EASAS SWEDEN CONFERENCE 2004 Lund, Sweden.

Paper of Shankpal PD INDIA :

*Theme Of the project/Abstract: Organisation & Health educational Research in developing nations.

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Background:

Health Alert Organisation of India [Registration no. MAH/BOM/783/93/GBBSD] [A Non-Governmental Organisation working in rural/tribal areas of India in field of HIV/AIDS, School education, Tobacco control.]

Service to the marginalised communities in Rural India since 1993.

Profile of selfless service done for HIV/AIDS CONTROL & Sex education:

We the founder members of Health alert Organisation of India are a team of young paramedical & social workers with the dedicated service of over a decade since 1993. We started with aim is of serving & educating the rural population of India. Our team is actively for counselling, rehabilitation, educating rural/tribal communities about Health promotion, Sex education, HIV/AIDS prevention, adolescent education, providing information & treatment access to sexually transmitted diseases . We have been carrying out HIV/AIDS awareness/education programs at grass-root level in collaboration with religious bodies, faith healers in this marginalised community. All along this efforts, our stress has been on active participation of Community in all activities. Also to our credit is the credibility of carrying out sexual health campaigns targeted at blood donors & migrating population of truck drivers on the national highways of India. Our NGO conducts behavioural change workshops by incorporating condom use, sex education in rural schools/colleges, factory workers.

Our annual activities involve,

[1] Organisation of seminars, workshops for education of Sexual health & HIV caregivers.

[2] Fight for the reproductive and sexual health rights within the context of their our rural/tribal society. Also we implement sexual and reproductive rights policies by Collaborating with other NGOs.
[3] Providing comprehensive facility for People Living With HIV/AIDS (PLWHA).
[4] Carrying out Anti-Retroviral drugs awareness & access programs.
[5] Forming & training teams of young volunteers for service to HIV control activities.
[6] Organising conferences, workshops & promotion programmes.
[7] Conducting awareness programs & feedback analysis on issues of sexual health.
[8] Incorporating community participation for better impact of health educational policy implementation.

All this work has been carried with support & goodwishes of volunteers.

We are ready to face the challenge created by this threat of HIV/AIDS with the active lead by the adolescents. At the heart of this rural organisation is a Field force dedicated to the cause of this minority community.

We are representing economically & socially backward community [Tilori-Kunbi], which is a backward marginalised community in India at the EASAS, Lund 2004 Conference.

We aim to
1] Work with other experts/organisations on strategy on Sex education & HIV/AIDS control & other issues of health promotion.

2] To evolve a novel concept to take HIV/AIDS prevention & education to primary level of rural\tribal population of India.

We are very thankful to SASNET & the EASAS organisers/sponsors for giving us a strong platform like EASAS conference at Lund to share our work & gain expertise.

Title: Incorporating peer educators in adolescent reproductive health information dissemination in schools and communities of Rural India.

Aims of this project:

To Elicit better policy implementation on this issue of HIV/AIDS Our NGO took the lead in carrying out this current project in Rural/Tribal areas of INDIA.

Issues:

Rapid spread of HIV/AIDS is a very serious threat to the adolescents population of developing nations. These adolescents are the pillars of future. But various studies in past have shown that the incidence of Sexually Transmitted Diseases [STD's] & HIV is very rampant in this population.

The etiological factors for this are ignorance about sexual & reproductive health as well as lack of health educational interventions such as education of masses about contraceptive methods , importance of limiting one's sexual partners etc. Over last five years various educational programs have been carried in developing nations of Asia. They were ranging from Local NGO sponsored projects to the Internationally conducted projects. What worried us was,

[1] Most of these programs were targeted to the general population . Youth as a separate group was not given priority.
[2] All of these past 11 projects in India were on HIV/AIDS education were in urban areas.
[3] The resource poor rural/tribal population is not responsive to the current policies of the educational system.
[4] All the stress was on preventing HIV, Enough attention was not given to the improvement of education about reproductive health.

Since our NGO has field force of Local volunteers who had strong background knowledge about these isolated communities of India, we decided to carry this project with following objectives,

[1] To devise a project targeted at Youth Carried By Youths.
[2] To give stress on community participation rather than dry teaching classes in schools.
[3] We roped in community leaders, Religious faith healers from these hilly area.
[4] To evaluate the outcome of this project on Step-By-Step Method, & to modify our methodology over eight months period to get optimum results.
[5] To overcome our constant difficulty of limited resources , we devised the PEER-EDUCATION system. This involves a three tier Peer support group trained by our NGO team in health education.

Why we used this Method.:

Due to cultural implications/barriers, adolescents are forbidden from discussing HIV/AIDS issues in public. Due to this adolescents in post primary schools receive wrong information on HIV transmission in youths and sexuality health issues from their peers & other sources like pornographic material. HIV community leaders form South Asian region always faced a long-standing demand to correct this wrong information received by adolescents. This is due to belief that adolescents are good listeners especially when it involves their peer. They also understand their likes better because they speak in same language. Additionally it reuires very little resources so can be implemented in resource poor setting.

Methodology: Between May-August 2003, our NGO volunteers carried out community baseline survey in 6 Post-Primary Schools in rural constituency of Mah. State.

We had filed volunteers of four teams. Each team has eight volunteers. The team was trained to determine how post primary adolescents receive HIV/AIDS & sexuality information & how we can improvise our current educational methods employed in Govt as well as non-governmental set-ups. From these 6 schools we formed 24 groups of peers. [Each group consisted 16 peers]. We trained these 16 selected peers over six sessions by NGO Team. These NGO sessions included lectures, demonstrations, graphic explanations, use of clay models. Here we roped in school teachers [Total 4], religious faith healers: Since they have tremendous impact on day-to-day life of this isolated community [Total 6]. The aim of this trained sessions was instituting peer counseling services in these selected target population of school children. **After this formal training the volunteers were sent to the schools from this region for project implementation. This was achieved by Total** 55 protocol interviews with school children's in 14 rural secondary schools in this tribal region with 3-4 interviews per school. Where it was found essential principal; parents, life skills or guidance teachers; plus others doing youth activities were involved. This was done to get maximum participation of the adolescents. Our NGO volunteers Focused group discussions with 4 school governing boards of teachers, parents and students.

Results:

Respondents had an average age of 16 years, 47% of them were female, 76% were single and 84% had no child. While 92% of them had heard of STDs & AIDS. Knowledge about routed of transmission, preventive measures, safer sexual practices, availability & efficacy of treatment options including antiretrovirals was below 16%. Only 48% could spontaneously recognize unprotected sexual intercourse as major transmission route, only 37% could mention blood transfusion, perinatal [MTCT] as other routes. When testing beliefs & attitudes in tribal women's, we found about 76% believed that one could get infected from kissing, living with or nursing of PLWHA. 60% spontaneously mentioned abstaining from sex as a means of preventing HIV. 54% of this isolated community believed that sex with virgins will cure them of HIV. Hardly 27% believed that sex with one in many positions is better that one position with many sex partners is the best policy for HIV control.

Discussions concerning sex were held mostly with their peers. 65% of respondents were sexually active by age of 14 with mean lifetime of four sex partners. About 58% of this tribal population believed that traditional faith healers with their doubtful methods & medications is still best option for treatment of HIV/AIDS. After giving due consideration to the social, economical, cultural factors , Adolescent's [N=645] activities were monitored over five months period [Pilot study protocol]. All the participants from this study were classified in four groups based on the criteria of age & educational activity grade [Class]. During this period they were evaluated for the basic level of knowledge, attitudes, beliefs, sexual practices. This was noted as the basic level of education on health. After this the project methodology was implemented to improve the level of HIV/AIDS & sexual health awareness & also the scientific base was incorporated in the educational curriculum. After the sixth month onwards post intervention evaluation was done with questionnaire [Proforma enclosed at the bottom of this paper.]. Proforma was devised & distributed by secondary class students who volunteered for this study. The contents of the proforma are given at the bottom page.

These same peers were later encouraged to further educate their classmates, neighbors & social circle friends. We did gave some encouragements to these peers as recognition certificates during the periodical religious functions of this community. All the peer educators in this program were called once in a 15 days to discuss their progress 7 solve their queries/difficulties. 12 such meetings were held todate. We found that these peer educators helped in disseminating correct information to their peers, additionally there was 70% improvement in level of their peers knowledge of sexuality & HIV/AIDS. This approach also increased leadership quality and general well being and self assertiveness of most of peer educators who were elected prefects/senior prefects in various schools.

Conclusion:

Health education is a long neglected matter of social concern in developing nations. Traditionally isolated communities are worse affected because of this. The current HIV/AIDS programme concentrate on the urban area [the so called urban development Phenomenon.] NGOs need to come together to share their work in such rural areas & devise newer methods/strategies to overcome this drawback. We need to penetrate the education system in the educational institutes of developing south Asian region to implement our ideas/projects. However attention must be paid to keep a follow-up of these projects. Because over a period of time we found that due to lack of motivational factors the community participants tend to drop-out of the educational plans. This happens due to the very poor economic background of the participants. They have to struggle daily for getting a days meal/food their families. Many a times we felt that we need to work hard over this issue of non-compliance. Because any plan to implement a newer educational system must have a foolproof methods to bridge this gap. Due to the constraints of economics of survival cost was the main obstacle we faced during our study.

For resource poor settings we need to encourage use of peer-educators counseling as a means of having better impact policy for sex education & HIV /AIDS control. NGO's should concentrate on reaching school adolescents community in isolated population. Sex education & sexuality development will be at optimum level by using this model. This model will prove very effective for HIV prevention in resource poor developing nations. To contain this rapid spread of HIV/AIDS we all NGO workers have to come together to strengthen our bonds to work together for this cause.

Peer HIV/AIDS & Sexual Educational Proforma: HEALTH ALERT ORGANISATION OF INDIA, Dhule.

Enrolment No:

Name:

Education:

Address:

Reference Volunteer Name:

Reference school name:

PEER Information:
A]Family Background:
2]Type of educational intervention method used:
3] When contraception use started:
4] Years since Use:
5] Factors considered for better outcome of educational methods:
6] Any STD complication/treatment in past:
7]Any concurrent substance abuse:
8]History of Recurrence of STD in past:
9] Methods/therapy employed by traditional faith healer/school teacher/community volunteer:

Remarks :

Evaluators Suggestions.

Evaluation PROGRAMME proforma: [FOLLOW-UP]
HEALTH ALERT ORGANISATION OF INDIA,
Dhule.

Reference/Follow-up failure evaluation proforma

Name:

Traditional faith healer /school teacher/community volunteer:

Follow-up centre/school:

Reasons for follow-up failure:

A]
B]
C]
D]
E]

Does the evaluators feel that candidate can be motivated back to education about safe sex/use of contraceptive:

Family / cultural/ educational background evaluation:

Measures suggested for further motivation:

Remarks: