

## **A Communication Project to Promote Safer Sex Practices among Young Female Out Of School Youths in Africa: The Botswana Example**

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**Abstract:** *It is estimated that one in four adult population, aged 15-49 years in Africa are HIV infected, with the highest age specific rate occurring among young women 25-29 years. This project is part of an intervention programme whose goal is to reduce the rate of HIV infection and unwanted pregnancies among female out of school youths in Kweneng East District, Botswana. In 2000, twenty (20) female out of school youths who are mainly school drop outs, unemployed, know their HIV status and are willing to participate in the project were screened and recruited as Peer Educators by the AIDS Secretariat in Molepolole, Botswana. Interventions include training in interpersonal communication, HIV prevention, safer sex practices, sexual negotiation, human sexuality, sexually transmitted infections, family planning, sexual assertiveness, income generation activities and entrepreneurship skills. For social support and community ownership of the project, there were advocacy and capacity building activities with health providers, community leaders, the private sector, the police and the legal system. Midterm evaluation of the project in 2003 shows that more young women participated in the project, twice more than the original number intended. The level of knowledge of HIV-AIDS prevention and contraception had improved among the group members. The demand for and use of condoms and reproductive health services increased, resulting in low rates of unplanned and unwanted pregnancies. Through the face to face contacts made by the Peer Educators in the community, several female out of school youths were reached with HIV-AIDS and family planning messages. Sustainability of the project however depends on increased local political commitment and sustained donor support.*

**Keywords:** *Interpersonal Communication, Promoting Safer Sex Practices, Peer Education*

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### **I. Introduction**

Since HIV-AIDS was first reported in Africa in the 1980s, many African governments have grappled with the multiple challenges of high rates of HIV prevalence among the youth and women, the resultant high level of vertical transmission, the preponderance of orphans and destitutes and the gigantic task of caring for the infected, including those with AIDS related complications. Young people are the most vulnerable age group to HIV-infection. It is also young people who offer the greatest hope for changing the course of the AIDS epidemic if they are given the tools and support to do so. (UNAIDS, 2002).

Most governments have used a multisectoral and decentralized approach to HIV-AIDS interventions that target sectors, individuals and groups at the local level with knowledge and skills that promote and sustain positive and responsible sexual behaviour. Governments have also formed alliances with community based organisations (CBOS), Non-governmental organizations, donor agencies and groups that have helped to legitimise and encourage HIV-AIDS action.

At the local level, where resistance is greater, the major operational challenge lies in developing strategies and approaches to bridge the gap between knowledge and responsible sexual behaviour (UNAIDS, 2002). Behaviour has an environmental component and as far as the youth and HIV/AIDS, most governments have not addressed the living conditions (social, economic and cultural) that predispose the young to practice risky sex and make unhealthy sexual decisions.

Because of the paucity of health workers, youth friendly reproductive health facilities, extensionists and other interpersonal reinforcements at the community levels, some young people have not had enough time to interact with programme staff to internalize the HIV-AIDS messages, some of which are not in consonance with traditional values and practices and the current socio-economic realities.

The mass media have created a lot of awareness about HIV-AIDS, alright, but in terms of impact they still operate under the burden of minimum effects. We need to reinforce mass media messages at the individual level, by using the youths to mobilize the youths. This way, they can place themselves in an active situation, approximately the information rather than merely being passive receivers of information. Interpersonal mediation using peer educators and community based youth focused NGOs can help to inform, clarify, explain

and convince young people about sensitive issues such as HIV-AIDS, HIV-Testing, Safer sex practices and family planning using face to face communication.

### **Obstacles to Prevention of HIV Infection in the African Setting**

In the absence of a cheap vaccine, the only practical course is to concentrate on prevention. But this too has been problematic for a plethora of reasons (UNAIDS, 2002). In the African setting, the dominant culture promotes sexual ignorance disguised as “innocence” among young women. At the same time, many young women actually have little control over how, when and where sex takes place (UNAIDS, 2002:71). Young women’s vulnerability is compounded by their scanty knowledge of how HIV is transmitted and how infections can be prevented. Many still harbour misconceptions about the disease (Imoh, 2008). According to the Economist of 2nd January 1999, the obstacles to prevention of HIV infection in Africa range from perception of sex as fun and of condom as reducing pleasure. This is compounded by the attitude of religious groups to condoms which they feel encourages promiscuity. In all settings, the discussion of sex is a taboo. There is also the widespread belief by men that one can get rid of HIV infection by passing it to a virgin. All over Africa, migrant labour and long distance drivers are forced to leave their homes and spend most of their time in hotels or brothels surrounded by prostitutes who often infect them. When they go home, they infect their wives. Today in Africa, war and political instability have been the norm, resulting in the movement of soldiers who often infect others through sexual abuse of young and vulnerable women. In such circumstances, women are often powerless in asking their promiscuous partners to use a condom. In which case, alcohol and drugs are commonly used as the quickest escape from stress, state of helplessness and poverty. Alcohol is known to reduce all inhibitions even when the people are substantially knowledgeable about the implications of unprotected sex.

Furthermore, young females in Africa are handicapped by factors such as low literacy, economic deprivation, lack of parental support and inadequate access to reproductive health information and services. These factors acting in conjunction with low self esteem, poor sexual negotiation power and lack of educational and entrepreneurial abilities and opportunities have created a feeling of disconnectedness and powerlessness among the youth. In this case, sex, alcohol, sexual violence and crime come in handy, as a means of self-gratification (Imoh, 2008:1). Due to high levels of youth unemployment, there is a high level of rural urban and intra-rural migration of young people in search of employment and educational opportunities. As migrants, many young people are unemployed and still depend on their parents and relatives for their upkeep. These factors coupled with the lack of governmental support programmes, have led to a high level of pre-marital sex, peer influences, alcohol and substance abuse, crime and sex related offences among young people.

### **Statement of the Problem**

As more and more young women in Africa opt for higher education and delayed marriages, the gap between physiological readiness and culturally acceptable practices of sex and fertility behaviour is widening. In the African setting, sex has been a taboo and continues to be a taboo in the home, church and the media. Because of this taboo, the youths are not sufficiently informed on sex, human sexuality and reproductive health issues. This development has led to unsafe sexual behaviour, unwanted pregnancies, induced abortions and other health hazards associated with sex (Markinwa, 1992:67). Part of this is because, the youth lack the requisite behavioural and communication skills needed for healthy interpersonal and sexual relations.

For the youths, out of school, the situation is exacerbated by poverty, joblessness, abusive background, lack of socioeconomic support, interpersonal limitation and powerlessness. (Family Care International, 1996:3).

Africa has one of the highest HIV prevalence rates in the world. It is estimated that one in four of the adult population aged 15-49 years are HIV infected with the highest age specific rate occurring among young women, 25-29 years (UNAIDS, 2002).

Studies have shown that girls are more susceptible to HIV infection than boys. For every HIV positive boy, 15-29 years old, there are three girls (Botelse, 2002). According to media reports, violence against young women including murder, physical assault, rape and defilement are becoming rampant in parts of Africa. These acts traumatize and dehumanize women and leave them exposed to the risk of unplanned pregnancies, STDs and HIV-AIDS infection. Our understanding of the dynamics of the AIDS epidemic requires that we deal with the educational, informational, legal, medical and psychosocial causes and effects of sexual violence among young women in African societies. One good way to start is to address the scepter of poverty and low socio-cultural status of women which predisposes them to HIV infection.

Efforts by national and local authorities to promote safer sex practices and reduce the spread of HIV among young and vulnerable women have failed to achieve the desired results because the programmes failed to address the pressing need for income generation. This is because poverty or economic factors may lead people to further frustration and lack of motivation to act on messages or gain new skills.

Programmes may also fail because of poorly defined roles, inadequate capacity and skills of implementers, poor interagency linkages, lack of shared vision, team learning, system thinking and partnership building that reduce high risk behaviours. Studies have shown that being a member of a known community youth group can reduce a woman's chance of becoming infected with HIV. The study also confirmed that higher education levels are associated with higher rates of condom use (UNAIDS, 2002:72).

## **II Theoretical Framework**

The key to the adoption of safer sex practices and the utilization of Reproductive Health Services by adolescents is motivation. The motivational factors are derived from the Health Belief Model (Rosenstock, 1966, and Gochman et al, 1971). They include among other factors, the following:

- i. Readiness to act, which is determined by the individuals perceived severity of a given situation.
- ii. The individual (group) perception of the benefit to be gained in comparison to the perceived barriers to the health behaviour.
- iii. Whether or not the advocated action produces results that are observable in the short term.
- iv. The influence of social pressure from peers, family members and other significant people.
- v. Previous experience gained from utilization of preventive health services.
- vi. Cue selection which is needed to bring about the behaviour change.
- vii. Enabling factors such as time, money, skills and availability of appropriate support services.

These factors can make the difference between intention and performance and they inform the design and implementation of this project. Against this background, a combination of multimedia and multisetting approaches based on an intricate network of interpersonal contacts is used to inform, clarify and convince young and vulnerable women to modify their STI/HIV-AIDS risk behaviours. Since knowledge on its own does not lead to behavioural change, the group is empowered with skills, including life skills, sexual negotiation skills, income generation skills, interpersonal and interactional skills, sexual decision making, fertility regulation, condom use and counseling.

As a reinforcement, educational and informational materials are developed to promote condoms, HIV testing; STI Clinics and family planning methods. It is only when people are aware of the existence of a service and the personal benefits they can derive from utilizing that service that they will decide to utilize that service. However, the promotion of safer sex practices, to be successful, must enlist the support of the social system, since the values attached to sex are group anchored. The project therefore is to establish linkages with families, religious and formal institutions, including health, economic, education and legal sectors. Their support is needed in the creation of employment and educational opportunities, gender sensitive and adolescent friendly reproductive health services, legal protection against sexual violence, establishment of recreational centers, building of healthy families and community relationships, human rights and freedom to decide, choose and act on the basis of informed choice.

The Peer Education concept derives also from the Social Diffusion Theory which states that in the diffusion of new ideas, potential adopters prefer personal sources of information because they are accessible, credible and reliable and can be sought out for clarification and consultation. Other theories such as the social learning, social expectation and homophily theories of learning stated that people are more receptive to those who share similar experiential and demographic characteristics with them. In this regard, peers can act as important sources of information to each other on sexual and reproductive health matters.

### **Regional Strategies for Empowering Young Women in Africa**

The African continent has been and continues to be a passive receptacle of models and programmes which derive essentially from western paradigms that are inevitably insensitive to the region's socio-economic, cultural and demographic constraints.

Programmatically, several basic strategies have been identified by UNAIDS (2002:72) as essential to helping young and vulnerable women in Africa. These include the following:

- i. Protecting and promoting the rights of young women, including the right to information, education, health and health care, freedom from rape and sexual coercion, right to employment, inheritance, marital law and sexual and reproductive decision making.
- ii. Promoting HIV/STI prevention and reproductive health through life skills training and provision of information to young and vulnerable women in and out of school.

- iii. Providing reproductive health services, including access to condoms, voluntary counselling and testing and diagnosis and treatment of STIs.
- iv. Targeting programmes to particularly vulnerable groups, especially young Out of school and unemployed youths.
- v. Empowering young vulnerable women against a wide variety of cultural and social inequities that make them more vulnerable than males.
- vi. Promoting access to youth friendly reproductive health services by providing access to reproductive health advice, information and services that are confidential and ensure privacy, including access to treatment of sexually transmitted infections.
- vii. Ensuring the use of peer education and interpersonal communication. Peer education is a key strategy that has been used in several countries to reach young out of school youths with reproductive health information.

Properly trained peer educators who meet regularly to openly discuss sexuality and relationships have promoted preventive behaviours relating to STI, contraception and condom use in Cameroon, South Africa and Kenya. (UNAIDS, 2000:76).

### **III Background on Botswana**

Botswana is a country located at the centre of the Southern Africa Plateau, sandwiched between Namibia to the west and North West, South Africa to the south and south east, Zambia to the north and Zimbabwe to the north east. It has an area of 582,000 square kilometres and an estimated population of 1.6 million people. About 60 percent of the population (aged 12-29 years) is youths.

Politically, the country is stable and the economy, a success story. However, poverty, especially rural and household poverty is visible. According to the Botswana Human Development Report 2002, Botswana remains a country in which one in two people live in poverty. The report indicated that 55 percent of rural households live in poverty, while 47 percent are female headed. Nearly 46 percent of female headed households are poor and have no income earners. There is a high level of rural urban and intra rural migration of young people in search of employment and educational opportunities. Many young people are unemployed and depend on their parents and relatives for tenancy and upkeep. These factors coupled with the lack of recreational facilities have led to a high level of premarital sex, peer influences and alcohol related risk behaviours among young people.

Botswana has one of the highest HIV prevalence rates in the African sub-region. According to UNAIDS estimates, more than one in four of the adult population (aged 15-49 years) are HIV infected with the highest age specific rate occurring among women (25-29 years old).

Studies have shown that girls are more susceptible to HIV infection than boys. For every HIV positive boy (15-29 years old), there are three girls (NACA, Boletse. December 2002) According to the Botswana Health and Demographic Survey Report (2000), the death rate for the age group, 24-29 years was 11.8 percent in 1998, the highest in the entire population below 65 years. These figures betray the incidence of deaths resulting from AIDS related diseases that originated from infections that occurred when the victims were either teenagers or in their very early twenties.

According to media reports, violence against young women , including murder, physical assault, rape and defilement are becoming rampant in Botswana. These acts traumatize and dehumanize young women and leave them exposed to the risk of unplanned pregnancies and Sexually Transmitted Infections (STI), including HIV. Reports have shown that one out of every 5 women in Botswana has been a victim of sexual harassment, rape, incest; severe beating, murder or emotional abuse, (Human Development Report 2000). It has been scientifically proven that coercive sex, including rape, facilitates the transmission of HIV and is especially efficient in doing so when the violations are against young women and girls. This is because the act causes extensive damage to the female genital mucosa. There is the need therefore to deal with the educational, informational, legal, medical and psychological causes and effects of sexual violence among adolescent women and society in general.

Vision 2016, for the people of Botswana, envisages a just, caring and compassionate society in which there will be no new HIV infections by 2016. Going by UNAIDS reports (1999), approximately 98 percent of the children of Botswana below 15 years were HIV negative. This represents a glimmer of hope for an “AIDS Free Generation”. However, in community Junior Secondary Schools across Botswana, pregnancy related dropouts remain high with young girls accounting for 70 percent. This suggests .high incidence of unprotected sex among young women whose first sexual encounter may be with older men who provide the medium through which the virus moves from one generation to another. Possibilities for achieving an AIDS Free Generation in Botswana lie in addressing the spectre of poverty and the low socio cultural status of women which aggravate the vulnerability of young women to HIV infection.



### **The Project**

Under the Medium Term Plan (MTP 11) 1997-2002, embarked upon by the Government of Botswana, young and vulnerable women were identified as a priority group for HIV-AIDS prevention interventions. Under a collaborative arrangement between the Government of Botswana and the Government of Norway, the Young and Vulnerable Women Project was initiated in Molepolole in Kweneng East District in 1998.

Kweneng East District is one of the largest districts in Botswana with a population of 249 000 people. Molepolole, the administrative capital of Kweneng district, has about 54,000 people. The Botswana 2001 sentinel surveillance report indicates that 16.8 per cent of young women, 15-19 years, and 36.3 percent of women aged 20-24 years are HIV infected in the district.

### **The Target Population**

The project targeted female out of school youths between the age of 15 and 29 years. The goal was to reduce the transmission of STIs and HIV and reduce the rate of drop outs resulting from teenage pregnancies. Initial needs and situation assessment undertaken among young females in Molepolole by the Ministry of Health revealed that many young people were engaged in risky behaviours even though they were aware of the existence of HIV-AIDS. There was a high level of premarital sex which led to high incidence of STIs and unplanned teenage pregnancies. Many young girls are handicapped by factors such as low literacy, economic deprivation, lack of parental support and inadequate access to reproductive health information and services. These factors acting in conjunction with low self esteem, poor sexual negotiation power and lack of educational and entrepreneurial abilities and opportunities have created a feeling of disconnectedness and powerlessness among the youth making a lot of them to drop out of school without a job and a future. In this case, sex, alcohol and sexual violence come in handy as a means of self gratification.

### **Baseline Data**

#### ***Knowledge of HIV-Prevention Methods***

A survey of the sexual behaviour of young people in Botswana (NACA, 2002), indicated that 10 percent of the youth aged 15-29 years, did not know that HIV was related to AIDS. Only 16.7 percent of males and 20 percent of females know four methods of HIV transmission.

#### ***Sexual and Contraceptive Behaviour***

Among young girls (15- 24 years), 50 percent admitted that their first sexual intercourse. was not planned, while 87 percent agreed that they had used a condom during the first sexual experience. About 12.3 percent of the girls interviewed, however indicated that they were forced to have sex the first time, while only 4.4 percent admitted that they exchanged sex for gifts or money (Boletse December 2002). About 7.1 percent of young females (15-24), have more than one sex partner, while 53.6 percent reported having non regular partners. Although most young people hold positive views about the need for condoms, 60-80 percent think that it is unrealistic to use condoms consistently. If a boy refuses to use a condom, 33.3 percent of them agreed that a girl cannot really insist: Boys may need to hit their girlfriends if they refuse to have sex with them. This view was supported by 25 percent of males and 15 percent of females interviewed.

Perception of risk of pregnancy among older girls (15-24 years) was low, even among those who had been pregnant once. Some feel that one could not get pregnant during the first experience of sexual intercourse. Their knowledge of human sexuality and contraception was low and this was reflected in the high rate of unplanned pregnancies.

While the culture may not encourage premarital sex or child bearing out of wedlock, young women are under parental and peer pressure to bear children even if they are not married. This is the time when they get exposed to the risk of both pregnancy and HIV infection. Young girls have been known to avoid using contraceptives or insist on condom use and allowed themselves to get pregnant in order to pressurize their partners to commit themselves to marriage.

#### ***Socio-Economic Factors***

According to the Botswana Human Development Report (2000), one in two people live in poverty. Poverty acts in several ways as an important co-factor in the transmission of HIV. It forces young women to engage in behaviours that expose them to HIV infection. Within Botswana, large public infrastructure projects and expanded private sector activities, there are young females who seek livelihood at one construction site after another. Here, multiple formal and informal sexual negotiations and networking are known to occur (Boletse, 2002).

Gaborone (the Capital of Botswana) has a push-pull effect on young people. There is high mobility of young women to Gaborone in search of pleasure, partners and in some cases informal commercial sex work. In the absence of recreational and leisure facilities in most rural and urban centres in the district, the youth are

attracted to the numerous bars and shabeens where games; alcohol and music can be found. Here, young men, older men, young girls and older girls meet and interact with their partners and sexual negotiations can take place.

### ***Sources of Information on STD/HIV-AIDS, Human Sexuality and Contraception***

Historically, culture forbids parents to discuss sex with their daughters beyond instructions on menstruation, personal hygiene and the admonition to stay away from boys. Consequently, their knowledge of sex and human sexuality is based on the little they got from friends, older sisters and cousins, romance novels, movies and magazines, some of which create illusions of reality. The District Health Team has distributed pamphlets on Adolescent Reproductive Health such as "I Need To Know". "Be a Woman Before Becoming a Mother", Family Planning Methods, STDs and HIV-AIDS. However, there is no available information on the beneficiaries of these educational materials and the impact they have made on the target population.

Recent reports (Botetse, 2002), indicate that young people still lack the correct knowledge about the modes of transmission and methods of prevention of HIV infection. This justifies the need to identify and use channels that can effectively carry messages to the hard to reach and disadvantaged young women, some of whom are semi-literate. Unless young people are aware of the existence of the HIV-AIDS prevention programmes and the benefits, they will not avail themselves of the services and comply with advocated behaviours.

### **The Objectives of the Project in Molepolole**

Following the successful implementation of the Peer Education Approach in two major cities in Botswana, the Government of Botswana decided to replicate the concept in order to reach more young and vulnerable women at the community level with HIV-AIDS and Family Planning information. These pilot projects in Palapye and Francistown were implemented by the National AIDS Control Agency, with support from donor agencies and the district councils. The objective is to reduce the rate of transmission of Sexually Transmitted Infections including HIV and reduce the incidence of teenage pregnancies among young women. Specifically the Peer Education project has the following Objectives

- i. To build the STD/HIV-AIDS prevention capacity of young women through education and life skills training.
- ii. To increase the number of young women who utilize family planning services, thereby reducing the rate of unplanned pregnancies among the youth.
- iii. To promote the utilization of preventive health services and measures such as STI clinics, HIV-testing, and condom use
- iv. To provide the youth an opportunity for educational advancement
- v. To empower young and vulnerable women with marketable income generating and entrepreneurial skills.
- vi. To provide social, medical, information, psychological and legal support to victims of sexual violence and abuse.

### **Justification for the Project**

Early child bearing remains an impediment to improvements in the social, educational and economic status of young women. The long term adverse impact on their lives, their children's lives and the community in general is unquantifiable. The need to provide female out of school youths with reproductive health information, social support and access to youth friendly health services cannot be overemphasized because of the socio-medical implications.

An essential component of any strategy towards an AIDS Free Generation is to equip female out of school youths with marketable employment skills in the form of vocational 'training opportunities. This way, they are economically empowered to be independent *in* sexual decision making and negotiations. Young women also need to be empowered with information on their rights within relationships with men and their families. This includes the right to choose a partner, the right to decide when to have a child and negotiate condom use. Issues such as sexuality, STDs, Family Planning Condom use and HIV-AIDS prevention are personal and sensitive issues. Human communication leading to persuasion and sexual behavioural change flows through natural social networks. There is therefore a need for interpersonal mediation by extensionists, health workers, parents and peer educators at the community level to inform, clarify, explain and convince young people using the local language.

### **Description of Interventions (Materials and Method)**

Multistrategic, multisetting and multistage approaches were used to implement the interventions with the expectation that the project will be replicated in other towns and villages in Botswana, if successfully implemented. Essentially, the key element of the intervention consists of the following strategies and activities.

- i. Recruitment of peer educators
- ii. Needs assessment and study tour to Palapye and Francistown, two towns in Botswana which have similar projects, to understudy these projects.
- iii. Development of educational (IEC) and motivational materials on HIV-AIDS, human anatomy and family planning methods.
- iv. Training of Peer Educators (recruits) in STD, HIV-AIDS prevention and education, including Family Planning, counseling and use of instructional materials.
- v. Health Provider Training to improve the quality of reproductive health services provided to adolescents.
- vi. Peer Education interventions which include, community based interpersonal, face to face contacts to share information with peers wherever they can be found.
- vii. Orientation of the law enforcement agencies on the regulation of alcohol sale, and support for victims of sexual violence.
- viii. Development of linkages with community social groups, religious leaders, Parent Teachers Associations (PTAs) and schools to strengthen positive family and traditional values that promote abstinence, postponement of sexual activity and moral values. This is accomplished through meetings, discussions and utterances.
- ix. Condom promotion and establishment of a reliable community based supply system.
- x. Support for entrepreneurial training and educational advancement to the participants.
- xi. Income generating activities such as candle making, gardening, poultry, dressmaking, catering, dressmaking, etc. by group members.
- xii. Establishment of linkages with and orientation of owners of bars, restaurants and supermarkets where a lot of young vulnerable women can be found.
- xiii. Financial and material incentives to regular members of the group in the form of uniforms and monthly stipend to cater for transport and other personal necessities.
- xiv. Monitoring and evaluation, which includes formative research, establishment of baseline indicators and monitoring of these indicators.

### **Procedure**

Twenty unemployed young women between ages 15 and 29 years were recruited from members of youth groups in Molepolole by the AIDS Secretariat. The group has the name "MAANO BOTSHELO" which means "Ideas for life". After screening the young women, a number of them went on a study tour to Palapye and Francistown to observe similar Peer Education Projects being implemented and learn their best practices. Upon their return, they were involved in the development of educational materials on STDs and HIV-AIDS prevention, Human Sexuality and Fertility Regulation.

This was followed by training in interpersonal communication, life skills and sexual assertiveness. The training was participatory, using role play. Topics covered, include;

- i. Sexually Transmitted Diseases (STDs), their causes, symptoms, consequences, prevention and management.
- ii. Recognition of early signs and symptoms of STDs and the need for early and appropriate treatment.
- iii. Family planning technology, family planning methods, their benefits and appropriateness.
- iv. Where to go for family planning.
- v. HIV-AIDS, causes, symptoms, prevention and management.
- vi. Safer sex practices
- vii. Risk factors associated with HIV transmission
- viii. Condom use, myths and misconceptions.
- ix. Sexual decision making, sexual negotiation skills.
- x. How to communicate messages on HIV/STD prevention and family planning benefits.
- xi. Skills in persuasion, interpersonal communication, including counseling.
- xii. Constraints encountered by young women in relation to compliance with HIV-AIDS prevention messages.
- xiii. Alcohol and substance abuse, their effects on sexual behaviour and sexual decision making.
- xiv. Sexual violence and abuse, how to avoid being a victim.

### **Expected Outcomes of the Project**

- i. Adoption of safer sex practices, increase in condom use and reduction in the number of sex partners.
- ii. Family Planning Education will reduce the incidence of STD/HIV infections and unplanned teenage pregnancies which kept many young women down.
- iii. Improved treatment of STDs which could reduce the efficiency of HIV transmission among young women.
- iv. Retraining of health providers on Adolescent Reproductive Health needs could improve the quality of care received by adolescents in health facilities and impact positively on the level of utilization of those services including STD clinics and Family planning services.
- v. Provision of entrepreneurial skills, income generating activities and opportunities for educational advancement will motivate young people to be assertive and confident in sexual decision making.
- vi. Linkages with community social system will legitimize the programme and give a feeling of ownership in the community.

### **IV. Management and Coordination of the Project**

The project is coordinated directly by the office of the District Commissioner with support from the District HIV-AIDS Technical Committee and the District AIDS Advisor (the author) who reports to the District Multisectoral AIDS committee headed by the District Commissioner.

The Peer Educators have an implementation committee with a chairperson, an assistant chairperson and secretary. A code of conduct was developed to guide the group and ensure harmony and discipline. Meetings are held regularly to discuss issues relating to their welfare and project activities. Members are required to recruit new members regularly and keep a record of their community contacts, medical check ups on their STD and pregnancy status every three months in order to stay in the group.

#### **Monitoring**

Initial needs assessment was conducted to establish baseline indicators for future impact evaluation. There are regular programme monitoring activities to ensure that interventions satisfy the content, coverage and output expectations of the project. There are also regular reports on meetings held by the group and these reports provide information on the activities of the group. Whenever possible, modifications are made on project strategies and content based on feedback received on project performance.

#### **Evaluation**

Midterm review of the project showed that many female out of school youths participated in the Peer Education project. This increased the spread of HIV-AIDS, STDs and contraceptive information among their peers. Moreover, the adoption of safer sex practices increased thereby reducing the incidence of unplanned pregnancies among group members. The training and orientation of health providers on Adolescent Reproductive Health Needs helped to improve the quality of services provided and increased the level of utilization for STD clinics and family planning services. The provision of entrepreneurial skills training to members of the group enabled the group members to get involved in income generating activities while others enrolled in remedial educational programmes at the Education Institute in Molepolole to improve their educational status and proceed to the University of Botswana or College of Education in Molepolole. This motivated and empowered them to be more assertive and confident in sexual decision making. Linkages with and orientation of the community social system, including the police, the community leaders and the economic sector helped to legitimize the project and gave a feeling of ownership to the community.

### **V. Summary And Conclusion**

Several obstacles stand in the way of empowering young and vulnerable women to practice safe sex as a means of preventing HIV infection in Africa. Early onset of sexual activity, multiple sexual relationships and unprotected sex, alcohol and drug abuse, peer influence, poverty, unemployment, lack of awareness of the threat posed by HIV-AIDS, feelings of personal invulnerability to HIV infection and lack of self esteem and sexual negotiation power are some of the major obstacles to adoption of safer sex practices among young female out of school youths.

Programmes targeting high risk groups such as young women should therefore effectively address situations in which these groups operate, including the social networks, the predisposing social, economic and cultural factors which prevent them from adopting preventive behaviours, despite their high level of awareness of HIV-AIDS. For instance, in Africa, women are subordinate to men and lack of economic autonomy exposes them to cultural, emotional and sexual exploitation and oppression by men. The pronatalist culture in Africa encourages child bearing by young girls to prove their fertility at the risk of getting infected, while community



norms and values encourage male sexual behaviour that separates sexual satisfaction from responsibility and encourages passivity in women.

Many young people still lack the correct knowledge about the modes of transmission and methods of prevention of HIV-infection. Even when knowledge has been substantially increased, knowledge is not necessarily enough. It is therefore essential to understand what protective factors help young out of school women to practice safe sex, develop positive self esteem and create a social support system for themselves. The Peer Education approach is one positive step in the right direction. The Peer Education approach is relevant when trying to reach a group of neglected and vulnerable young women who are educationally, emotionally and economically disadvantaged. The approach has succeeded in fostering equal participation for all group members and empowered them with preventive health information, interpersonal communication and entrepreneurial skills and opportunity for educational advancement needed for self assertiveness, economic independence and positive sexual negotiating power.

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