as their information needs are often different. All modules are interactive and entertaining. Many of the favourite modules include role-playing and games that challenge personal risk assessment.

The training covers many different themes relating to technical knowledge of HIV, methods of protection from HIV and STIs (including abstinence, partner reduction and condom use), HIV myths, stigma associated with HIV, and psychological and communication skills (initiating conversations with youth at events, developing good listening skills, etc).

Each training session combines general and specific knowledge, communication skills and tools and games available for providing training to other youth.

"I have become more communicative and self-confident since becoming a volunteer" (Anton, 17, peer educator). Dasha, a medical student, says: "I am able to use my knowledge at university - some of my teachers do not know much about HIV/AIDS and so they come and ask me for information."

To become a peer educator volunteers participate in approximately 20–30 training sessions, and when they feel ready, complete a computer-based test and an oral examination. On passing, the peer educator is deemed capable of providing independent peer education in schools, youth camps, hostels and universities.

"There are questions I have to answer almost every peer education session or event. For example: 'Can I be infected with HIV because of an insect bite?' or 'Do condoms really protect me from HIV?'" (Aleksej, age 18, peer educator).

Peer education in schools

UNAIDS highlights school-based HIV/AIDS education as an essential component of prevention intervention in low-income and middle-income countries, and studies conducted among varied populations have revealed that peer education is one of the most effective ways to communicate information about health. As a result, peer education has become an important component of many behaviour change strategies.

In Russia there is a lack of sex education in schools - for both teachers and students it is often easier to talk about sexuality, HIV, STIs and reproductive health with someone external, and students, in particular, enjoy talking to someone their own age. Often, peer education is the first time youth have the opportunity to learn about sexual health and to pose questions to someone who

really understands their situation technically and emotionally. However, gaining initial access to schools to implement peer education activities can be challenging. In Samara, conducting the first training sessions proved difficult, due to the anxiety school board members felt that open talks about safer sex could be perceived as promoting promiscuity. To win public support, PSI/Samara began educating teachers, parents and local authorities to reassure them of the true goal of the programme, to protect their children from disease. PSI/Samara now



receives numerous invitations from local authorities and educational institutions to provide peer education at schools, youth camps and universities.

The PSI/Samara peer education strategy has made a shift in recent months, rather than carrying out one-off activities, it has moved towards the implementation of recurring sessions, which use structured, robust participatory approaches to ensure young people internalise and personalise HIV/AIDS issues. In Samara, Dr Volik strives to undertake ongoing, long-term activities in all the programme schools, but with limited resources and access this can prove challenging. In the time since the PSI Peer Education Programme was initiated in Samara there has been a significant increase in the percentage of repeat sessions, and as a result an improvement in the effectiveness of such training. The latest initiative to train volunteers from other youth programmes to produce

their own in-house peer education is also proving very successful.

"We can't cure AIDS, but we can easily prevent it. Let's do it together!" is the PSI/Samara motto.

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PEER EDUCATION IN EASTERN EUROPE AND CENTRAL ASIA-ONE WAY TO ADDRESS YOUNG PEOPLE'S VULNERABILITY

Greta Kimzeke

In the past decades a number of factors have dramatically increased young people's vulnerability in eastern Europe and central Asia. Overall, the social and economic transition in this region has disproportionately affected young people. The collapse of social controls and values and the non-emergence of alternatives has led to more pronounced risk behaviours – in particular increased sexual activity and experimentation with drugs and alcohol.

Circumstances contributing to such risk behaviour include increased poverty; migration and conflict; falling rates of enrolment and completion of secondary schooling; an absence of after-school recreational activities; and unemployment, which is three times higher among young people than among the adult population. At the same time, the increasing accessibility of imported illicit substances such as opium and heroin has increased young people's vulnerability to substance abuse. Other risk factors include exclusion and discrimination as a result of ethnicity, disability, citizenship status and sexual orientation.

In the light of the above, it might not be a surprise that also in this region, which currently faces the most rapidly increasing HIV epidemic in the world, the majority of new HIV infections occur in young people. They lack the knowledge and skills to protect themselves and have insufficient access to confidential, appropriate services. In addition, the incidence of sexually transmitted infections among young people shows an upward trend.

Today, investing in HIV, STI and substance abuse prevention among young people is more than ever needed. Just as in other parts of the world, peer educa-

tion in central and eastern Europe and the countries of the former Soviet Union has recently become a popular approach to address these issues. There is a global body of evidence that peer education, when integrated in other supportive prevention strategies, and when solid training and supervision are guaranteed, can be very effective in promoting behaviour change. Furthermore, there is growing recognition that peer education is a strategic vehicle for motivating and directly involving young people in their own health and development. However, research also signals a number of challenges in the implementation of peer education, especially in the area of programme methodology, stakeholder involvement and sustainability. In order to assess the quality of peer-led interventions in the region and to identify possible needs for technical support, in 1999 the UN Inter Agency Group on Young People's Health Development and Protection, Europe and Central Asia (IAG) organized a regional assessment workshop, followed by a stocktake of peer education programmes in the region (1).

This initial stocktake identified 73 peer education programmes in 12 countries, predominantly initiated by the NGO sector and conducted both in and out of the school setting. Peer-led approaches in the region are in particular used in the context of sensitive issues such as sex education and prevention of substance abuse - subjects which are most often not included in the school curriculum. This assessment revealed a difficult working situation for peer educators in the region.

Programming on peer education appeared to be happening in an uncoordinated, and sometimes even antagonistic fashion. Projects were (and still are) largely dependent on international support with little involvement of the government sector. In addition, there seemed to be a lack of qualified trainers and tools for peer education. However, this assessment also identified the potential of good practice to build upon. There are strong indications for a move beyond a pure information approach towards so-called "behaviour change interventions", based on skills building and using participatory training methodologies, as discussed elsewhere in this issue.

Based upon the results of the afore-

mentioned assessment, the IAG – Subcommittee on Peer Education has implemented a series of sub-regional training workshops and supports peer education networking activities both at regional and national levels. The UNFPA Division for Arab States and Europe and the UNICEF Regional Office for CEE/CIS and the Baltics have taken the lead in this work, in close collaboration with their field offices. Today, 165 peer educators, project managers and UNFPA and UNICEF programme officers have taken part in trainings. Discussion and exchange of experience and ideas is taking place through an electronic network (see page 27 in this issue). In a number of countries (for example, Bulgaria, Latvia, Serbia and Montenegro, and the Ukraine) the joint work of the IAG in the area of peer education over the past three years has resulted in an increased policy support for implementation of peer education both in school and in out-of-school settings.

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HEALTH EDUCATION AND THEATRE FOR AND BY YOUNG PEOPLE

Cydelle Berlin and Ken Hornbeck

The use of theatre in education has been proven to be a powerful tool for social change. It can strengthen the emotional and psychological appeal of the messages and provide a credible and compelling vehicle to explore sensitive issues with young people. Watching a carefully designed educational show can alter the way a person thinks and, possibly, the way s/he acts. Comprehensive programming is the only way of assuring that young people receive a message regarding safer sexual behaviour, and theatre education provides an opportunity to get that message across in a compelling and exciting way. At a minimum, live theatre provides information, provokes discussion and stimulates thought. At its best, live theatre can change how people act: it can lead youth away from risky, and toward safer behaviours. But how does theatre do this?

Primarily, by capturing attention: even young people bored by regular classroom work perk up at the sounds and visions of live theatre. Theatre “hooks” the audience, focusing their attention and actively involves the audience in an experience. Active involvement means that the audience’s emotions, and not only their intellect or cognitive skills, are affected. It is this ability to touch emotions that allows theatre to influence attitudes in ways that more traditional instruction cannot. But, for theatre to change the behaviour of young people, it must do more than simply tug at their heartstrings. It must deliver its messages in ways that young people can understand and that will impel them to act.

Theatre, like other forms of “entertainment education”, does this based on the principles of social cognitive theory. Bandura, the theory’s author (see page 5 of this issue), recognized that people learn how to behave and how to change their behaviour by watching other people. In the edutainment show, the actors model behaviour for the audience. The audience notes the behaviours of both positive and negative role models depicted in scenes. What may be most important for health education through the use of theatre is the “transitional” model: the adolescent character or model who changes his or her behaviour from risky to safer, demonstrating to the adolescent audience that this can be done, that the

adolescent is “efficacious” enough, powerful enough, to control his or her own behaviour, and even, to some degree, his or her future.

Health education theatre should also implement insights of other researchers and learning theorists. Research has shown that youth tend to model their behaviour most closely on those with whom they would like to be associated. Therefore, those who provide health education through theatre must be careful to craft situations and characters who convey: “cool” or “hip” at the same time as they demonstrate safe behaviours. Because adolescents are proverbially attracted to risky behaviours and those who exhibit it, this insight is particularly useful in the creation of Bandura’s transitional models:

- The characters are hip;
- They use hip language;
- They wear hip clothes;
- They recognize and may even have succumbed to the appeal of high risk behaviour; yet
- They show how and why they are converting to safer sex and other safer behaviours.

Culturally appropriate theatre

Finally, for education of any sort to work, it must be culturally and developmentally appropriate. Adolescents will not be moved by theatre designed for primary school students; and primary school students will not understand an intervention designed for older students. Theatre that is culturally and developmentally appropriate can dispel myths, provide more accurate information and change attitudes and behaviours through its effective use of models who engage the audience’s attention and emotions.

Most researchers have concluded that theatre education about health issues is an effective way to begin to inform young people about sexual and reproductive health including pregnancy prevention, HIV/AIDS, sexually transmitted infections, domestic/ partner violence, gender issues and much more. Theatre education, however, is not a panacea. A single theatre performance may get a teenager or pre-teen started on the road to safer sexual options, but it cannot ensure that he/she stays there. For that, parental, school and community involvement are crucial.

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Given the effectiveness of theatre as a way of starting the conversation among young people about health issues including protection and prevention, live theatre intended to address these issues should be available to young people. Given that the most effective theatre programme for young people is that developed and acted by young people themselves, and that that teen or peer educators who participate in these activities are even more likely than their audiences to have a wealth of information about sexual health and to exhibit safer behaviours, the time is now to place theatre companies in schools and community associations.

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Dr. Berlin and Mr. Hornbeck served as trainers in the use of theatre in education at the UNFPA advanced training of trainers, which took place in Estonia in February/March 2003. During that training a series of four workshops were presented which gave the peer education trainees information and skills on how to incorporate role-play and drama into their repertoire of educational activities.

A EUROPEAN TRAINING CURRICULUM IN ADOLESCENT HEALTH FOR PROFESSIONALS WORKING IN THE FIELD OF

Pierre-André Michaud, István Batár and the members of the EuTEACH working group

Adolescent medicine is an emerging field in most European countries, which makes the setting up of structured training mandatory. Moreover, sexual and reproductive health constitutes one of the major issue of concerns within this age group. The EuTEACH curriculum (www.euteach.com) was developed by a group of European adolescent medicine physicians as a teaching tool available to any physician teacher in charge of delivering courses at the pre- and post-graduate and CME levels.

Research is accumulating showing that the training of physicians is a crucial factor for the improvement of adolescent health care and adolescent health status. In the US, Canada and Australia, specific intervention strategies and services are being developed, including multidisciplinary training for medical and non-medical professionals (1-3). In Europe, despite the fact that the “Health 21” policy framework of the World Health Organization (4) includes specific targets aimed at improving the general as well as the sexual and reproductive health of young people, training opportunities in adolescent health and medicine for health care providers are scarce (5,6).

Given the current lack of training programmes and resources adapted to the European context, the Multidisciplinary Unit for Adolescent Health, a university-based training, research and clinical centre in Lausanne, launched an initiative in 1999 for the development of a training curriculum in adolescent health and medicine (EuTEACH for European Training in Effective Adolescent Care and Health). The major goal of the project, inspired by similar projects (7-10), was to improve adolescent health and wellbeing in the enlarged European community. Specifically, the training curriculum's aims were: 1) to select and propose a set of knowledge, attitudes and skills essential for European professionals involved in the care of adolescents; 2) to gradually develop, implement and evaluate a training package that covers the selected areas and issues; and 3) to encourage the long-term development of adolescent health multidisciplinary networks which would promote training in adolescent health in as many European countries as possible.

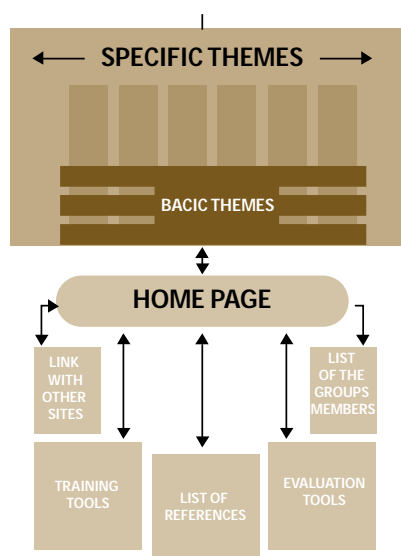
Development, structure and content of the EuTEACH site

In an attempt to develop an agreed curriculum covering the most important target learning objectives in the field and to comply with the approach described above, a group of physicians from eleven European countries and with various professional specializations ranging from paediatrics, internal medicine and general practice to public health, gynaecology and psychiatry was convened. The group has met biannually since 1999, initially to outline the purpose and architecture of the curriculum and then to develop the content of the various modules. Its work is supported by consultants and interested European and international professional associations are linked to the network with designated representatives who have been periodically informed on the progress of the work. Several non-governmental organizations officially support or formally collaborate with the project, including WHO. In developing the curriculum, the experts have been guided by two basic questions: 1. What is different about the health and health care of an adolescent as compared with a child or an adult? 2. What does the learner need to know and which kind of skills need to be acquired to adequately assist and treat an adolescent with everyday health burdens or with a specific health problem/disease?”

The EuTEACH curriculum is not a distance learning tool, but provides teachers in charge of training activities in the field of adolescent medicine an instrument which assists them in selecting the areas they want to cover, in defining appropriate objectives and in choosing relevant learning techniques and adequate evaluation methods. The curriculum is developed from basic areas to more specific themes,

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so that the use of some modules requires the coverage of preliminary basic areas. Each module and each part of the module focus on knowledge, attitudes and skills, and provides the user with explicit learning objectives, with corresponding teaching methods as well as concrete examples, such as case stories, issues to be debated in small groups or themes for role-playing. For each learning objective, the user is also provided with suggestions regarding the way the evaluation of the trainee should be carried out. This approach has been greatly inspired by a structured approach to curriculum development (11).



As shown in the figure, the curriculum includes two major parts, one devoted to basic issues that form the foundation of care and management of adolescents, and the other dealing with more specific topics such as sexual and reproductive health, substance use and eating disorders. The 17 modules each focus on one thematic area: basic modules include issues such as definition of adolescence, bio-psychosocial development; an overview of adolescent health; the family; setting, confidentiality, rights, communication and clinical skills; risk and reliance; school health and health promotion. The second part of the curriculum targets more specific issues such as growth and puberty; sexual and reproductive health; mental health; substance use; eating disorders and violence. The different themes can be covered separate-

ly. Depending on the setting as well as the needs and basic knowledge of the audience, the users can choose much less extensive versions, select the objectives that suit their time schedule and their target audience's needs.

The curriculum provides suggestions as to what the top priority objectives are. Although primarily developed for "in-practice" physicians, the curriculum is adaptable to the specific needs of professionals from different fields and disciplines. As exemplified in the figure, the user is provided with guidelines as to how to conduct a needs assessment before the course, a list of basic references and an introductory document focusing on the various evaluative methods suggested within each module to test acquired knowledge, attitudes and skills and adaptable evaluation sheets, which allow for feedback from the trainees at the end of each session and at the end of the course. The site also provides the users with links to other organizations and facilities targeting adolescent medicine and health, as well as a direct e-mail link to the members of the working group.

Practical application of the curriculum

In July 2002, the EuTEACH working group set-up a one week summer school at Lausanne University. The target audience included practising physicians involved in adolescent medicine and health, in-training paediatricians and general practitioners as well as school physicians and professionals involved in policy-making. The course, run by several members of the working group, covered eight modules, in their shortened version, and used a variety of training methods. Twenty-five physicians from 14 eastern and western European countries participated in the course, many of whom worked part-time or full-time in the field of sexual and reproductive health. One month before the course the applicants were invited to complete a training needs assessment sheet, so that the final programme was tailored to meet the expressed needs of the audience: it covered both basic themes such as confidentiality, settings or working with the family, epidemiology, public health and school health as well as more specific

areas such as sexual and reproductive health, the use and abuse of substances and issues related to mental health. Plenary lectures alternated with group sessions, including discussions on clinical cases and role-playing.

The EuTEACH curriculum programme has also been used in several other forms and in several other settings, primarily within western European countries such as Italy, Portugal, Germany, Belgium, Switzerland and the United Kingdom. Special one-day sessions are organized one day before each meeting of the European chapter of the International Association for Adolescent Health .

As the module on sexual and reproductive health can be used in an extensive version lasting 2 to 3 days, it is possible to run an entire week of training specifically addressing the needs of professionals involved in this field: a one-day introduction on adolescent growth, development and family life is followed by a second day focusing on the setting and special needs of various populations of adolescents such as migrants or drop-outs and then the discussion moves for the three other days to more specific topic of sexual and reproductive life in a clinical and preventive perspective. Such a course was recently set up by the Department of Obstetrics and Gynaecology of the Faculty of Medicine, University of Debrecen, for representatives from eastern European countries.

Perspectives, conclusion

Given the special situation of the teenagers living in those eastern European countries facing a major societal transition (4), it is of utmost importance to adapt the curriculum to the specific needs of those who train the professionals involved, especially those working in the field of sexual and reproductive health. It is thus currently foreseen to form a group of specialists from these countries, to set up a meeting during which the content of specific modules will be reviewed and then to translate it into Russian and make it available on the internet, using the same approach which was used for the implementation of the English version . This adaptation should be available by the end of the year 2004.

The value of the EuTEACH programme lies in the fact that it is freely

and easily accessible online (www.euteach.com). The fact that it is modular allows for an easy tailoring, both in length and content, to the needs of the different target audiences. However, currently there is uncertainty as to whether all those professionals at whom the programme is aimed, actually possess the skills to use the up-to-date interactive methodologies suggested in the module, and the group is developing guidelines and a set of tools (slides, case stories, reference papers available on the site, etc.) to assist the interested trainer in the use of the different educational approaches suggested.

Finally, it is important to stress that the European Community is currently defining the content of pre- and post-graduate training of the medical profession and of the various specialties (5, 12, 13). It is hoped that in future, adolescent medicine and health will be recognized as a sub-specialty, as this is already the case in North America and Australia, and that the EuTEACH curriculum could be used as one template for the content of the training of various professionals in disciplines related to adolescent health.

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The organization and content of the EuTEACH website

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The next one-day course will take place in French, on September the 25th. 2003 Professionals familiar with teaching activities and adolescent health who are interested to participate in such a process may connect with the EuTEACH group. A prerequisite would be to be fairly fluent in English, as well as, if possible, in Russian.

UPHOLDING EUROPEAN SUPPORT FOR SEXUAL AND REPRODUCTIVE HEALTH CARE AND RIGHTS

By Patricia Hindmarsh

Although there were many attempts to stall its progress through the European Parliament, and much heat generated in the debate, the “Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries” report was successfully adopted this February.

The report, which was drafted by Ms Sandbaek, Chair of the European Parliament Working Group on Population, Sustainable Development and Reproductive Health (EPWG), on behalf of the Development Committee, drew unwelcome, if unsurprising, attention from “anti-choice” groups and some Members of the European Parliament (MEPs).

The report forms the basis of a new regulation which was adopted by the Council of European Union Development Ministers on 20 May 2003. It replaces the 1997 Regulation on Population Policies and Programmes in Developing Countries, which expired at the end of 2002. A new regulation is long overdue as previous resolutions and regulations on the European Community’s activities in the areas of population, family planning, HIV/AIDS and gender in development did not focus primarily on sexual and reproductive health. The new regulation will provide an important perspective on the years since the International Conference on Population and Development (ICPD, Cairo 1994) and a reflection of “post-ICPD” priority areas.

The Commission’s original proposal for the regulation was a sound and solid foundation for the new policy. Nonetheless, certain points were missing. One vital amendment which Ms Sandbaek introduced aims to reaffirm the commitment of the Community and its Member States to the specific reproductive health goal, agreed at ICPD, to “make accessible, through the primary health care system, reproductive health care to all individuals of appropriate ages as soon as possible and no later than the year 2015”.

The ICPD Programme of Action provides the basis for a number of the health-related Millennium Development Goals (MDGs) - the ambitious agenda for reducing poverty and improving lives that world leaders agreed at the Millennium Summit in September 2000. The eight MDGs include goals to reduce child mortality and improve maternal health, and yet make no mention of the key reproductive health goal agreed at the ICPD (see www.developmentgoals.org). The EPWG therefore wanted to ensure that the Community’s new policy should

explicitly refer to the ICPD goal as the mandate for all reproductive health actors.

The amendments Ms Sandbaek introduced on the contentious subject of unsafe abortion sought to highlight two key issues. Firstly, to re-affirm the ICPD language on unsafe abortion (paragraph 8.25) which states that “abortion should in no case be promoted as a method of family planning”. Secondly, to emphasise that levels of unsafe abortion will be reduced by improving access to reproductive health care. New language introduced by the European Parliament now recognizes that “unsafe abortions threaten the lives of a large number of women, and that deaths and injuries could be prevented through safe and effective reproductive health measures”.

Improving access to quality reproductive health services for vulnerable, underserved groups is of vital importance. Ms Sandbaek therefore drafted new language recognizing the sexual and reproductive health needs of refugees and internally displaced persons. Given that half of the world’s 6.1 billion people are under the age of 25, and that their sexual and reproductive health needs are overlooked in many countries, an amendment was tabled to stress the importance of involving young people in the design and implementation of such programmes.

It is unsettling that financial resources for population and reproductive health services for developing countries and countries with economies in transition have actually declined in recent years. According to the latest information from UNFPA, external assistance and domestic expenditure for reproductive health services totalled just US \$9.4 billion in 2001, well short of the ICPD target of \$17 billion. However, it is encouraging that the new regulation will ensure that 73.95 million of the EU development budget is allocated to reproductive health between 2003 and 2006. The Community is also using its influence to put pressure on other donors, and an amendment has been tabled in Parliament “calling upon the international community, in particular the developed countries, to collectively ensure the appropriate share of the financial burden defined in the Cairo [ICPD] Programme of Action”.

These parliamentary amendments

should be viewed against a backdrop of frequent and sustained threats to the ICPD consensus. In recent months there has been a rapid rise in the number of campaigns aiming to erode support for reproductive health and to unravel the Cairo consensus.

The challenges to the ICPD consensus originate from a minority of anti-choice groups – mainly US based - who seek to subvert the reproductive health agenda by focusing on the issue of abortion. In US President George W. Bush they have found a natural ally. Symbolically, on his very first day in office in January 2001, the President reintroduced the Mexico City Policy, also known as the “Global Gag Rule”. This stringent policy disqualifies foreign non-governmental organizations from receiving US funds if they provide legal abortion services, lobbying or counselling and referral for abortion, even with their own money. Ironically, this law would be considered unconstitutional if imposed on US organizations. At United Nations international fora, the US has also consistently fought to erode the ICPD language.

In the US, so-called pro-life research organizations, such as the Population Research Institute (PRI) and the Family Research Council, achieve their dubious aims by disseminating misinformation and distorting the facts. UN reproductive health agencies are the prime target of their sustained campaigns. PRI, which promotes the view that “family planning is inherently coercive in a developing country context”, is actively engaged in propagating falsehoods about UNFPA’s role in China. As a result, in July 2002, Bush blocked the release of a grant of \$34million to UNFPA, based on unsubstantiated claims that it supports coercive abortions and sterilisations in China. The Bush Administration has also frozen \$3 million to the WHO’s Human Reproduction Programme, which is currently conducting research on women’s experience of abortion in China. The good news is that the House of Representatives has recently passed an amendment, which if enacted into law, might increase the chances of UNFPA receiving US funding again.

It is alarming that these opposition groups are extending their web here in Europe. They have increasingly raised

their European profile over the last year, setting up satellite branches of the US organizations, and making alliances with anti-choice MEPs. One such example is “euro-fam” which is linked to the organization “c-fam” (the Catholic Family and Human Rights Institute). The euro-fam website closely monitors EU policy on reproductive health and provides tailor-made letters which can then easily be sent to MEPs and the Commission. It also records roll-call votes, giving MEPs a grade, depending on how they have voted.

Not surprisingly, given its subject matter, the Sandbaek report was the target of campaigns by opposition MEPs. Led by the Portuguese MEP Ribeiro e Castro the minority group of MEPs failed to win support for its proposed amendments on abortion. This was due to the tireless support of members of the EPWG and other non-members, including Irish MEP Proinsias De Rossa and Spanish MEP Elena Valenciano, who both defended the ICPD agenda.

The European Commission has also been targeted by opposition groups who are stretching its already limited human resources. Tactics include writing to Poul Nielson, Commissioner for Development and Humanitarian Aid, and tabling numerous parliamentary questions (PQs). Anti-choice MEPs have tabled 20 PQs relating to sexual and reproductive health and rights to the Commission and Council since March 2000. These questions encompass many subjects, including EU funding for UNFPA, the definition of population and reproductive health, and EU support for sexual education programmes which promote abstinence only. One PQ even states: “The term “sexual health and rights” has never been defined and can include paedophilia for example”. The Commission has been obliged to allocate some resources to monitoring opposition and responding to campaigns. Even this has been criticised by the Irish Conservative MEP, Dana Scallon, who in alliance with PRI is questioning whether “EU taxpayers’ money” can be justifiably used for these purposes.

The Commission has made it clear that it will not be intimidated by these tactics. In reply to a letter from 46 MEPs concerning aid for reproductive health,

Poul Nielson stated that, “I would regret if the development policy of Europe were instrumentalised to pursue an issue arising predominantly because of a US domestic policy debate”. The Commission’s granting of 32 million to UNFPA and IPPE, the day after the US decision to de-fund UNFPA, sent an important message of EU support for ICPD. The Commission has also indicated that it may issue a statement re-affirming its commitment to ICPD. Certainly, the EU statement made at the recent 36th Session of the Commission of Population and Development was extremely encouraging (1).

These efforts to re-affirm commitment to reproductive health are particularly valuable in the run-up to the tenth anniversary of the ICPD. With 10 new countries joining the EU in May 2004, it is vital to safeguard European support for reproductive health if the ICPD targets and Millennium Development Goals are to be achieved.

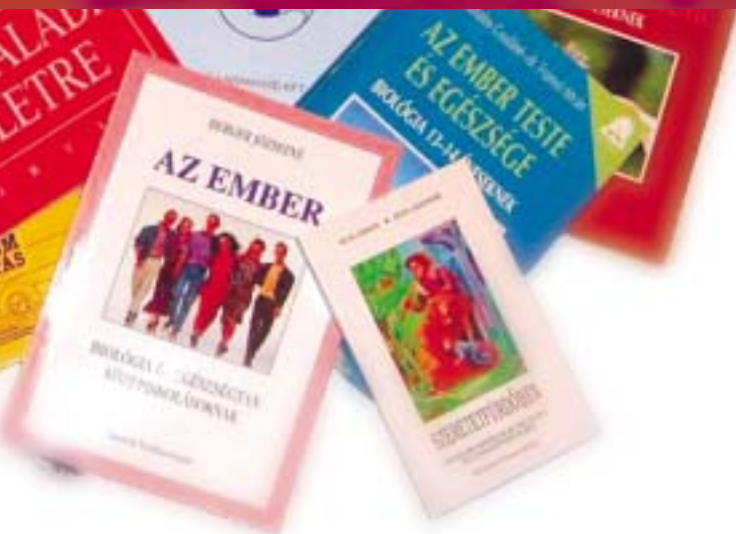
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SEX EDUCATION IN HUNGARY

István Batár



Excerpt of a report presented by István Batár, Head of Family Planning Center, University of Debrecen, Hungary, at the Conference on Sex Education as the Implementation of the Sexual and Reproductive Rights of Youth, held in Warsaw, Poland on 12 December 2002.

In Hungary, the official name of the sexual education programme is “education for family life”, which is more than simple sex ed. It is started in the first year of primary school, according to the regulations of the so-called “skeleton curriculum”, to eventually become “real” sex education in the direct meaning of the word, i.e. considering the intellectual level and interest as well as the specific features of the different age groups when choosing the topics each year.

However, if one asks the question, “How does the school prepare children for family life?”, the frank and straightforward answer is “it doesn’t at all”. This is not my interpretation nor my judgement. The citation comes from a textbook written by a recognised secondary school teacher, who wrote a methodological guide for colleagues to help them with teaching the subject. Before going into detail about it, we should go back 40-50 years into the past to understand the background of the problem.

At the end of the 1940s, or rather the beginning of the 1950s, the “baby boom” was the main demographic feature in post-war Hungary. One can compare that era to the 1970s–1980s in Romania, during the period of Ceausescu. Although the openly pro-natalist policy applied Draconian severity in prohibiting induced abortions, there were no modern contraceptives available. The legalisation of abortion took place in a few stages between 1954 and 1956 resulting in the “abortion boom”, which reached record figures in the early 1960s and was accompanied by never-seen before low birth rates. Induced abortion had become a

method of contraception and was available for nearly everyone (the “abortion committees”, brought about to control abortions, had practically no effect on the increase in the incidence of interventions).

The government decided to interfere in the second half of the 1960s and tried to stop and reverse the unfavourable tendency by introducing socio-political measures such as extended maternity leave and financial allowances. Contrary to expectations, those measures were ineffective. Having recognised the need for such intervention, the Parliament worked out a law describing the objectives of the new population policy, which was introduced in 1973. Some of its most important decrees were prescribing stricter conditions for induced abortions; broadening contraceptive accessibility (introduction of intrauterine contraceptive devices (IUD), commercialisation of new contraceptive pills, etc.), the founding of the family planning network, the introduction of the premarital counselling and the launch of “education for family life” in schools.

Although the latter programme became mandatory in Hungarian schools in 1975, there had been voluntary initiatives before. Obstetricians-gynaecologists, “infected” with the in-tention to improve, offered help to schools and, if those schools were receptive, lectured about the once taboo topics in the frame of a weekly assembly called “class matters”. Of course, they met with considerable resistance at the beginning, since many of the parents and teachers, brought up in a completely different spir-

it, did not welcome the idea of educating youth in “indecent” lifestyles. Such attitudes have gradually changed but still have considerable influence and should not be neglected.

After 1975, the introduction and maintenance of the programme in schools remained a problem. Regular training required properly trained staff, which was lacking. As a result, for many years education was occasionally and arbitrarily supplied by volunteering “outsiders”. In almost all schools there were some children whose parents worked as physicians. The director of the school or the head teacher asked these fathers or mothers to help the school with presenting some classes in sex education. In general, although these doctors were not gynaecologists, they were more familiar with the topic than the teachers were, but, due to lack of experience in school presentation, they were sometimes inefficient in fulfilling such requests.

Such a programme can only be realized if schools can employ teachers specially trained in these questions. Unfortunately, this has not been the case until now. Teacher training institutions (colleges, universities) have failed to launch the training of these specialists. Over the past 30 years all the governments (before and after the political changes in 1989) kept promising to solve the problem, but there have been no successes to date. The present situation is clearly analyzed in a document published by the Center for Reproductive Law and Policy (New York, 2000) which states, “There is neither a general overall policy, nor a unified practice, regarding sex education for adolescents in Hungary”.

The National Basic Educational Program (NBEP) puts the end of the programme in education for family life in the tenth form (16 years of age). As mentioned above, this topic includes many issues such as personal hygiene, learning about the human body and risk factors (e.g. smoking, drinking alcohol, AIDS, sexual abuse, drugs), but real sex education is just part of this training. Several NGOs take their share of the job and there are plenty of individual volunteers as well. Only the unified policy and direction are missing. Excellent textbooks (see illustration) have been published but there is no curriculum to lay down the

principles of training for the different age groups valid for the whole of the country. A governing principle to be observed everywhere would be sufficient since plenty of material is at our disposal to fill the “frames”. Lack of uniformity should be given special emphasis here, because there are, after a long period, church and private schools in Hungary again, and one cannot expect them to be engaged in explaining about, for example, the different methods of contraception putting the same stress on every issue. This is the case with the available training material. Some of the books have been a pioneering work to break down sexual taboos. However, they immediately turn out to be “conservative” when they start discussing on contraceptives.

That is why the initiative by the National Institute for Health Promotion in 1997 was aimed at the introduction of an independent school subject entitled “Preparation for family life”. The Ministry of Education, based on the “expert” opinion of the National Institute for Public Education, refused it and approved only its facultative trial in the frame of a project.

That is the situation today, after 30 years, and it is being repeated that schools “have not prepared to meet this task yet”. When will they be ready then? In one of the excellent books mentioned earlier, a whole chapter – entitled “We need a subject!” (i.e. a subject dealing with education for family life) – was devoted to the problem. But it appears that the only ones to see it (e.g. teachers, doctors, parents) are those who experience its lack and the resulting problems in every day life and practice. According to the logic of NBEP, the issue of including education for family life in the school curriculum is not suitable for introduction as an individual subject. There is, after all, some education – in one way or another – because NBEP prescribes a minimum requirement in teaching about “hygiene”. It includes education for family life, which should also cover sex education. According to a ministerial decree, school doctors and nurses are to do this job wherever the programme includes information about family planning and contraception. The efficiency of teaching about this “hygiene” is clearly reflected by the facts.

In the mid-1990s, a book of studies (1) was published about the health and health related behaviour of Hungarian adolescents. In addition to many interesting issues, the authors presented a detailed description of the adolescents’ sexual knowledge, sexual behaviour and their habits injurious to health. The book says, “It can be concluded from the data, that the role of families and educational institutions in providing knowledge about sexuality is equally unsatisfactory.”

A similar study by the World Health Organization (WHO) shows the health and health behaviour of pupils from several countries, based on a survey conducted in 1997/98. Hungarian data are also included and the document is also available in Hungarian. In addition to discussing matters of smoking, alcohol consumption, sports and leisure activities, the publication also contains useful information about sexual behaviour. Young people “smell powder for the first time” at a very early age: 31.5% of the Hungarian secondary school boys and 27.9% of the girls have their first sexual experience before they are 15.

International comparisons also show that the 15-year-old Hungarians are at the top of the list of starting sexual activity at an early age. In addition to this questionable reputation, they are the ones (independently of gender), however, whose use of contraceptives is the lowest.

Our own survey also supports these data and justifies the ineffectiveness of education. Recently, 500 women, seeking abortion at our department, were asked about some important features of their sexual lives. Among the 27 questions, the most important ones with relevance to this issue are as follows:

- When did you have your first sexual intercourse?
- How old were you when you were first informed about sexual matters?
- Who were you informed by?
- What contraceptive methods do you know?
- What methods of contraception have you used so far?
- What method did you use when the present pregnancy conceived?
- Why do you think you became pregnant although you used a contraceptive?

The results are as follows: Twenty per cent of those questioned were younger than 20. By 14 years of age, 76.6% had been given some sort of sexual education. In only 42.2% the source was a member of the family, basically the mother (37.8%). The “share” of the others is detailed in the Table

Source of the first sexual information among Hungarian abortion seekers (a survey of 500 cases)

Source	(%)
Mother	37,8
Father	0,4
Sibling	3,4
Relatives	0,8
Girlfriend	15,4
School	32,8
Physician	0,8
Book/TV/etc.	8,6

As for the first sexual contact, 68.4% claimed to have had it before 17 years of age. The majority (over 70%) knew of contraceptives (knowledge about the condom, the pill and the IUD exceeded 99% each) and many of them were familiar with more than just one. They not only knew these methods but had used them earlier. Despite all of the above, 30% did not use anything when the current pregnancy conceived. Also, the cumulative proportion of those who had never used contraceptives and of those who applied contraceptive methods of lower efficacy (such as the withdrawal and/or calendar method) was 64%. Among those who used some sort of contraception when the present pregnancy conceived, 48% claimed that they had not used the method according to the instructions. These are telltale figures, also demonstrating the ineffectiveness of the current educational-informational system.

Hungary’s demographic situation is best characterised by negative growth. A decrease in the population affects first and foremost the young generation. There are just over 1.2 million young people aged 10-19 and just fewer than 1.9

million people are found in the age group 5-19. Basically, these data should be considered when the statistics about the required staff for the proper education of these schoolchildren is calculated. The mean size and the approved annual number of classes are also important factors. But to achieve anything at all, “education for family life” should become an officially recognized, independent subject in the school curriculum at last.

In summary it can be said that nearly 30 years after “education for family life” was made compulsory in schools, adequate conditions for its success are still absent. Would-be teachers are not given proper instruction by training institutions and the government’s educational policies still neglect the conditions for introducing a unified and individual subject into the curriculum. Individual personal initiatives are seen and various non-governmental organizations also try to implement improvements. But dissonance needs to be turned into nationwide harmony – something that might yield measurable results in only a few years. We strongly hope that we will not have to wait another 30 years to achieve this.

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THE ROLE OF MEDICAL STUDENTS IN THE PREVENTION OF HIV/AIDS

Henrietta Bencevic

In many countries around the world, medical students have felt the need to organize themselves and provide additional training in public health issues to their fellow students and universities. The International Federation of Medical Student's Associations (IFMSA) has members from nearly 100 countries around the world and, as an organization run by medical students, it helps its members to establish trainings and other programmes for both medical and other students (1). Since 1992, IFMSA has been participating in the fight against HIV/AIDS. And in 2001 it issued a set of recommendations on HIV/AIDS in medical education curricula. Moreover, the first peer education programmes on HIV/AIDS in some communities were organized through IFMSA members (2).

There are many modes of HIV transmission and the disease is often associated with gender inequality, poverty, a lack of education and substance abuse. The dominating patterns of transmission differ around the world and in eastern Europe it is mostly through injecting drug use, while, for example, in Africa it is mostly sexually transmitted (3). But wherever HIV and AIDS appears, medical doctors have a specific role to play in their communities, where they are often role models or health educators, as well as in their working settings, where they have a leadership position.

At medical schools, students, the future professionals, gain knowledge and skills to prepare them for their future tasks. The occurrence of HIV/AIDS has forced us at IFMSA to face some of the problems of medical education, which often focuses too much on the diagnostics and treatment of diseases, at the expense of prevention, which in turn colours the way medical students approach health problems.

Becoming a physician is a long and expensive process. Taking in mind that knowledge in medicine is constantly increasing, it is a hard task for decision-makers to update medicals school programmes. Implementing the latest discoveries in modern medicine is not realistic in many settings around the world - and where doctors practise with stethoscopes as their only tools, it is impossible.

Teaching public health is often already marginalized with only a limited amount

of time allocated to it in medical school curricula. It is well known that the prevention of disease is key to ensuring the sustainable development of communities. As a matter of preparedness for future physicians to educate populations or to pass on the message of healthy living, some skills in this area have to be acquired, for example communication skills, health project methodology and the ability to see health problems from all angles: human rights, occupational medicine, psychological, etc.

Experiences within IFMSA and among its members have shown numerous advantages of peer education led by medical students. The motivation is manifold, both professional and generational. Medical students are often young people just out of high school. The fact that they are medical students means that they are developing themselves to become physicians and does not mean that they already know how to behave like one. This is the task ahead of them.

However, they do have an advantage when compared to physicians, they are great peers for high school students and other university students. They are also young and a population with a great deal of risk of acquiring sexually transmitted diseases including HIV (4).

One of the main problems that medical students face when establishing peer education project is a lack of qualified educators and tools for evaluation of their projects. The enthusiasm is there, but not always the background of proper training and adequate experience. While it is easy to memorize facts, acquiring communication skills or being able to handle problems caused by religious influence or the denial of reproductive health needs of teenagers by their parents and teachers requires suitable training. Investing in the education of medical students to become well-trained peer educators is vital in this respect.

Medical students are an enormous human resource and by educating their peers, they are important agents of change in the prevention of HIV/AIDS. They make information about HIV/AIDS accessible and help curb the epidemic and fight stigma and discrimination. Empowered with their skills, knowledge and awareness in public health they can be a bridge for a gap of needs in

HIV/AIDS prevention and be ready to timely recognize and help fight back any future epidemics (5).

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NEW HEALTH COMMUNICATORS AT SCHOOL: MEDICAL STUDENTS

Inon I Schenker

“I always enter the classroom dressed in jeans and a T-shirt. When one of the 12-year-old girls said after a month or so: ‘to me you’ll always be a young doctor in a white coat’ I knew the programme would achieved its goals”.



Jerusalem branch of the FHEP started to incorporate education for HIV/AIDS prevention among the topics taught (Schenker, 1988). Since then, training materials, skill-building workshops and training-of-trainer modules for medical students teaching HIV/AIDS prevention in Israeli schools were developed.

Rami (age 24) is one of 42 medical students volunteering in Jerusalem schools as a peer health educator. Every week they visit primary and secondary school classes providing students aged 10-16 with health education sessions, covering a wide range of topics: infectious diseases, oral health, non-communicable diseases, sex education and HIV prevention, physical health and nutrition, smoking and substance use prevention, and even mental health. For the pupils they teach they are “a doctor in a white coat” – authoritative, reliable and trustworthy, and at the same time “a bit older peer”.

Under the “Perach” (Flower) programme, supported by the Israeli Ministry of Education and the four medical faculties in Israel, several dozens of students, mostly in their second or third pre-clinical year, participate in one of the advanced national health promotion projects.

“When I see those who have been taught to spread knowledge about AIDS among their classmates and friends, I have a feeling of success”. Ying Zi is a third year medical student in Shanghai Medical University, and an active participant in an Australian-Chinese AIDS/STI/Safer-Sex Peer Education Programme for Youth. “At the beginning I felt a bit hesitant to talk publicly about HIV/AIDS”, she told a local newspaper, “but later I was encouraged by the fact they all liked my teaching”. Eighty senior medical students have been trained since 1998 to provide education for HIV/AIDS prevention at local high schools.

Unlike traditional methods of conducting sex education programmes through lectures and leaflets, their approach involved more interaction

between students and the educators. They are trying to utilize methods such as role-playing, videos and games that make the learning more meaningful to the pupils.

“As a peer educator, you learn to be a better listener, a caring helper, communicate better, and gain confidence in confronting people. You feel good about yourself and your efforts to improve the lives of those around you”. This message, emphasized by the Schiffert Health Center Office of Health Education in Virginia, USA, is a leading concept in the development and preparation of wellness peer educators: students who positively influence other students.

The mission is to provide an effective peer network to encourage, support, and promote healthful living for all students under the notion that students can play a uniquely effective role in encouraging their peers to consider, talk honestly about, seek professional advice, and develop responsible habits and attitudes toward the use or non-use of alcohol, safer sexual behaviours or abstinence, healthy eating choices and other related health issues.

Developed in Beer Sheva, Israel, and launched in the early 1980s, the “Perach”, Flower Health Education Programme (FHEP), is considered among the first national peer educators’ projects in the world which facilitates the provision of school-based health education by medical students. While the Perach Programme had begun as a general health promotion project, covering a wide range of topics, a strong push for its wide implementation was in the early days of the HIV/AIDS epidemic.

In 1986 the Hebrew University of

The Israeli national curricula for primary and then secondary schools on HIV/AIDS prevention and anti-discrimination emerged in 1986 out of this initiative, which was at that time strongly criticized. Ministry of Education officials, teachers and schoolmasters did not like the idea of non-certified individuals teaching “sensitive” issues at schools. They also rejected the idea that young, non-experienced students could ever bring any change in kids’ knowledge, attitudes or behaviours relating to HIV/AIDS prevention and anti-discrimination. Many considered HIV at that time to be a non-issue for the general school system, being a disease that “only strikes at gays, prostitutes and drug users”. Others argued against a “bio-medical” approach if medical students were to teach HIV/AIDS prevention.

A strong, stubborn, articulated and creative advocacy, over a period of several months, mobilizing decision-makers, influential personalities in medicine, education, public health and parliamentarians led to an official acceptance of the notion that medical students may well be influential peers for primary and secondary school children, even – and perhaps more so – in areas of great sensitivity (e.g. sex education, HIV/AIDS prevention and substance abuse). The formal legislation of the Ministry of Education accepted in 1988 the curricula “Explaining AIDS to Children” (Schenker and Yechzkiyaho, 1987) for national use, and stated, among the qualified to introduce it into schools, “medical students”. This became a European landmark in the formal acceptance of medical students as health educators in schools.

Parallel to the Israeli initiative, similar



initiatives (Cohen & Cohen, 1991) in the United States tried to engage medical students as peer HIV/AIDS educators.

At the University of Missouri, a programme called Students Teaching AIDS to Students (STATS) was proposed (Haven, 1989). The goal of this project was to help train medical students to become AIDS educators in the schools, churches and youth organizations of their local communities. The project involved preparation and distribution of a package of materials, which were used by medical students to initiate a STATS program. The curriculum material was tailored for presentation to students over two school-class periods on separate days and contained age-appropriate information. Another component of the package was a slide show tailored to explain STATS to community stakeholders and a video tape to help answer questions posed by students.

In Norfolk, in the spring of 1987, 20 medical students from the Eastern Virginia Medical School of the Medical College of Hampton Roads were involved in a pilot program to teach about AIDS to high school senior students (Johnson et al, 1988). The medical students received instruction about AIDS from basic science and clinical faculty members at the medical school in preparation for the project.

In Europe, the International Federation of Medical Student's Associations (IFMSA) led a series of "STOP AIDS Summer Schools". From 1995 to date this annual event (IFMSA, 2003) is aimed at equipping students of medicine and other health sciences with theoretical knowledge about HIV infection and AIDS and practical skills to

transfer that knowledge to others - thus creating a global network of peer educators on HIV/AIDS prevention.

The Summer School was one of the outcomes of IFMSA's General Assembly decisions in 1991 in Londrina, Brazil, to create a new Standing Committee devoted to HIV/AIDS and STIs: SCOAS – Standing

Committee on AIDS and STDs. SCOAS was created as the result of medical students' increasing awareness of the growing problem of HIV infection and AIDS and their will to do something about it. The person behind that decision was Ms Victoria Dai, then an active medical student who was with the first groups of medical students who participated in the Israeli FHEP programme.

"We realized from the beginning that the only way of fighting AIDS is through prevention and that the best way of prevention with adolescents is through education". Dr Dai is now a practising physician in Israel.

In the course of recent years, SCOAS added reproductive health and became SCORA (Standing Committee on Reproductive Health and HIV/AIDS). It is working within IFMSA as one of its six standing committees. It has a Standing Committee director and in every country there should be a national coordinator.

IFMSA took this initiative even further. In a clear statement to the World Health Organization 109th Executive Board, Dr Henrietta Bencevic of Croatia, then the IFMSA Liaison Officer with WHO stated: "WHO and IFMSA have decided to work together on scaling up education, empowerment and training on HIV/AIDS for medical students, being the next generation of medical professionals." (WHO, 2002).

IFMSA presidents echoed this notion in what became an important World AIDS Day set of statements over the recent years emphasizing the role medical students could have in the global, regional and national campaigns aiming at reducing HIV infections among youth by 25%, as noted in the Millennium

Development Goals documents (UNAIDS, 2001).

How effective are these initiatives? How sustainable are they? How much of a support do they gain from the international and national bodies?

Research on the pilot project in Israel (Schenker & Greenblatt, 1993) concluded that the pilot programme has succeeded in correcting misleading information, adding relevant information and reinforcing exact knowledge on HIV/AIDS among junior high school students in Jerusalem. Further studies (Sunwood et al, 1995, Schenker et al, 1996, 2001) have shown that not only do adolescents appreciate, respect and enjoy the new health educators in class, they actually listen to the medical students' advices and cooperate with the behaviour change processes in class.

While very few evaluation studies have been published on medical students as peer health educators, and most have concentrated around HIV/AIDS and sexuality education, the overall results are positive and promising. They stress the message that medical students can do not less – and often better – of a job in educating school children on health (and particularly sensitive issues like: HIV/AIDS, STIs, sexuality) than school teachers. Moreover, the literature supports the idea of outsider involvement in school sex education.

Dick (1994) describes benefits both to pupils and peer educators in a peer-led school education programme. Wight and Scott (1994) had noted that pupils express a desire for more relaxed teachers, since teacher anxiety exacerbates pupil embarrassment and that outsiders frequently show more expertise, are usually easier to talk to and can deal with problems that teachers often find difficult (Forrest J et al, 1994).

Medical students at Monash university, Melbourne, Australia, providing sex education as quasi-peers in local schools were studied. This programme has suggested that medical students are particularly suitable because they are closer in age to the target audience, are not embarrassed and are generally more open than established providers of sex education (Grinzi & Gelperowicz, 1996). So far this scheme has achieved favourable results (Wight, 1996).

Johnson et al (1988) reported that responses to 10 subjective post-test questions assessing the program indicated that the high school students were interested in learning about AIDS and having medical students as their teachers. They also concluded that the programme provides an example of how medical institutions can develop a collaborative community education project that contributes to the education of medical students.

Jobanputra et al (2002) looked at medical students' lack of teaching experience, including specific skills such as group work and awareness of key issues (sexual abuse) and concluded that these did not lead to problems in the pilot study they conducted in Edinburgh. They also report that the response received from schools was better than had been anticipated.

Several key factors are associated with the success of medical students as effective health teachers at school:

- An organized group of students, lead by a senior medical or public health professional;
- A well defined curriculum, which is age and gender specific, respecting cultural norms and needs of adolescents;
- Structured, pre-activity intensive training, which also takes into account teaching and facilitation skills, not only content;
- Good rapport with the educational authorities and schools;
- Materialistic incentives (e.g. scholarship, course credits) for participating students;
- Strict selection (by pre established criteria) of participating students;
- Ongoing monitoring and process as well as outcome evaluation;
- Student-centred approaches when working in schools;
- Team-oriented approaches when working and training participating students;
- Advocacy and communication strategy as an integral part of the project;
- A good project coordinator.

As more schools open their doors to carefully selected, properly trained and enthusiastically performing medical students – we may see an increase in effective school-based health education and

physicians who are more attune to community needs and approaches. Participants in health promoting schools and healthy cities networks could be in the forefront of supporting and strengthening such programmes.

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Hands on! A Manual for Working with Youth on Sexual and Reproductive Health (from Dev. Gateway)

<http://www.gtz.de/srh/download/Hands%20On%20Publikation.pdf>

This manual lays out useful methods and approaches to support people working with young people in the development and implementation of sexual and reproductive health measures in a practical way. It consists of 16 separate yet complementary papers written largely by practitioners from the field with a focus on giving examples and checklists. Available in English only. (GTZ, April 2002)

http://www1.worldbank.org/hiv_aids/publications.asp

This World Bank publication argues that the education of children and youth deserves the highest priority in a world afflicted by the HIV/AIDS epidemic. Education has proven to be one of the most effective means of HIV prevention. Countries need to strengthen their education systems immediately in order to offer hope for escaping from the grip of HIV/AIDS.

The global HIV/AIDS epidemic has already killed 20 million people and another 40 million people are currently infected. The magnitude of this epidemic requires a response that confronts the disease from every sector, but education plays a particularly important role. Education and HIV/AIDS provides a strategic direction for the World Bank in responding to the impact of HIV/AIDS on education systems. The central message of this book is that the education of children and youth deserves the highest priority in a world afflicted by the HIV/AIDS epidemic. Education has proven to be one of the most effective means of HIV prevention. This book finds that countries need to immediately strengthen their education systems in order to offer hope for escaping from the grip of HIV/AIDS.

Resources on peer education from IPPF

In the light of the global HIV/AIDS pandemic and its disproportionate effect on young people, the International Planned Parenthood Federation European Network (IPPF EN) has worked effectively to include youth in its programme planning and implementation and not just as the target of activities. A youth stakeholder group was set up in different countries to design their own strategy on sexual and reproductive health and rights, which has a special focus on HIV/AIDS. Below, a few of IPPF EN's most recent publications on the subject are reported.



Lessons learnt: The peer education approach in promoting youth sexual and reproductive health (2001)

This study focuses on the different peer education approaches and experiences of youth groups based in the five central Asian republics. The publication is designed to be used as a guideline by youth programme managers in family planning associations and other people who what to plan and carry out peer education projects. The best practices and key lessons learnt can be used to start a new project or to integrate peer education into an existing youth project. Although the focus of the document is on non-European countries, it offers a variety of practical ideas and guidelines which may be useful to the European Region.



"Peer led sexuality"

In recent years the situation of HIV-infected individuals has deteriorated throughout Kazakhstan most likely due to the increase in drug-trafficking from Afghanistan and the emergence of new problems such as the trafficking of women. The number of drug addicts now accounts for more than 300 000 persons throughout Kazakhstan, many of whom use infected needles. It is very likely that this core transmitter group may spread HIV to the general population through heterosexual contact via so-called "bridge groups".

Peer-Led Sexuality Education: Learning from Equals is a regional initiative of the IPPF European Network field office for Central Asia, funded by UNFPA. The booklet reports on new initiatives in the sub-region, many of which are based on the results of a knowledge, attitudes, practices and behaviour survey from 2001. This survey revealed that while it is clear that most young people discuss topics relating to sexuality and sexual relations mostly with their peers, the information exchange is rarely accurate. However, the report does make clear that although work on the "ground" is important, so is advocacy to influence policymakers, religious leaders and the media, in order to improve the sexual and reproductive health and rights of young people. Given that the relevant skills are provided, young people often make their own best advocates.

INTERNET RESOURCES

Prepared by Aleksandar Bodiroza and Srdjan Stakic

Y-PEER: The Youth Peer Education Electronic Resource – Networking in peer education

Peer educators in eastern Europe and central Asia can now ask each other questions, share experiences and get updates on available resources through Y-PEER.

In eastern Europe and central Asia, HIV incidence is rising faster than anywhere else in the world. There were an estimated 250,000 new infections in 2001, and there are now an estimated 1.2 million people living with HIV. Most of the infections continue to occur among injecting drug users (IDUs), and most IDUs are young people under the age of 24. In parts of the region, as many as half of the newly reported cases are in people younger than 20. The growing awareness of the vulnerability of young people to HIV, STIs and injecting drug use has brought issues related to young people's health, development and protection (YPHD&P) higher on the political agenda. Increasingly, young people are being considered as not only a vulnerable group, but also a resource for changing the course of the epidemic: they are both responsive to HIV prevention programmes, and are effective promoters of HIV preventive action.

Throughout the world, the past decade's experiences have presented youth peer education as a successful approach to developing young people's capacities, promoting their active participation in the process, and facilitating health education, especially in the area of HIV/AIDS. There is, indeed, a global body of empirical evidence that peer education can be extremely effective in promoting behaviour change when solid training and supervision are implemented. Research suggests that peer education activities are particularly successful when they are integrated in other supportive prevention strategies. Moreover, there is a growing recognition that peer education is a strategic vehicle for motivating and directly involving young people in their own health and development.

In attempts to foster the development of peer education, the Inter-Agency Group on Young Peoples' Health Development and Protection (IAG) Sub-Committee on Peer Education was formed to develop and guide the imple-

mentation of this Joint Workplan for Development of Peer Education. In discussions on joint action, UNICEF, WHO/Europe and UNFPA have been the agencies expressing a commitment to lead the process in the immediate future. This programme on peer education is closely coordinated with the IAG Joint Workplan to support and develop Life Skills-Based education initiatives and the IAG Joint Workplan on Youth Friendly Services.

In past two years the project has achieved the following:

Assessment: A total of 158 initiatives in 27 countries have been identified, which is confirmation of the increasing use of this strategy and the potential of good practice to build upon.

Training: UNFPA has organized five sub-regional and two advanced peer education-training workshops; trained 165 trainees and 31,000 young people have been reached in roll-out national training activities. The training curriculum applied at the workshops has ensured an integration of gender perspective into HIV/AIDS prevention and supported a skills-building approach to work with youth.

National Capacity Building: Four national peer education networks for Ukraine, Bulgaria, Bosnia and Herzegovina and Serbia and Montenegro were created.

Guidelines: A manual for peer education gender sensitive training has been developed.

Networking – IT – Information Sharing:

With an intention of producing an alternative and effective mode of information dissemination and internationally available resource utilization for peer education initiatives in eastern Europe and central Asia, UNFPA has developed a distance learning initiative, entitled Y-PEER or the Youth Peer Education Electronic Resource (www.youthpeer.org). Y-PEER consists of three main aspects:

- Y-PEER Networking (electronic exchange of information through listservs);
- Y-PEER Website (Internet based

resource peer education-related information); and

- Y-PEER Distance Learning (CD-ROM on peer education and other distance learning efforts, such as video conferencing).

Y-PEER currently links 370 members, from 27 countries, who are active peer educators who can contribute to, or benefit from the availability of resource materials and training programmes. The development of Y-PEER will be an ongoing, continuous process with constant updates to reflect the expressed needs of peer educators and others involved in the peer education process in the region.

The Phase II of the development of Y-PEER includes its translation into Russian, including the technical information; implementation of a search engine, and other technically advanced improvements to the site, such as a searchable database of experienced trainers of trainers from the region.

The connection of the Y-PEER website and Y-PEER distance learning projects is not only technological. The Y-PEER distance learning project was established in order to provide the most up-to-date, language-, culture-, and gender-sensitive technical and subject materials to those who need it most: peer educators, trainers of peer educators and trainers of trainers in eastern Europe and central Asia. The modalities of Y-PEER distance learning will be through a CD-ROM (which is currently under development), print materials (a peer education manual for trainers of trainers is in print), and via the website, for those with technological ability to access large Internet files. The multiple cutting-edge format of information dissemination will only supplement and support the current ongoing in-person trainings.

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