



Federal Ministry
for Economic Cooperation
and Development



Coming of age

Fifteen years of the Join-In Circuit on AIDS, Love and Sexuality

A publication in the German Health Practice Collection

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German Health Practice Collection

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■ **Front cover photo:** *The Join-In Circuit is an interactive behaviour change communication tool which has been used to promote HIV prevention and improve sexual and reproductive health in more than 20 countries. Here, a JIC facilitator leads a discussion about living positively with HIV at a teacher training institution in Chicuque, Mozambique.*

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Acronyms and abbreviations

BMZ	Federal Ministry for Economic Cooperation and Development, Germany (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung)
BZgA	Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung)
DED	Deutscher Entwicklungsdienst
FACT	Family AIDS Caring Trust
GDC	German Development Cooperation
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH
HIV	Human Immunodeficiency Virus
HPZ	HIV Prevention in Zimbabwe project
JIC	Join-In Circuit on AIDS, Love, and Sexuality
JTSU	JIC Technical Support Unit
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
PSI	Population Services International
USAID	United States Agency for International Development
ZAN	Zimbabwe AIDS Network

Executive summary

Box 1. Key Messages

Situation. Approximately one-third of adults newly infected with HIV worldwide are between the ages of 15 and 24. Many young people do not have accurate and comprehensive knowledge of HIV or access to effective interventions which can prevent and treat HIV.

Approach. The Join-In Circuit (JIC) on AIDS, Love and Sexuality is an interactive behaviour change communication tool which stimulates discussion and personal reflection about HIV and sexual and reproductive health. It is used with diverse audiences to educate and to promote protective behaviour.

Results. More than 200,000 people, most of them young people, have participated in the JIC since 2011. The JIC increases knowledge about HIV and sexual and reproductive health. When implemented as part of a package, it provides opportunities for participants to access services such as HIV testing and counselling.

Lessons learned. Where possible the JIC should be implemented in combination with interventions which seek to reform health systems and to transform community-level attitudes towards young people and their sexual and reproductive health needs.

This case study is about the Join-In Circuit (JIC) on AIDS, Love and Sexuality, a behaviour change communication tool which has been used with support from Germany's Federal Ministry for Economic Cooperation and Development (BMZ) to promote HIV prevention and improve sexual and reproductive health, particularly among young people, in countries worldwide. This publication presents experiences from four countries – Kyrgyzstan, Nepal, Zambia and Zimbabwe – where the JIC has been implemented widely in recent years.

Situation

Despite a 35% decline in new HIV infections globally since 2000, an estimated two million people were newly infected with HIV in 2014. Thirty-four per cent of newly-infected adults are young people between the ages of 15 and 24; the majority of these are young women and girls. Over the past 15 years the percentage of young people with accurate and comprehensive knowledge about HIV has increased, but levels of knowledge remain too low. While many effective interventions are now available to prevent and treat HIV, young people do not always have easy access to them.

Approach

The Join-In Circuit is a behaviour change communication tool which engages large groups of people in interpersonal communication on HIV and sexual and reproductive health.

Originally developed in Germany by the Federal Centre for Health Education (BZgA), the JIC has been used in health, education and HIV prevention programmes implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) in selected low- and middle-income countries in Africa, Asia, Europe and Latin America since 2001.

The JIC is premised on the idea of education through dialogue. Groups of 10 to 15 participants rotate through a series of stations, each of which focuses on a particular topic (e.g. modes of HIV transmission, contraception, positive living). Trained facilitators use interactive problem-solving, games, and visual material to stimulate discussion and personal reflection in a safe, open and relaxed atmosphere. Afterwards, they provide participants with information about HIV and health services available in the area. In some settings, condoms are distributed and mobile services, such as HIV testing and counselling, are available on site.

Since 2001 GIZ has supported the adaptation and use of the Join-In Circuit in more than 20 countries. It has worked with governmental and non-governmental partners to customise the content of the JIC so that it reflects social and cultural norms, to train cohorts of JIC facilitators, and to implement the JIC with diverse target groups. Young people are a core audience in most countries, but the JIC has also been used with soldiers, factory workers, farm workers, sex workers, truck drivers, prisoners and other groups of adults.

Over the past five years, the content of the JIC has been revised in several countries to better reflect the connections between HIV and other aspects of sexual and reproductive health and rights, such as family planning, antenatal and neonatal care, and gender-based violence. The JIC has been used to mobilise demand for services, such as HIV testing and counselling and medical male circumcision, and integrated with national HIV and sexual and reproductive health strategies and programmes.

Results

Since 2011 more than 200,000 people in ten countries have participated in the Join-In Circuit, the great majority of them young people between the ages of 15 and 24.

In Zimbabwe, more than 31,000 young people in two provinces have taken part in the JIC, which has been implemented as a package alongside mobile HIV testing and counselling and referrals to health facilities with youth-friendly corners. Important results include:

- **JIC participants have increased knowledge about HIV and sexual and reproductive health** compared to non-participants. They also have fewer sexual partners and are more likely to speak with friends and family about sexual and reproductive health topics. This impact was confirmed in a randomised control trial.
- **The JIC encourages participants to use health services.** Thirty-seven per cent of participants have tested for HIV directly following JIC sessions, and more than 1,000 young men have gone for voluntary medical male circumcision after being referred by JIC facilitators.
- **Successful handover to a local NGO points to a sustainable future for the JIC.** Now coordinated by Family AIDS Caring Trust, a Zimbabwean NGO, the JIC will continue to be implemented under the auspices of other development partner-funded initiatives following the end of German support in late 2015.

In **Kyrgyzstan**, where the JIC is endorsed in the Den Sooluk National Health Reform Programme as a recommended HIV prevention measure, more than 20,000 young people, predominantly in rural areas, have participated in the JIC at 650 schools since 2011. A process is underway to institutionalise the JIC in the Kyrgyz school system through the life skills curricula and teacher training institutions.

Known as SangSangai, the JIC in **Nepal** has reached 36,000 young people aged 15 to 19 in two regions of the country since 2013, generating strong increases in comprehensive knowledge about HIV among participants. SangSangai has been redesigned with German support to cover a wide range of adolescent sexual and reproductive health topics beyond HIV and sexually transmitted infections.

Since 2011 60,000 people in **Zambia** have taken part in the JIC, which is coordinated by Afya Mzuri, a local NGO. While many of the participants are young people, the JIC has been used widely with adults in workplace programmes and community settings. GIZ is currently working with the Ministry of Education to introduce the JIC into schools.

Lessons Learned

Key learnings over the past five years include:

- **The JIC is an adaptable tool that can address a range of sexual and reproductive health topics.** As the JIC continues to evolve and cover more issues, changes must be introduced carefully to ensure that it retains its interactive and participant-centred methodology.
- **Investments in monitoring and evaluation and sustainability planning should start early.** A systematic approach to monitoring and evaluation is essential for quality assurance. Careful planning with national partners can secure the institutional sustainability of the JIC following the end of German support.
- **The JIC should be implemented in combination with interventions which strengthen health systems and address community attitudes.** There are limits to what a one-time intervention like the JIC can achieve in terms of individual behaviour change. In many settings structural and socio-cultural factors strongly influence young people's willingness to access health services and to practice safe sexual behaviours.

An innovative tool inspires self-reflection and change

On a bright March afternoon, 58 pupils from the Devuli Secondary School in eastern Zimbabwe gathered in the shade of two large trees at the edge of the school grounds. Lessons were over for the day, but the young people¹ were not done learning: they had volunteered to spend the afternoon participating in the Join-In Circuit on AIDS, Love and Sexuality – commonly known as the JIC – an interactive tool for initiating discussion and stimulating personal reflection about health, sexuality, and relationships.

■ Don't give AIDS a chance!

Seven thematic stations – printed material mounted on collapsible metal frames – were set up in a large circle under the trees. Prosper Mhlanga, a slight young man of 24, stood in the middle of the circle and called the boisterous group to order. Prosper had been chosen by his co-facilitators as the team leader for that day's session and, despite having played this role many times before, he was uncharacteristically nervous. Until recently, Prosper had been enrolled at Devuli Secondary School and he wasn't sure if the pupils would listen to him.

They did. As Prosper introduced the three main messages of the JIC – inform yourself about HIV and sexual and reproductive health, take responsibility for protecting yourself and

others, and show solidarity with those infected with and affected by HIV – his voice became louder and more confident. Warming up the crowd, he led them into a call-and-response rhythm: 'JIC!' he would cry. 'Don't give AIDS a chance!' came the reply.

Prosper handed over to a young male nurse in a crisp white uniform who works at a nearby clinic. The nurse, who has been specially trained to provide youth-friendly health services, introduced himself and spoke to the pupils in a calm and relaxed manner about the human immunodeficiency virus, CD4 counts, opportunistic infections and the benefits of early enrolment in antiretroviral treatment. He then pointed out the empty classroom nearby where he would be available over the course of the afternoon to answer questions and to offer rapid HIV tests for anyone 16 or older who wished to learn their status.

And with that, the JIC run began. The pupils were divided into seven mixed-sex groups and each group was assigned to a starting station, where a facilitator was waiting for them. For the next 90 minutes, the young people rotated through the stations, engaging in games and interactive activities to raise their awareness of HIV and other aspects of sexual and reproductive health. Animated discussions were punctuated



■ After placing green ('no risk') and red ('risk') cards on a series of images, JIC participants at Devuli Secondary School discuss with a facilitator and with one another why they think HIV can or can not be transmitted in certain situations.

¹ The World Health Organization defines young people as those between 10 and 24 years old, youth as those between 15 and 24 years old, and adolescents as those between 10 and 19 years old. While aware of these definitional distinctions, for stylistic reasons we primarily use the term 'young people' throughout this publication to refer to participants in the Join-In Circuit. Where relevant to the discussion, specific age groups are indicated.

by bursts of laughter and occasional shouts of 'Don't give AIDS a chance!' More than a hundred of their peers were playing football on the sports fields just a short distance away, but none of the participants at the JIC run seemed to notice. On this hot and dusty afternoon, the JIC had succeeded in capturing everyone's attention.

■ Raising awareness of risks

This was not the first time the JIC had visited Devuli Secondary School. Kumbirai Farai, the deputy director, is a strong supporter and welcomes JIC runs at the school. 'What we like most about the JIC is the approach itself; how it involves young people. It allows them to talk and express themselves,' he says. 'This really works.'

Farai's colleague, Mtisi Simbarashe, the school's health master, acknowledges that sexual and reproductive health issues are very relevant for the 610 pupils at Devuli. 'We live close to the bridge,' he says, matter-of-factly. The bridge in question is Bircheneough Bridge, a 378-metre suspension bridge which spans the Save River. A village on the western side of the river takes its name from this famous landmark, and serves as the commercial centre for the sparsely populated surrounding area, which is dominated by small-scale farming. 'All kinds of people travel to the bridge to sell products,' explains Farai. 'Sometimes pupils are there selling products at the market well into the evening, as late as 9 PM. Older people can take advantage of them there, even prey on them.' The setting around the bridge presents a tangle of risks for young people of both sexes, including sexual harassment, casual (and often unprotected) sexual encounters, and transactional sex.

According to the two men, the JIC has been very important in raising awareness among young people about the risks that can come with sexual relationships, particularly with people who are older than they are. They believe that young people have become more aware of dangers, and are more able to reach out to their parents, peers and siblings with information and questions. 'We see that they share their knowledge with others. A lot of them also take the opportunity to go for tests. Because of the JIC, they understand the benefits of getting tested earlier and onto treatment earlier,' says Farai.



■ *Trained as a facilitator by Rujeko, an NGO in the Buhera District of Manicaland Province, Prosper Mhlanga has facilitated the Join-In Circuit dozens of times over the past two years.*

As the sun dropped lower in the sky and the JIC facilitators packed up their stations and prepared to leave, the nurse finished his last counselling session in the empty classroom. Twenty-one of the 58 JIC participants that afternoon had gone to see him and had been tested for HIV.

■ 'The JIC has changed my life'

For the young people who are trained to facilitate the JIC, the experience can be life-changing. Prosper Mhlanga thinks that, if it weren't for the JIC, he would almost certainly be in jail. 'Before I became a facilitator, I didn't care about life or about where I was going. Both my parents are dead. I didn't have any money and my only option was to steal. Then I was trained to be a JIC facilitator,' he continues, 'and I became more aware of life. Aware of my health. Aware that I could do something for myself.' He now uses the allowances that he receives for facilitating JIC runs to support his sister and grandparents, with whom he lives. He is studying to re-sit the mathematics exams which he failed at school so that he can continue his education.

Prosper feels that his life is now on track and he is proud that he is able to reach out to other young people. 'Before the JIC, many of us lived in situations in our homes, with HIV-positive family members, where we didn't understand all the ways HIV can be transmitted. We need this information for ourselves and our families. Without information you can live your life, and become an adult, without understanding certain things.'

Prosper's story illustrates the power of the JIC not only to convey key messages about HIV and sexual and reproductive health, but also to stimulate personal reflection and action. After moving through the stations, each of which grapples with a different aspect of a larger problem, participants are prompted to ask themselves a series of questions: Is this issue relevant to me? Is it important to my life? Am I informed enough? Is there something I can improve?

■ The Join-In Circuit comes of age

The Join-In Circuit was first developed in Germany in 1992 by the Federal Centre for Health Education (BZgA) as part of a larger behaviour change communication campaign called *Don't Give AIDS a Chance*. In 2001, the former Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), now part of the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), entered into cooperation with the BZgA to introduce the JIC into HIV prevention programmes in selected low- and middle-income countries. On behalf of the Federal Ministry for Economic Cooperation and Development (BMZ), the JIC has been incorporated into a variety of health and education programmes supported by German Development Cooperation (GDC) in more than 20 countries worldwide.

This publication in the German Health Practice Collection, which builds upon an earlier report published in 2008, takes a look at the Join-In Circuit in the midst of its own adolescence. How has the JIC grown and changed over the past 15 years? How have the content and focus of the JIC shifted in keeping with the course of the global HIV epidemic? What lessons have been learned about the partnership and financing arrangements needed to sustain the JIC? What has been established about the tool's effectiveness?

Rather than providing a comprehensive overview of the JIC in all its diversity, this publication focuses on innovative aspects of JIC implementation in four countries. At its heart is a detailed case study from Zimbabwe, where the JIC has been implemented particularly intensively since 2011; briefer vignettes from Zambia, Kyrgyzstan, and Nepal offer complementary experiences which illustrate some of the ways the JIC has evolved in recent years.



Other resource materials related to the Join-In Circuit, including an earlier publication about the JIC in the German Health Practice Collection, can be found at <http://health.bmz.de/good-practices/GHPC/Join-In-Circuit/>

An overview of GIZ-supported implementation of the Join-In Circuit between 2011 and 2015 is provided in the annex at the end of this publication.

A brief history of the Join-In Circuit

The origins of a behaviour change communication tool

By the early 1990s, the global HIV epidemic was accelerating rapidly. In Germany, a country with a relatively low HIV burden, there had been a roughly five-fold increase in the number of new cases of HIV reported between 1985 and 1990, from 313 to 1,559 cases annually. In 1992, 1,944 new cases of HIV were reported (Federal Health Monitoring System, 2015).

That same year, Germany's Federal Centre for Health Education, which was responsible for the national HIV prevention campaign *Don't Give AIDS a Chance*, added a new tool to the campaign's arsenal: the Join-In Circuit on AIDS, Love and Sexuality. Premised on the idea of education through personal communication and dialogue, the JIC was intended to complement the information about HIV being conveyed through the mass media. Building popular awareness of HIV and how it can be transmitted was essential, but this alone was unlikely to bring about lasting changes in people's attitudes and behaviours. The JIC worked in a different way: it allowed participants to examine the topic of HIV risk and prevention through the lens of their own lives, values, needs and fears, thereby triggering a process of personal reflection, further questions and, ultimately, action.

The ideas underpinning the JIC were being taken up in other settings, too. Over the course of the 1990s, behaviour change communication interventions played an increasingly prominent role in national and international HIV control programmes. These 'second generation' HIV prevention strategies moved beyond a narrow focus on teaching about infection risks and experimented with ways to actually shift the behavioural patterns of specific target groups, often in the direction of abstinence, condom use, and limiting the number of sexual partners (Bertrand et al., 2006).



■ A trained facilitator demonstrates how to use a female condom at a Join-In Circuit station in Ethiopia.

While some behaviour change communication interventions sought to reach large audiences via television and radio, others, like the JIC, worked at a smaller scale, using face-to-face, interactive methods in community settings. 'Small group' approaches to HIV prevention², such as peer education and counselling-based interventions, placed a strong emphasis on interpersonal communication and came to be seen as an essential complement to mass media campaigns (Kalichman, 1998, cited in UNAIDS, 1999a and 1999b).

How does the Join-In Circuit work?

The Join-In Circuit allows groups of up to 75 people to engage in interpersonal communication on HIV prevention in a short period of time.³ It is structured as a series of individual stations, each of which elaborates a particular dimension of HIV prevention (see Table 1 on the next page for an overview of the original German version of the JIC). Participants are divided into small groups of 10 to 15 people and rotate through the stations, spending approximately 15 minutes at each. The stations can be visited in any order, as the content of each one builds upon and reinforces messages from the others.

² Led by a facilitator or group leader, who works closely with participants in an atmosphere of trust and mutual support, such approaches aim to sensitise people to their personal risks, guide them on actions they can take to protect themselves, and help them practice new ways to communicate with their sexual partners (Kalichman, 1998, cited in UNAIDS, 1999b).

³ This section summarises the original design of the Join-In Circuit. As is described in the remainder of the publication, the JIC has been modified in some countries to address topics which relate to, but extend beyond HIV.

Trained facilitators are present at each station. Their role is to ask questions and to encourage participants to challenge accepted ways of thinking. They use role-playing exercises and games to spark a lively exchange of views. One of the main principles of the JIC is to be participant-centred: the role of the facilitator is not to teach, in the conventional sense, but rather to meet participants 'where they are' and to guide a group discussion, clarifying misconceptions and incorrect information which may arise.

A full JIC run, with five stations, takes about 75 minutes to complete. At the end of each run, the facilitators distribute brochures and other printed material with contact details for local organisations, such as HIV support groups, and health care providers where participants can turn for more information, support or services. In some settings, condoms are distributed and mobile services such as HIV testing and counselling are available to participants on site. 'Questions arise during the JIC and people finish it keen to learn more,' says Paola Frattola, a behaviour change communication expert and JIC master trainer. 'The JIC itself is only half of it: if you don't give participants information and concrete opportunities for action afterwards, you've missed a big chance.'

Table 1. Stations and objectives of the original Join-In Circuit

Station name and objective	What happens?
<p>Ways of HIV transmission <i>Objective:</i> Participants learn to accurately assess the risk of transmission.</p>	<p>Participants consider a number of situations, and illustrations, depicting common experiences of young people – going to the dentist, hugging, sexual intercourse, etc. – and use red, yellow and green cards to rank each one in terms of infection risk.</p>
<p>Love, protection, sexuality <i>Objective:</i> Participants are enabled to speak about love and sexuality without shame or fear of breaking taboos.</p>	<p>Symbols on a 'Wheel of Fortune' direct participants to answer questions about one of five themes: partnership, HIV protection, personal attitudes, condom use and HIV testing.</p>
<p>Contraception <i>Objective:</i> Participants assess various methods of contraception and learn that only condoms provide protection against HIV and other sexually transmitted diseases.</p>	<p>Members of the group draw a common contraceptive from a bag and say what they know about it. Participants then match each contraceptive with corresponding statements that have been prepared in advance.</p>
<p>Body language <i>Objective:</i> Participants speak about love and sexuality and learn to understand and use non-verbal communication.</p>	<p>Participants mime acts and emotions related to love, sexuality and partnership (putting on a condom, jealousy, etc.) while their peers guess what they are miming. The acts and emotions are also written on the reverse side of large puzzle pieces, which, when correctly assembled, portray a pair of young lovers.</p>
<p>Living with HIV <i>Objective:</i> Participants become aware of problems faced by people living with HIV, and are encouraged to support them.</p>	<p>Participants climb into the shoes of somebody their own age living with HIV, by considering illustrations and discussion of aspects of their daily lives: sports, family, relationships, etc.</p>

The Join-In Circuit goes global

■ Country-specific adaptations of the JIC

Starting in 2003, the JIC began to be used as an HIV prevention tool outside Germany. The Federal Centre for Health Education, in cooperation with GDC and national ministries of health, initially supported the development of country-specific JIC adaptations for five countries – El Salvador, Ethiopia, Mongolia, Mozambique and Russia – and trained master trainers to work with the tool in each country. The piloting process was thoroughly documented and attracted interest from other countries where GDC was active in the health sector.

By the end of 2007, GDC had supported the adaptation and use of the Join-In Circuit in 13 more countries: Bangladesh, the Democratic Republic of Congo, Ecuador, Kazakhstan, Kenya, Kyrgyzstan, Latvia, Lithuania, Nepal, Ukraine, Uzbekistan, Zambia and Zimbabwe. In each of these, GDC worked with local experts to ensure that the content of the JIC reflected social and cultural attitudes and norms. While

the basic structure of the JIC was maintained everywhere, the content varied to some extent depending on the shape of the HIV epidemic and on identified target audiences.

In countries such as Mozambique, Zambia and Zimbabwe, where sexually transmitted infections were an important factor in the spread of HIV, a sixth station was added on this topic. In Kyrgyzstan, the JIC included a station exploring the HIV transmission risk posed by intravenous drug use. Gender issues were emphasised in the JIC versions developed in Bangladesh, Ethiopia, Kenya, Mongolia and Nepal. While the JIC was used widely with young people, some countries also used the same or modified versions of the JIC with adults, including soldiers, factory workers, stock breeders, sex workers and prisoners.

The steps which were taken to introduce the JIC, secure support from partner institutions (either non-governmental organisations or government ministries), and implement the tool with various audiences are outlined in Box 3 on the next page, and described in detail in the earlier publication on this approach (GIZ, 2011).

Box 2. Facilitator selection and training

The success of the Join-In Circuit depends greatly upon the quality of the facilitators at each station. Ideally, participants should closely identify with these facilitators and adopt them as role models. Given the facilitators' central role in the JIC, their selection and training requires particular attention.

Facilitators are generally identified by JIC implementing organisations from among the JIC target audiences. Good facilitators are motivated by a desire to communicate with their peers about sexual and reproductive health issues, can speak clearly and confidently about sensitive topics, and are able to engage in respectful, non-judgemental dialogue with others. A prior understanding of sexual and reproductive health topics and relevant experience with peer education approaches are helpful, but not essential, as the pool of potential facilitators with these qualifications differs across countries and settings.

JIC facilitator training lasts from five to seven days and follows a standardised curriculum which includes both theoretical and practical components. A facilitators' manual is central to the training and serves as a detailed methodological and content resource for facilitators following training. Facilitators are generally trained by JIC master trainers who have themselves been trained in Germany or by JIC experts in their own countries. Key topics which are covered include:

- The concept and objectives of the JIC;
- The roles and responsibilities of facilitators;
- Basic background information about HIV, sexually transmitted infections and other topics covered in the JIC stations; and
- Facilitation skills, including how to encourage participation among both male and female participants, manage group dynamics (e.g. respond to dominant or aggressive participants), and interact with participants who are directly or indirectly affected by HIV.

■ **Positive reactions, but unanswered questions about quality, sustainability and impact**

During those early years, the GDC programmes which supported the implementation of the JIC were primarily focused on adapting it to country contexts and testing whether the JIC could successfully cross cultural barriers; less attention was paid during this time to measuring the JIC's actual effects on participants and to integrating it into comprehensive HIV response strategies. Over time, however, a new set of questions increasingly came to the fore for GDC and its national partners:

- **The JIC is popular, but is it effective?** Countries using the JIC tended to focus efforts on outreach (i.e. reaching as many representatives of target groups as possible), rather than on measuring the JIC's effectiveness against well-defined learning goals and behavioural objectives.
- **Which other services should complement the JIC?** Even the best quality JIC facilitation is unlikely to lead participants to change their behaviours if they are not given the means to act on the tool's messages and recommendations. Access to condoms and links to specific clinical services such as HIV testing and counselling and screening for sexually transmitted infections are necessary if participants are to adopt protective behaviours following participation in the JIC.

Box 3. Ten steps for introducing the Join-In Circuit

1. Talk with decision-makers to gain acceptance for the JIC at a political level
2. Identify national and international partners to support the adaptation process
3. Establish objectives and formulate learning goals
4. Adapt and develop the content of the JIC to align with local context
5. Prepare images, stations and printed material
6. Form a core team to coordinate the JIC
7. Build a team of facilitators
8. Pilot the adapted JIC version with select audiences
9. Establish monitoring and evaluation procedures for quality assurance
10. Publicise the JIC and search for financing to support the longer-term implementation of the JIC

Source: GIZ (2011). *Boosting Prevention: The Join-In Circuit on AIDS, Love and Sexuality*



■ *In Mongolia the Join-In Circuit has been used to reach military recruits with information about HIV, sexually transmitted infections and safe sexual behaviour.*

- **What does it take to ensure high-quality implementation of the JIC?** The JIC appears relatively simple on the surface, but implementing it in a consistent manner, on a large scale, requires considerable effort and a commitment to systematic monitoring of JIC runs, including facilitator performance.
- **What conditions are needed for the JIC to be sustainable?** One of the greatest challenges facing JIC implementers at country level was to secure the financial and human resources needed for continuous implementation: adapting the JIC and training master trainers was not enough to ensure its long-term sustainability following the end of GDC support.

A changing epidemic and new opportunities for the Join-In Circuit

The core questions facing the JIC were similar to the ones being asked – at a different level – by HIV practitioners, public health experts and policymakers the world over as the first decade of the twenty-first century drew to a close. With an elaborate HIV response infrastructure now in place, including the greatly expanded availability of HIV testing and treatment services in many countries, more and more attention began to be directed towards understanding the longer-term direction of the epidemic and what would need to be done better, or differently, in the future to radically reduce the number of HIV infections and AIDS deaths (Larson, Bertozzi & Piot, 2011). What works? How do we know? How can programmes be linked and made more efficient? How can they be scaled up and sustained?

Between 2010 and 2015, the JIC underwent a process of maturation in a number of countries, examples of which are described in the next two chapters. With global HIV control strategies emphasising more evidence-driven responses⁴, and the seamless integration of HIV interventions with other health programmes, GDC and its partners sought to integrate the JIC more closely with national HIV strategies, to invest more in monitoring and evaluating its effectiveness, and to secure its sustainability.

■ Intensified outreach to young people

As part of this process, the JIC in many countries has come to be deployed much more strategically to reach young people, and particularly adolescent girls and young women, who have emerged as key target groups for HIV prevention, treatment and care. Of the estimated 250,000 new HIV infections among adolescents worldwide in 2013, nearly two-thirds of these occurred among girls; in Africa, the proportion was nearly three-quarters (UNAIDS & African Union, 2015).

While many effective interventions are now available to prevent and treat HIV, young people do not always have easy access to them, and do not always utilise them when they do have access. Programmes which help to increase health service uptake among adolescents, especially female adolescents, are particularly needed to reduce the new infections, late diagnoses and poor health outcomes which are common among adolescents with HIV (Mavedzenge, Luecke & Ross, 2014).

■ Linking HIV and sexual and reproductive health and rights

The JIC was designed at a time when the need for a rapid response to the mounting HIV epidemic led to a proliferation of HIV-specific vertical initiatives. For at least a decade now, however, concerted efforts have been made to better integrate responses to HIV and efforts to promote sexual and reproductive health and rights at the level of both policies and programmes. Strengthening the natural linkages between HIV and sexual and reproductive health and rights programmes and services is a GDC policy objective (BMZ, 2012; GTZ, 2008) and seen as key to generating better sexual and reproductive health outcomes overall.



■ *Young women and adolescent girls, such as these in Mozambique, have emerged as one of the main target groups for HIV prevention, treatment and care strategies in recent years.*

The implementation of the JIC in recent years reflects these broader shifts. Although HIV still stands at its core, in a number of countries the content of the JIC's stations now emphasises more strongly the connections between HIV and other aspects of sexual and reproductive health and rights, such as family planning, antenatal and neonatal care, and gender-based violence. GDC and its national partners have sought to align the JIC with countries' sexual and reproductive health strategies, including those targeting adolescents and young people, and are actively using the JIC to link participants to a range of health services, not only those related to HIV.

The next chapter on the JIC in Zimbabwe and the vignettes from Zambia, Kyrgyzstan and Nepal which follow illustrate how the JIC has been adapted and used in specific settings over the past five years against this changing global backdrop.

⁴ Approaches which simultaneously combine behavioural, biomedical and structural prevention strategies to meet the needs of specific target groups.

A detailed look: the Join-In Circuit in Zimbabwe

The course of the HIV epidemic in Zimbabwe over the past 20 years illustrates both the promise and the limitations of behaviour change strategies for reducing the spread of HIV. From a high of 28.7% in 1997, HIV prevalence among adult Zimbabweans (aged 15 to 49) dropped to 15% in 2013, and the incidence rate fell from 4.4 to 0.98 (UNAIDS, 2015). This dramatic decline – which has been attributed to reductions in extramarital, commercial and casual sexual relations and associated reductions in partner concurrency – was aided by HIV prevention programmes utilising the mass media and interpersonal communication activities in a variety of settings (Halperin et al., 2011).

Despite these gains, there are still an estimated 69,000 new HIV infections each year in Zimbabwe (UNAIDS, 2015). One-third of these occur among young people between the ages of 15 and 24, and of these, two-thirds are among young women.⁵ Overall, young women are more than twice as likely as young men to be infected with HIV; among those aged 20 to 24, HIV prevalence is nearly three times greater among females than males. Awareness of HIV is nearly universal in Zimbabwe, but only about half of young people – 52% of women and 47% of men – have comprehensive and correct knowledge about HIV transmission (Zimbabwe National Statistics Agency and ICF, 2012).

Young Zimbabweans' sexual and reproductive health needs go beyond information and services related to HIV. –twenty three per cent of 15- to 19-year-old females in Zimbabwe are already married or in an informal union, as are 13% of 15- to 17-year-olds. Although two-thirds of married adolescent females indicate that they don't want to become pregnant for at least two years, only half are using a modern form of contraception. The result is a high adolescent birth rate – 115 live births per 1,000 women aged 15-19 – which barely changed between 1999 and 2011. There are striking differences between urban and rural populations, with adolescent females in rural areas much more likely to marry and to give birth than their counterparts in urban areas (Guttmacher Institute, 2014).

Both young women and young men need access to comprehensive sexual and reproductive health services, including family planning, diagnosis and treatment of sexually transmitted infections, pregnancy-related services, and HIV-related services. They face many obstacles in accessing these, however: youth-specific interventions are not available in all areas of the country; health care workers are generally not well trained in the specific sexual and reproductive health needs of young people (including those who are HIV-positive) and are often not welcoming to young people; health clinics can be hard to reach due to long distances and transportation costs; confidentiality cannot be taken for granted; and user fees can act as a deterrent.

The content of sexual education in schools is restricted in scope and many young people have limited understanding of their right to health care. Church norms and teachings are an important influence on sexual and health-seeking behaviour in Zimbabwe (Manzou, Schumacher & Gregson, 2014; Maguranyanga, 2011). Certain faith communities accept or promote polygyny, for example, or favour faith healing over the use of formal health services. In rural areas in particular, cultural norms which discourage sexual activity prior to marriage further deter young people from seeking out sexual and reproductive health services.

The early years of the JIC in Zimbabwe

■ Adapting the JIC to Zimbabwean sensibilities

The Join-In Circuit first came to Zimbabwe in 2005 by way of Mozambique, where it was being used by a German-supported health programme to promote HIV prevention. Seeing the tool in action during a study tour to Mozambique, Theresa Ndikudze-Gatsi, a coordinator with the GIZ-implemented HIV Prevention in Zimbabwe (HPZ) project, was immediately won over. The JIC addressed the topics most relevant to the HIV epidemic in Zimbabwe and did so through an interactive approach that was unlike anything being used in the country at the time. HPZ's goal was to improve the capacity of Zimbabwean NGOs to increase young people's knowledge of HIV and to promote behaviour change; as a tool explicitly designed to raise awareness, provoke self-reflection and stimulate action, JIC seemed to be an excellent fit.

⁵ HIV Estimates 2013, Zimbabwe National AIDS Council. Provided by HIV Prevention in Zimbabwe project.

In late 2005 HPZ set out to pilot the JIC in two provinces, in cooperation with the Zimbabwe AIDS Network (ZAN), a consortium of AIDS service organisations.⁶ With input from national experts, the Mozambican version of the JIC was adapted to reflect local norms and the content was reorganised into seven, rather than six, stations (see Box 4). In 2007 the Zimbabwean version of the JIC was finalised and an evaluation recommended that the JIC be extended country-wide. HPZ supported ZAN to train a team of JIC facilitators in each of Zimbabwe's 10 provinces. Using JIC kits provided by HPZ, one ZAN member organisation per province began organising JIC runs.

As in other countries, the JIC met with receptive audiences and plenty of praise. However, during these early years, the tool was being deployed more or less randomly. ZAN member organisations that were keen to use the JIC could do so, after being trained by ZAN in its use, but there was no overarching strategy, no systematic links to other elements of Zimbabwe's national HIV response, no system for ensuring quality, and no focus on monitoring the JIC's results beyond tracking the number of JIC runs conducted. Ndikudze-Gatsi recalls that it was difficult to know how many people the JIC was reaching and what effect it was having: 'We gave them the tool and encouraged them to use it, and they did. But we had no sense of its actual impact.'

Box 4. Stations in the Zimbabwean Join-In Circuit

1. HIV Transmission
2. Contraception
3. Condom Use
4. Sexually Transmitted Infections
5. Body Language
6. Positive Living
7. Protection

A project progress review conducted in 2010 noted these limitations and urged HPZ to bring a sharper strategic focus to JIC implementation, including by working towards greater coverage of the JIC in a smaller geographical area and strengthening the approach to monitoring and evaluation (M&E) to better understand the JIC's outcomes. The following section describes how these recommendations were taken up.



■ Images from the HIV transmission station in the Zimbabwean version of the Join-In Circuit. When the Mozambican Join-In Circuit was adapted for use in Zimbabwe, new images were created and tested with local audiences to ensure that they were socially and culturally acceptable.

⁶ Since 2002 development cooperation in Zimbabwe does not directly involve the Government of Zimbabwe. Measures are implemented in cooperation with civil society organisations.

The JIC matures

Beginning in 2011, the Join-In Circuit became HPZ's main tool for generating demand for sexual and reproductive health information and services, including those related to HIV, among young people. Between June 2011 and September 2015, more than 31,000 young people aged 15 to 24⁷ – roughly 13% of the total youth population in the participating districts⁸ – took part in the JIC.

What is notable about the recent history of the JIC in Zimbabwe is not only the tool's extensive reach, but also the way it came to be directly linked to sexual and reproductive health services, and particularly HIV testing and counselling. Working in close partnership with a handful of NGOs, HPZ gradually transformed the JIC from a stand-alone behaviour change communication tool to a package intervention which was strategically deployed in the context of combination HIV prevention. Doing this effectively required a number of fundamental changes in the way the JIC was implemented, as the remainder of this section describes.

■ A narrower focus: fewer partners, an emphasis on mutual learning

In order to make the most efficient use of project resources, in 2011 HPZ began to concentrate its support for the JIC in six specific districts of two provinces: Manicaland, along Zimbabwe's eastern border with Mozambique, and Mashonaland West, in the northwestern part of the country. It also changed its partnership approach: rather than continuing to work globally with ZAN, HPZ began working directly with selected NGOs in these areas, providing them with financial and technical support to implement the JIC and, importantly, linking this support to performance (see section on monitoring and evaluation, p. 19).

Chosen on the basis of their previous performance and other quality criteria, most of these implementing organisations were members of ZAN and were already familiar with the JIC. As HPZ project partners, however, they now received direct capacity building and supervisory support to ensure that the JIC was being implemented in a consistent, high-quality manner. HPZ and the implementing organisations met frequently, both one-to-one (e.g. during quarterly support visits) and as a group (e.g. during annual review meetings).



■ Nurses from Population Services International set up their mobile HIV testing and counselling tents in a shady spot on the campus of the Mutare Teachers College prior to the start of the Join-In Circuit. Fifty-three of 76 participants tested for HIV following the run.

This intensive contact was critical for building the core capacities of individual partner organisations to plan, cost, implement, monitor and learn from JIC implementation. Equally important, however, it led to the creation of a robust learning community in which a best practice approach to JIC implementation was refined collectively through the regular sharing of experiences, discussion and debate. A project progress review conducted in 2012 cited HPZ's 'strong focus on learning and innovation' as a major success factor (GIZ, 2012).

■ A new element: mobile HIV testing and counselling

One of the main issues which HPZ and its partners tackled was how to build closer relationships between the JIC and existing health services so that, at the end of each JIC run, participants had clear entry points to further information and services.

The first part of the strategy they developed was to make HIV testing and counselling available to participants immediately following JIC runs. While fear of stigma and discrimination still deters many from testing at local health facilities, mobile HIV testing and counselling, with its greater guarantee of anonymity, is seen by many as a more acceptable way to learn one's HIV status.

⁷ Unless otherwise specified, all figures in this chapter related to the implementation of the JIC in Zimbabwe derive from HPZ project monitoring data.

⁸ According to the 2012 Census, the youth population of the six participating districts was 245,554.

Starting in 2011, mobile testing and counselling gradually emerged as a standard element at JIC runs in Zimbabwe. Each implementing NGO was responsible for ensuring that testing was available at the runs it organised. Most of the time this was done in cooperation with Population Services International (PSI), which administers a national network of New Start and New Life centres that provide a range of sexual and reproductive health services. PSI also deploys outreach teams offering mobile services in the community.

In some areas, as a result of long distances and poor quality roads, it was difficult for the PSI mobile testing vans to reach the JIC runs and return home by evening. In these cases, the implementing NGOs developed alternative strategies. Sometimes they would schedule a series of JIC runs over the course of one week in a particular area, and arrange for the PSI testing vans to spend the whole week on site, rather than travelling back to the New Start centre each day. In other cases, they made arrangements with the Ministry of Health and Child Care to have clinic nurses – preferably those trained to administer youth-friendly services – perform the testing and counselling.

Between 2012 and mid-2015, more than three-quarters of all JIC runs in Zimbabwe were done in combination with mobile HIV testing and counselling.

■ Forging links to other services

Bringing mobile HIV testing and counselling to JIC runs was an important first step, but young people also required access to other sexual and reproductive health services, such as family planning, diagnosis and treatment of sexually transmitted infections, and male circumcision, which could not be provided on-site at JIC runs. The second part of the strategy, therefore, was to integrate the JIC with existing clinic-based services, as close as possible to where they were available.

HPZ and the implementing NGOs initially focused on strengthening linkages between the JIC and the one health centre per district where the project had supported the establishment of a Youth-Friendly Corner and additional training for nurses in adolescent sexual and reproductive health. These were obvious places to refer JIC participants for follow-up services and the connections were easily established through project channels. However JIC runs were sometimes carried out in places far from the health centres with such corners: what options were there for these young people? HPZ and the implementing NGOs began to systematically



■ Following a JIC run in a rural area outside Mutare, facilitators with FACT provide participants with information about the various sexual and reproductive health services available at the nearby clinic, which has a Youth-Friendly Corner and nurses specially trained in adolescent sexual and reproductive health.

network with the district offices of the National AIDS Council and reached out to health centres not yet trained in adolescent sexual and reproductive health to explore whether they would welcome referrals via the JIC. Some of the NGOs began cooperating with PSI, which supports the Ministry of Health's Voluntary Medical Male Circumcision programme, to generate demand for the procedure. JIC facilitators were trained by PSI on the benefits of male circumcision and how

to address common myths and misconceptions about the intervention; the JIC facilitator's guide was updated to reflect this information. When Voluntary Medical Male Circumcision campaigns were scheduled for a certain area, JIC facilitators were able to introduce relevant information into JIC runs and refer young men interested in circumcision to PSI/Ministry of Health teams.

Box 5. Bringing light to communities near Bircheneough Bridge

Rujeko, which means 'light' in Shona, is a small NGO based near Bircheneough Bridge, in the Buhera District of Manicaland Province. Founded in 1995 as a home-based care programme, Rujeko has shifted its focus in recent years to HIV prevention activities among young people whose families have been affected by HIV.



■ *Sheila Hellane, director of the NGO Rujeko*

'For a long time we didn't have the right tools for working with young people,' explained Sheila Hellane, the head of Rujeko. 'During the early years of the epidemic children were a very protected group in society. Parents were HIV-positive, and sometimes the children were too, but parents kept this information from them. Young people often acted as caregivers and were exposed to risks, but didn't always realise this, or didn't know how to protect themselves.'

Hellane and her colleagues feel that the JIC has helped to fill this gap. Not only does the tool offer comprehensive information about HIV which young people need, but it also addresses issues of love, sexuality and relationships – something missing from other approaches to prevention.

Rujeko first became acquainted with the JIC in 2008 through ZAN, but began working with it regularly in 2011, when Rujeko was chosen as an HPZ implementing partner. This came at a critical time for the organisation: its previous funding sources were running out and efforts to attract additional funding had been unsuccessful. 'We had reached a point where it wasn't clear if we could continue,' said Hellane.

Ramona Wong-Grünwald, the head of HPZ, admits that the project took a leap of faith in entering into a partnership with Rujeko. The cooperation has, however, been a success: despite its small size, Rujeko has emerged as one of HPZ's most active and dedicated partners, reaching some 7,700 young people with the JIC since late 2012 and mobilising hundreds of young men for medical male circumcision. The organisation has found creative solutions to the logistical difficulties of arranging for mobile HIV testing and counselling in remote areas, and has secured the support of district education officers for JIC runs to be conducted on school grounds, despite policies which currently restrict NGO-led activities inside schools.

Over the past three years, Rujeko has contributed much to the network of JIC implementers in Zimbabwe, and benefited from it as well. 'The JIC has given us exposure to other opportunities, through trainings, meetings and networks,' says Hellane. 'Now, as a result of our cooperation with HPZ, when we see funding opportunities advertised, we feel equipped to apply for them.' Rujeko has already secured additional funding to continue the JIC after cooperation with HPZ ends in December 2015 (see 'Real prospects for financial sustainability, p. 21).

■ **Using mapping to achieve greater coverage**

In the past, the timing and location of JIC runs had largely been determined by convenience. Increasingly, however, HPZ encouraged its partners to bring a programming logic to its use of the JIC. Were they implementing the JIC close to services? Were they concentrating on areas where the greatest number of young people lived? And in those places where the JIC was being implemented, who was being reached by runs: young people in schools, or in the community, or both?

HPZ worked with the Geography Department of the University of Zimbabwe to develop, for each project district, detailed maps which showed clinic catchment areas, the location of recent JIC runs, and the density of the youth population by ward. The maps helped the implementing NGOs make more informed decisions when planning JIC runs. Some, for example, began to shift their attention to areas with large youth populations inside clinic catchment areas where the JIC had not been heavily used in the past.

‘The mapping exercise helped us decide where to concentrate efforts. Looking at it, we saw that it made sense from a programmatic point of view to change our emphasis,’ explains Rodwell Nyamanza, the national coordinator of the JIC, based at Family AIDS Caring Trust (FACT) in Mutare. ‘It’s also affected where we recruit our facilitators. We see that it doesn’t make sense to bring them from elsewhere. Now we recruit teams close to where we implement.’



■ *Rodwell Nyamanza points to an area with a large youth population on a map of Mutare Rural District. ‘I always ask myself the “So what?” question,’ says Nyamanza. ‘The JIC gives young people information, but how will they use it? Mapping the services helps us to be sure they can get to them.’*

Investing in quality and sustainability

■ **A robust approach to monitoring and evaluation**

Alongside the innovations described above, HPZ invested significant effort into the development of a robust M&E framework for the JIC. In doing so, it arguably created the most evidence-driven approach to JIC implementation which has emerged within GDC to date.

HPZ’s comprehensive and integrated M&E system comprises regular monitoring activities undertaken by implementing partners (e.g. data collection at JIC runs, quarterly reports) and activities supported directly by HPZ (e.g. baseline studies, monitoring visits to partners, focus group discussions with target groups). The data from multiple sources are brought together, along with project management data (e.g. indicators, targets, financial flows), into a spreadsheet-based monitoring matrix which provides the HPZ team with a continuous overview of JIC-related activities and results.⁹ Qualitative data sources, including key findings from focus group discussions with young people and the collection of individual stories from JIC participants, provide important context for interpreting quantitative data.

⁹ Detailed information about HPZ’s approach to M&E can be found in *Monitoring and Evaluation in the HIV Prevention Project – Zimbabwe* (GIZ, 2015a).

The monitoring matrix has greatly enhanced the team's ability to track the performance of partner NGOs, to steer project activities on an on-going basis, and to document and report results to the BMZ, the Zimbabwe National AIDS Council and other stakeholders. It has also been critically important for institutional learning: both HPZ and its implementing partners regularly review M&E data to track project progress and to identify areas where changes are merited. An early commitment to sex-disaggregated data, for example, allowed HPZ and its partners to recognise quickly that greater efforts needed to be made to mobilise young women to participate in the JIC and to link them to health services.

This steady, constructive approach to M&E contributed to a culture of open discussion, learning and improvement around the JIC – and benefited the NGOs institutionally, as well. Sheila Hellane, the head of Rujeko, is unequivocal on this point: 'Because of the training on monitoring and evaluation which we got from HPZ, we've managed to get more funding for our organisation from other partners. We've gained capacity via HPZ and can now stand on our own feet in terms of quality and standards.'

■ Institutionalising the JIC: FACT takes the reins

With an eye to the sustainability of the JIC in Zimbabwe, HPZ began looking for a local partner organisation to assume responsibility for coordination and oversight of the JIC following the project's closure at the end of 2015. In late 2013 FACT, which had been implementing the JIC in Mutare District since 2011, agreed to give the JIC an institutional home in Zimbabwe and a phased handover process began.

Founded in Mutare in 1987 as Zimbabwe's first AIDS Service Organisation, FACT was a logical partner for this role. The NGO had well-established financial systems, strong links to both the health system and civil society organisations, and excellent technical capacities.

With support from HPZ, FACT established a JIC Technical Support Unit (JTSU), staffed by a full-time coordinator and a Development Advisor, Vaida Kontrimaite, seconded from GIZ. Its core tasks were to provide technical support to other implementing NGOs, to oversee quality standards, to provide JIC-related training, to promote the JIC in Zimbabwe, and to support resource mobilisation efforts.



■ *'The JIC's participatory method is a masterpiece,' says Gertrude Shumba of FACT. 'I really appreciate the focus on dialogue, the chance to freely discuss and ask questions.'*

In establishing the JTSU, HPZ and FACT benefited from lessons learned in neighbouring Zambia, where GIZ had already handed over the JIC to a local NGO, Afya Mzuri, in 2011 (see section on Zambia, pp. 25). In 2013 Rodwell Nyamanza and Vaida Kontrimaite of the JTSU visited Afya Mzuri and saw firsthand how the team there had created a strong coordinating unit for the JIC within the organisation; how it was actively marketing and 'selling' the JIC as a product in order to generate income for the organisation; and how it had built up a network of partner organisations capable of implementing the JIC nationwide.

Over the course of the next year the JTSU grew into its new role. It emerged as a technical resource for the other implementing NGOs, assisting in particular with M&E processes and quality assurance, and in doing so gradually reduced the administrative and supervisory role of the HPZ team. It developed a communication strategy for the JIC, and actively promoted the tool both within FACT and at district, provincial and national levels. It also prepared an easy-to-use costing guide, in spreadsheet form, which allowed interested organisations to calculate the resources which would be required to implement the JIC in various settings. All of these lessons, tools and standards were captured in a step-by-step guide to JIC implementation (GIZ, 2015b).

The learning curve was steep and not without bumps. It took the JTSU team time to find the right balance between implementing the JIC itself directly and coordinating the work of the other implementing NGOs. And it took the better part of a year – and relentless internal promotion – until the team succeeded in integrating the JIC across FACT's extensive programme portfolio and generating interest from external stakeholders. By early 2015 the number of JIC runs being commissioned by other FACT programmes and outside groups was steadily rising.

'There's no one at FACT that doesn't know the JIC,' says Vaida Kontrimaite, 'or any organisation in Mutare working on HIV or sexual and reproductive health who doesn't know the JIC. We have really marketed it, and they know that technical support is available right here.'

■ Real prospects of financial sustainability

By early 2015 these investments were beginning to pay off. Not only had the technical support function been consolidated within the JTSU, but there were encouraging signs of sustainable financial support for the JIC. When asked about the JTSU's most important achievement, Rodwell Nyamanza answered immediately: 'The JIC will continue after HPZ. This is the biggest accomplishment.'

According to Gertrude Shumba, the organisation now regularly builds the JIC into its resource mobilisation efforts. In 2015 it won programme funding from the United States Agency for International Development (USAID) and the United Kingdom Department for International Development which will allow FACT, among other activities, to reach more than 70,000 young people with the JIC over the next three to five years. Rujeko, a much smaller NGO, has secured support from UNICEF to implement the JIC for just over 9,000 young people, and will also work in partnership with FACT on the USAID-funded project.

Current indications suggest that when HPZ concludes its work in Zimbabwe at the end of 2015, it will have handed over a high-quality tool with promising prospects for sustainability. One key to the JIC's future success in Zimbabwe will be continued oversight by the JTSU, whose role will

become even more essential given the envisioned scale of JIC implementation in years to come. FACT and other implementing organisations will need to ensure that the JTSU remains funded in the future, for example by instituting a cost-recovery model whereby JIC coordination and implementation costs are shared across programme budgets.

For the JIC's longer-term sustainability, it would be ideal if the approach was adopted by the National AIDS Council or by the ministries of health and education for integration into national programming, as is being discussed in other countries (see section on Kyrgyzstan, p. 27). However for the foreseeable future in Zimbabwe, the JIC is likely to remain dependent upon support from development partners, channelled through implementing NGOs who are ready to oversee the next chapter of the Join-In Circuit in the country.

Achievements

■ Broad reach among young people, both in and out of school

Since its introduction to Zimbabwe in 2006, more than 45,000 young people have participated in the JIC. This includes more than 22,000 young people between November 2012 and September 2015, when the JIC was being systematically implemented in Manicaland and Mashonaland West provinces, in combination with mobile HIV testing and counselling.

Young people in Zimbabwe have been reached in three settings: schools, the community and, starting in 2014, tertiary education institutions (e.g. teacher training colleges). Implementing the JIC at schools was the easiest way to reach large numbers of young people, and, despite the introduction of restrictions in 2014, by the Ministry of Primary and Secondary Education, which limited access by NGOs (including JIC implementing partners) to schools, two-thirds of all JIC participants in Zimbabwe between 2012 and 2015 were school pupils. Almost one-third were young people mobilised in communities, and the remainder were students at tertiary education institutions.

More males than females have participated in the JIC in Zimbabwe (54 versus 46%).¹⁰ While JIC runs held at schools have reached girls and boys in relatively equal numbers, it has proven more difficult to mobilise females in community settings. Young women are often busy with household chores, have limited free time and do not always enjoy the support of their parents or husbands to participate in activities like

the JIC. Implementing organisations developed a variety of strategies to recruit out-of-school youth, particularly young women, including outreach through churches, nurses, and peer educators at Youth-Friendly Corners (see Box 6 below). To reach young people who are not affiliated to churches or other programmes, they also promoted the JIC through ward counsellors and village headmen.

Box 6. Reaching out to young women



■ *Young women from an Apostolic group near Mutare participate in the Join-In Circuit with their infant children. Members of the Apostolic movement are often difficult to reach with health information and services.*

Young women, particularly those who are married, are one of the groups most vulnerable to infection with HIV and most in need of sexual and reproductive health services. They are also least likely to be in school (Guttmacher Institute, 2014), which makes them more challenging to reach with interventions.

JIC implementing organisations in Zimbabwe discovered this firsthand. In rural areas, where traditional values and conservative religious beliefs are widely held, many parents were sceptical about allowing unmarried girls to participate in the JIC: they didn't know what kind of information they would receive there, and were concerned about the girls mixing with male facilitators. Adolescent girls who were already married were generally busy with household duties, including childcare.

Mobilising young women to participate in the JIC required creativity and perseverance. Implementing organisations experimented with JIC runs at various times of day, attempting to find the time window most conducive to female participation (the conclusion: late morning). The NGO Rujeko organised some JIC runs just for young women and worked closely with nurses at the nearby clinic to recruit participants. Getting the nurses on board 'broke down the hesitation in the community. When the announcement comes from the clinic itself, it's something official and the parents and husband will then agree,' explained Sheila Hellane, the head of Rujeko.

FACT succeeded on several occasions in mobilising young women from one of the Apostolic church groups near Mutare to participate in JIC runs. An estimated 2.5 million Zimbabweans belong to the Apostolic movement, which comprises more than 160 groups countrywide (Maguranyanga, 2011). While the movement is heterogeneous, some Apostolic groups follow a doctrine whose practices include early marriage, polygyny, wife inheritance, and a rejection of modern health services. FACT has been working with church leaders near Mutare to improve the health status of women and children in the Apostolic community and secured permission to invite young women to participate in the JIC. 'When you introduce something good, those who benefit and see the goodness can cascade this to neighbours who resist,' says Elijah Nyamavuvu of the Gender and Church Partnerships programme at FACT. 'It's happening. Some women are now quietly making private arrangements to come to clinics for services.'

¹⁰ Over the period June 2011 to June 2015.

■ An increased demand for services

Since November 2012, more than 8,000 young people – or 38% of all JIC participants – have been tested for HIV and counselled on their results directly following JIC runs. This includes 40% of female participants and 34% of male participants. The proportion of JIC participants who use mobile testing and counselling services at JIC runs has risen year on year, from 25% in 2011 to 41% in 2014.

The JIC has generated demand among young people for other sexual and reproductive health services as well. Since 2013, more than 1,000 young men have gone for circumcision after being referred to PSI/Ministry of Health during JIC runs. While it has proven difficult to systematically track the uptake of referrals to Youth-Friendly Corners and health centres, a pilot effort to monitor service uptake using referral slips showed that young people do access health services following JIC runs. Anecdotal evidence from nurses at clinics located near JIC runs further corroborates that the JIC prompts young people to seek care.

■ Routine monitoring shows changes in knowledge, attitudes and behaviours

Data from pre- and post-questionnaires administered to participants at each JIC run indicate that 61% of participants have improved knowledge about HIV, sexually transmitted infections and methods of family planning following JIC runs. In addition, focus group discussions conducted with young people who have participated in the JIC point to some of its longer-term effects:

- Participation in the JIC leads young people to speak more openly about sexual issues with members of the opposite sex.
- Attitudes towards condom use have improved and there is increased knowledge of correct condom use, including use of the female condom.
- The JIC has reportedly led some young people to limit their number of sexual partners, particularly those with whom there is a large age difference.
- Young people who have participated in the JIC demonstrate improved attitudes towards people living with HIV.
- Young girls, including those from Apostolic churches, are demonstrating greater willingness to access health services following participation in the JIC.

■ A rigorous impact study provides mixed evidence on the JIC's effectiveness

In 2015 HPZ, in cooperation with researchers from Columbia University in New York, designed and implemented an impact study on the effectiveness of the JIC (see Box 7 for details of study design). Since HPZ's monitoring data suggested that the JIC had a positive effect on participants' uptake of mobile HIV testing and counselling and other health services in nearby clinics, the main purpose of the study was to determine whether this was actually the case. The study also investigated whether the JIC led to changes in participants' knowledge about HIV and sexual and reproductive health, their sexual behaviour, and their willingness to communicate about sexual and reproductive health topics. At the time this publication was written (October 2015), the results of the study were still being analysed; however some preliminary findings can already be reported.¹¹

While **higher proportions of JIC participants have tested for HIV, accessed family planning services at health facilities, and visited Youth-Friendly Corners** to speak to peer educators about HIV and other sexual and reproductive health issues, the measured differences are not statistically significant. The study could therefore not confirm that the JIC leads to increased utilisation of health services.

At the same time, the study did confirm other expectations about the JIC's effectiveness:

The JIC improves young people's knowledge about HIV, family planning, condoms and sexually transmitted infections. JIC participants are more likely than non-participants to know how HIV is transmitted, how to protect against infection and where to get tested for HIV. They are also more likely than non-participants to have heard of sexually transmitted infections, to know the types and symptoms of such infections, and to know where they can go for treatment. Finally, JIC participants are more likely to have heard of family planning and to know specific family planning methods, and are more likely to have heard of condoms, to know the advantages of condom use, and to express confidence in their ability to use a condom.

¹¹ Preliminary findings, provided by HPZ and Nedico. Results are statistically significant at 95% confidence interval unless otherwise noted.

JIC participants report having fewer sexual partners over the past year. There is a significant difference between the number of sexual partners reported by JIC participants and by non-JIC participants.

The JIC leads to greater communication about HIV and sexual and reproductive health issues with others, including friends and family members. Young people who participate in the JIC report speaking to a greater number of people about HIV and sexually transmitted infections than those who do not participate. The JIC's influence on communication is particularly significant among females.

The study findings also included a number of unexpected outcomes which will require further study and analysis. Participants in the JIC expressed significantly less confidence than those in the control group to undertake a number of actions, including visiting health facilities, getting screened for sexually transmitted infections, and disclosing the presence of a sexually transmitted infection to a sexual partner. They are also less confident to insist on condom use with a partner and to refuse sex if their partner does not agree to do so. Finally, young people exposed to the JIC see themselves as being at lower risk of becoming infected with HIV than do those who were not exposed to the JIC.

How and why the JIC is leading to participants having diminished confidence to act, and a lower perception of personal risk, was explored through follow-on focus-group discussions with young people in Manicaland Province. The findings from

these focus groups and the questions these raise about the effects of the JIC will be discussed in more detail in forthcoming articles. However one possible explanation for the diminished risk perception is that unmarried young people who are not sexually active¹² feel better informed, following the JIC, about how HIV can be transmitted and therefore more certain that they are not presently at risk of becoming infected with HIV, due to the fact that they are not sexually active.

Overall, the study findings provide evidence of the JIC's positive effects in increasing young people's knowledge about HIV and sexual and reproductive health and, to some extent, changing their sexual practices (i.e. reducing sexual partners). However, at least for this setting, the JIC's effectiveness in changing young people's sexual and healthcare-seeking behaviour appears to be limited. These results raise a set of difficult questions for GDC going forward: Can the content of the JIC, or the approach to its implementation in various settings, be changed in order to improve participants' healthcare-seeking behaviour? Or should the JIC be seen first and foremost as an effective method for improving knowledge and promoting health services? What types of results are realistic to expect from an intervention aimed at generating demand for services in a context where structural as well as socio-economic, cultural and religious factors deter young people from seeking care? What complementary interventions might enhance the JIC's impact? These and other questions are taken up again in the final chapter of the publication.

Box 7. Study design: a randomised control trial

A total of 997 young people, most of them between the ages of 15 and 24 years, from three districts in Manicaland Province, were randomly allocated at site level to a control or intervention group at 49 randomly selected sites (including in-school, out-of-school, and college settings). Those randomised to the intervention group participated in the JIC between January and June 2015 and completed an interviewer-administered questionnaire – a 56-question Knowledge, Attitudes and Behaviours survey – in June 2015. Those allocated to the control group completed the same interview-administered questionnaire in June 2015, prior to participating in the JIC.

The study design, known as a randomised control trial, allows for meaningful comparisons in knowledge, attitudes and behaviours between young people who have participated in the JIC and those who have not. Because the treatment and control groups are identical, apart from their exposure to the JIC – and the influence of other variables, such as exposure to additional programmes, was controlled for through the study design – any differences in measured indicators can be ascribed to the JIC.

¹² A large proportion of the respondents in both arms of the study.

Diverse applications: the Join-In Circuit in Zambia, Kyrgyzstan and Nepal

After a detailed examination of the evolution of the Join-In Circuit in Zimbabwe, this chapter takes a much briefer look at three other country-level applications which shed light on different aspects of the JIC. For information about how the JIC has been used with GIZ support in other countries since 2011, please refer to the annex at the end of this report.

Zambia: a flexible tool used with diverse audiences

In perhaps no other country has the JIC been used in as many different settings, and with such varied audiences, as in Zambia. Since 2005, when a Zambian version of the JIC first came into use as part of a German-supported youth project, more than 70,000 Zambians of all ages and walks of life have participated in the JIC in workplaces, schools, prisons, town marketplaces, and other community spaces. Among the groups reached by JIC organisers are teachers, pupils, parents, company managers, municipal workers, farmers and farm workers, water technicians, students, factory workers, sex workers, taxi drivers, and truck drivers. The experience from Zambia has shown that when facilitators are well-trained and have credibility with their target audience, the JIC can go practically anywhere and be used with practically any group.



■ *Members of a facilitation team on route to a JIC run in Mongu, Zambia. Zambia was the first country where the JIC's original bulky hardware was transformed into a lightweight, mobile tool.*

■ The JIC 'on the go'

While many countries have used the JIC with narrowly-defined target groups as part of a larger health or HIV programme, the JIC in Zambia evolved differently. Between 2005 and 2011, the JIC was primarily used as an enabling tool to promote HIV prevention and to support HIV mainstreaming in existing German-supported projects and programmes. It was used regularly, for example, in HIV workplace programmes run by GDC partner institutions, from water companies to municipal administrations. Demonstrations of the JIC¹³ were also carried out in marketplaces and other public areas, in combination with mobile HIV testing and counselling via New Start centres, which were supported by German financial cooperation. From the earliest stages, the JIC in Zambia was slotted fluidly into a range of settings and programme contexts.

'The flexibility and variation of target groups is a unique feature of the JIC in Zambia,' says Jutta Lorey-Wagner, a consultant who has advised on JIC implementation in Zambia and Zimbabwe. 'What made this possible was a technical innovation that turned the original, bulky JIC hardware into a truly mobile tool.' With the help of local welders and seamstresses, German development advisors re-engineered the JIC sets. The large wooden frames, which had to be transported by truck, were replaced by customised metal poles which slotted together to form a tripod-like stand. When disassembled, the poles fit into heavy-duty canvas bags which facilitators could carry by foot, or on minibus taxis. The Zambian version of the JIC (later copied in Zimbabwe) was compact, relatively light, and easy to set up.

■ A locally-owned product

Until 2010, development advisors with the former Deutscher Entwicklungsdienst (DED)¹⁴ coordinated the JIC in Zambia, and the costs of JIC runs were covered by the organisations who requested JIC runs. In 2011, however, as part of a sustainability strategy, responsibility for coordinating the JIC was gradually handed over to Afya Mzuri, a local health-focused NGO specialising in behaviour change and community empowerment initiatives. Afya Mzuri incorporated the JIC into the portfolio of HIV-related interventions it offers to clients and built up a network of cooperating NGOs, trained in the JIC, which work with a wide range of target groups. GIZ continues to provide institutional support to Afya Mzuri

¹³ Not complete runs, but a selection of stations.

¹⁴ In 2011, DED merged with GTZ and Internationale Weiterbildung und Entwicklung (InWEnt) to form GIZ.

through the long-term placement of a development advisor who focuses on organisational and business development, but the JIC has increasingly become a locally owned and implemented product.

‘The JIC has added a lot of value to our organisation,’ says Mu-bita Simonda, the JIC Coordinator at Afya Mzuri. ‘It has given us another sound behaviour change communication tool to work with, and has also raised Afya Mzuri’s profile both within Zambia and internationally as we’ve shared our experiences with the JIC at various conferences and gatherings.’

During 2013 and 2014 Afya Mzuri coordinated the wide-spread implementation of the JIC in Livingstone district as part of the Multisectoral HIV Programme commissioned by BMZ. Over this period, more than 20,000 residents of Livingstone district between the ages of 15 and 49 – roughly a quarter of the population – participated in the JIC. More than 12,000 young people – including school pupils, out-of-school youth and students – took part, as did roughly 600 teachers and 4,000 parents of school pupils. More than 2,500 participants were representatives of high-risk groups, including commercial sex workers, mobile populations (truck and taxi drivers) and prisoners.

In the next phase of the Multisectoral HIV Programme, GIZ will continue to collaborate with Afya Mzuri. Particular attention will be paid to the development of a systematic and com-

prehensive approach to quality assurance and M&E for the JIC, which is set to be extended into the Zambian school system and used in support of comprehensive sexuality education.

■ Many types of JIC facilitators

Reaching such diverse target groups with high-quality JIC runs requires a broad and differentiated pool of facilitators. The Zambian experience has shown that facilitators are not interchangeable: even the most talented young facilitator, for example, cannot successfully facilitate a JIC run with older adults, as it is not culturally acceptable for a younger person to speak directly about intimate topics with older persons. ‘The JIC is not just for young people; adults love it, too,’ says Karin Perl, a Technical Advisor with the Zambian-German Multisectoral HIV Programme. ‘Even senior managers in their suits really enjoy it, but we have learned that you must have mature facilitators who are confident and strike the right tone.’ Facilitators need to be comfortable working with the target audience, and have the standing with that audience to gain their trust.

Over the years, GIZ and Afya Mzuri have invested significant effort in training a range of facilitators from cooperating NGOs, including mature facilitators who can work effectively with adult audiences. They have also trained members of the Network of Zambian People Living with HIV/AIDS to facilitate JIC runs – a unique feature of the Zambian approach which brings the lived experience of people living with HIV directly into the content and facilitation of the JIC.

Box 8. Using individual JIC stations to explore particular topics



■ *Employees at the Hybrid Poultry Farm participate in a condom demonstration as part of a workplace programme. In Zambia, individual JIC stations are sometimes used to explore a particular topic in detail during a short period of time.*

In some of the settings where the JIC has been used in Zambia, it has not been practical to implement full JIC runs. One distinctive feature of the JIC in Zambia is the way the circuit has sometimes been broken up into smaller parts, with one or two stations used during a single session to illuminate a particular topic, such as positive living or condom use.

Under this model, a trained JIC facilitator and a resource person work together, the facilitator using the JIC’s interactive methodology to engage participants in the station and the resource person providing additional information, including referrals to services. This model has proven particularly popular at workplaces, where employees often cannot be released from their duties long enough to complete all six stations in one go. This ‘modular’ approach to the JIC provides the opportunity to cover the JIC content over the course of several sessions.

Kyrgyzstan: using the JIC to support sexuality education in schools

In Kyrgyzstan, a predominantly Muslim country of 5.6 million people in Central Asia, very few parents speak openly with their children about sexuality, relationships and reproductive health (UNFPA, 2015). Apart from anatomy lessons at secondary schools, young people in Kyrgyzstan – particularly those in rural areas, where two-thirds of the population live – have limited access to information about their health, to youth-friendly health services, and to programmes which promote life skills and responsible decision-making. This has led to some worrisome gaps: only 23% of young people, for example, both correctly identify ways to prevent the sexual transmission of HIV and reject major misconceptions about HIV (Government of Kyrgyzstan, 2015). Public health

experts have pointed to troublingly high teenage pregnancy and abortion rates and to the spread of sexually transmitted infections as evidence of the urgent need for formal sexuality education for young people (UNFPA, 2015).

Since 2008, the JIC has been used by the Republican Centre for Health Promotion, an agency under the Kyrgyz Ministry of Health, to help meet this need. Working through its regional and village-level structures, as well as with youth NGOs in urban areas, the Republican Centre for Health Promotion has enabled 25,000 young people to participate in JIC runs organised at more than 750 schools, the vast majority of them in rural areas. The JIC has been officially included in the government's Den Sooluk National Health Reform Program (2012-2016) as an HIV prevention method recommended for use with young people at village level.

Box 9. 'Marshrut Bezopasnosti': the JIC in Kyrgyzstan



■ A facilitator speaks with tenth-graders at a secondary school in Bishkek, Kyrgyzstan about condoms and the dual protection they offer against sexually transmitted infections and pregnancy.

In Russian, the JIC is known as 'Marshrut Bezopasnosti' (roughly translated: 'Route of Safety'), a name which gestures at the notion of navigating a voyage through adolescence and its incumbent risks.

The Russian version of the JIC first came to Kyrgyzstan in 2007; with German support, it has subsequently gone through two rounds of revision. In addition to the five original JIC stations, the Kyrgyz version also includes:

- A station called 'Your Choice,' added in 2011, which addresses the risks of HIV transmission in the context of drug and alcohol use, and
- A station on sexual and reproductive health and rights, added in 2013 as part of a comprehensive revision of the tool undertaken by the GIZ-implemented regional health programme in Central Asia.

In 2012, GDC also supported the development of a modified version of the JIC aimed specifically at parents of school children. Here, parents are not only introduced to the issues covered in the JIC (as a way of securing their support), but are also engaged as participants in their own right through stations which address relationships between parents and adolescents and how to identify signs of trouble, anxiety or depression in their children.

In addition to these changes in content, the JIC hardware has been transformed in Kyrgyzstan into a lightweight kit with fabric panels which is easy to transport and suitable for hanging on classroom walls.

■ Scaling-up the JIC in the school system

Kyrgyzstan is one of the countries where, right from the outset, the JIC has been used with strong backing from an official partner. Through the efforts of the Republican Centre for Health Promotion, 773 schools – roughly one-third of the country's total – had played host to the JIC by the end of 2014. Over time, however, it became clear that to reach more young people and to scale up further, it would be necessary to change the implementation model and to secure the formal involvement of the Ministry of Education.

Since 2013 GDC has been working closely with the ministries of health and education to develop a new model for the JIC in which the latter will assume the primary implementation role and the former will provide technical support, i.e. training JIC facilitators and monitoring implementation. In 2014, the Ministry of Education approved the JIC as part of its 'Healthy Lifestyles' curriculum for secondary schools, thereby formally opening the door for the JIC to be implemented nationally in the school system. While facilitators will continue to be trained by the Republican Centre for Health Promotion through its local structures, teachers will coordinate the JIC in schools, which requires that they be trained in its content and approach. To this end, a computer-based training course covering core sexual and reproductive health issues is being introduced in Kyrgyz teacher training institutions during the 2015-2016 academic year, to be supplemented by JIC-specific face-to-face trainings organised jointly by the teacher training institutions and the Republican Centre for Health Promotion.

■ A multi-sectoral implementation model

'The institutionalisation process has been long and challenging,' concedes Bolotkan Sydykanov, who coordinates the JIC in Kyrgyzstan on behalf of GDC, 'but it is moving steadily forward.' Significant effort was required to bring together representatives from the two ministries, as well as youth NGOs which implement the JIC in urban areas, to agree on the outlines of a multi-sectoral implementation model, to develop an operational plan, and to establish communication channels and a coordination mechanism to link the various parties.

In the end, growing calls for sexuality education in Kyrgyzstan helped to move the process forward. 'There were increasingly visible consequences of not having preventive education activities for young people,' Sydykanov says. 'Pregnancy rates, cases of violence and sexual harassment in schools, official and unofficial statistics about abortion among adolescents: more and more voices were calling for the adoption of international standards for sexuality education in Kyrgyzstan.'

The JIC's new implementation model in Kyrgyzstan is unfolding at an auspicious time. In July 2015 the country's president signed into law a hotly-debated bill on sexual and reproductive rights which requires the introduction of sexual and reproductive health education in Kyrgyz secondary schools. The JIC appears poised to play an important role in the introduction of systematic sexuality education in the coming years.

Nepal: integrating HIV and sexual and reproductive health and rights

In Nepal the Join-In Circuit is known as SangSangai, which means 'Let's play together, let's learn together.' Inspired by the original JIC, but developed for the Nepali context, SangSangai has been used since 2008 with more than 53,000 adolescents (aged 15 to 19)¹⁵ in- and out-of-school in three of Nepal's five regions.

From the outset, SangSangai's content has been broader than that of the original JIC. The first version, developed in 2007 with support from GDC, had HIV and sexually transmitted infections at its heart, but also included two unique stations: 'My Body,' which addressed basic concepts of puberty, and 'You and Me,' on gender. With German support, two NGOs – Youth Action Nepal and Women's Empowerment Action Forum – implemented this version of SangSangai with some 17,000 adolescents in Kathmandu and Dailekh districts between 2008 and 2010. Pre- and post-questionnaires showed that 30% more participants had comprehensive knowledge of HIV after participating in SangSangai, compared to before (GIZ, 2013).

¹⁵ We use the term adolescent throughout this section about Nepal to refer to the young people between the ages of 15 and 19 who have participated in SangSangai.

■ **Widening SangSangai's focus in line with adolescent health needs**

Nepal has a small, concentrated and relatively stable HIV epidemic: approximately 40,000 people (0.2% of the adult population) are living with HIV, with infections concentrated among people who inject drugs, men who have sex with men, transgender people, male labour migrants and their spouses, and sex workers (Government of Nepal, 2015). While adolescents in Nepal, as elsewhere, are at risk of contracting sexually transmitted infections, including HIV, other health issues present greater risks. Early marriage and childbearing, for example, are exceedingly common in Nepal: in 2011, 29% of girls aged 15-19 were already married, and 17% were already mothers or pregnant. Only 14% of currently married 15-19 year olds used contraception (Khatiwada et al., 2013).

In 2011 a comprehensive evaluation of SangSangai was undertaken with the objective, among others, of assessing the tool's alignment with national policies and programming on sexual and reproductive health. The evaluation praised SangSangai as an effective, relevant, entertaining and broadly accepted method for communicating with adolescents on sensitive subjects. At the same time, it recommended that SangSangai move away from a core focus on HIV and sexually transmitted infections and embrace a wider range of topics related to adolescent sexual and reproductive health (HASTI-AIDS, 2011).

Following an 18-month redesign process, undertaken in co-operation with the Family Health Division of the Ministry of Health and the National Health Education, Information and Communication Center, a 'new' SangSangai was introduced in Nepal in early 2013. The updated version features five (rather than six) stations: HIV transmission and prevention, sexual health, sexual and reproductive rights, contraception and family planning, and gender, including gender-based violence. It also works towards a new set of goals: to increase the utilisation of health services, particularly those related to family planning and sexually transmitted infections, among adolescents; to encourage communication about adolescent health issues; and to motivate young people to respect and care for sexual and reproductive health and rights.

'SangSangai facilitators sometimes hike for hours to reach remote schools in mountainous areas of Nepal,' says Kathrin Schmitz, who coordinated SangSangai in Nepal from January 2013 to June 2014. 'Once there, they have a unique and valuable opportunity to share comprehensive information about sexual and reproductive health and rights. Our experience has shown that the JIC can carry more information, on more interrelated topics, than one might expect.'

■ **Implementing the new SangSangai**

On the basis of their long-standing experience with sexual and reproductive health and rights interventions for adolescents and their country-wide networks, the Nepal Red Cross



■ *The JIC in Nepal, known as SangSangai, addresses a wide range of topics related to sexual and reproductive health and rights. Here, a group of school girls take part in a SangSangai event.*

Society and the Family Planning Association of Nepal were selected as implementing partners for the new SangSangai. Between 2013 and 2015, with financial support from GDC and in close cooperation with district-level health and education officials, the organisations reached more than 36,000 adolescents in the Mid-West and Far-West regions of Nepal. In all four participating districts, the proportion of adolescents with comprehensive knowledge of HIV and AIDS after participating in SangSangai rose markedly (from lows of 17 to 41%, before participation, to 76 to 81%, afterwards).

In order to bridge barriers between schools and local health and social services, SangSangai organisers invited community health volunteers and representatives of organisations working on sexual and reproductive health- and rights-related topics to attend events and to participate in ‘adults only’ groups alongside groups of adolescents. Contact details for these local services and organisations were provided in the booklets given to each participant at the end of the event (see Box 10 below).



■ SangSangai uses colourful floor mats, rather than standing or hanging panels, to display pictures and information. This makes the tool easy to pack up and move in mountainous terrain.

The decision to closely involve both government and civil society partners in the implementation of SangSangai increased the likelihood that the tool would be widely used in Nepal. It has indeed taken root and, in 2014, UNICEF contracted the Nepal Red Cross Society to further implement SangSangai in schools and communities. At the same time, GDC continues to support the implementation of SangSangai under the current Nepali-German Health Sector Support Programme.

Box 10. SangSangai: playing and learning together



SangSangai is designed to help adolescents learn, alongside their friends and peers, about the life changes and new responsibilities that come with adulthood. A SangSangai ‘event’ is organised much like JIC runs in other countries: groups of 10 to 12 participants rotate through the stations, which are staffed by teams of male and female facilitators who have completed an intensive seven-day training.



Each station is built around a set of key messages and involves three separate interactive activities. In order to allow ample time to share opinions and to cover the broad range of topics, SangSangai participants spend 20 to 23 minutes per station (compared to 15 in most JIC versions).

Source: SangSangai Facilitator's Manual (2012)

In the station on sexual health, for example, participants use pictures to explore the functions of male and female reproductive organs, how babies are made, and the role of menstruation. With the help of two images of adolescent girls (see right, top), they talk about the personal and societal consequences of adolescent pregnancy. In a final exercise, they discuss a series of statements about sexual relationships and sexual desire, sharing information and questioning stereotypes and assumptions (see bottom).

At the end of each event, each participant receives a 50-page booklet with information about the topics addressed during SangSangai, as well as some related topics not covered in detail in the stations. ‘The SangSangai booklet is a very important complement to the interactive event,’ explains Kathrin Schmitz. ‘The goal was to maximise SangSangai’s great potential for stimulating discussion and changing people’s attitudes, rather than making participants absorb a lot of facts. Detailed information, such as the symptoms and treatment options available for specific sexually transmitted infections, is better conveyed through the booklet.’ The booklet serves as a resource for participants to consult, and can also be shared with friends and siblings, thereby reaching greater numbers of adolescents.

Discussion

Nearly 15 years after the Join-In Circuit first moved beyond Germany's borders, it continues to inform, challenge and inspire audiences around the world. Since 2011, the JIC has reached over 200,000 people in ten countries in Africa, Asia and Eastern Europe.¹⁶ The majority of these have been young people between the ages of 15 and 24, a population group critically in need of access to HIV prevention, treatment and care services and, more broadly, to sexual and reproductive health services.

As this publication has described, the JIC has evolved considerably over the past 15 years: the individual country versions no longer resemble one another to the extent they did previously, and the partnering and implementation arrangements vary significantly by country. Given this diversity of experience, it is difficult to generate broad conclusions about the JIC. However, drawing upon the country examples presented in this publication, this section reflects upon some general lessons that have been learned in recent years as approaches to JIC implementation have become more systematic and rigorous. It also highlights issues which will need to be addressed in the future as the JIC continues to be used in support of adolescent sexual and reproductive health strategies.

■ The JIC is a living product, whose growth must be managed with care

The Join-In Circuit has not only proven itself as a tool with universal appeal, but also as one particularly well suited to local adaptation. Indeed, two decades after its creation, it is now perhaps most accurate to speak not of 'the JIC,' but of multiple 'JICs', each with its own look and character.

The first round of country-specific adaptations, in the mid-2000s, focused primarily on language and imagery, and on tailoring content to each country's cultural norms and particular HIV epidemic. Since then, the JIC hardware has been re-engineered in several countries to make the sets easier and cheaper to transport, and suitable for use in virtually any setting. Special versions of the JIC have been developed for particular audiences, such as parents. The core content has also shifted and broadened: in many countries stations have been combined or omitted, and new stations have been added to better reflect the linkages between HIV and other aspects of sexual and reproductive health.

Because the JIC is, at its core, a communication method, it

can, in theory, be used to address any topic. However the messages from the various JIC stations need to be carefully calibrated to ensure that they link to one another and further participants' understanding of one central problem. Expanding the set of issues addressed via the JIC runs the risk of overloading the tool with too many topics or taking it in a direction where, to cover more ground in limited time, facilitators spend more time conveying information and less time guiding the group discussion.

As the JIC continues to evolve, a key challenge will be to retain its participant-centred, interactive methodology while addressing a broader, more complex range of topics. New versions of the JIC should continue to respect the tool's core attributes: being participant-oriented, built around interaction and dialogue, using real-life situations, connecting with participants at an emotional level, and stimulating concrete strategies for personal behaviour change. Changes to the JIC should be introduced carefully, and with the involvement of communication experts and JIC master trainers who have a thorough understanding of the methodology and can ensure that the local influences on sexual and healthcare-seeking behaviour are identified and reflected in new adaptations of the tool.

■ Implement the JIC as part of a package of complementary interventions

The JIC was never intended to be used as a stand-alone intervention, but the importance of systematically linking the JIC to other interventions and to existing health services has become increasingly apparent over time. As has been seen in Zimbabwe, the high rate of uptake of mobile HIV testing and counselling services (38% of participants since late 2012 have tested for HIV directly following JIC runs) and the large number of young men mobilised for medical male circumcision are testament to the JIC's effectiveness in encouraging participants to seize opportunities for services. However not all relevant services can be offered via mobile teams and, after a JIC run is over, participants may not summon the initiative to actually visit clinics and health providers of their own volition. To bring about meaningful changes in participants' healthcare-seeking behaviours, the JIC should not only be linked to specific services, but also be implemented alongside complementary interventions aimed at the community and health systems levels (e.g. youth empowerment, family- and community-centred programmes, youth-friendly health services).

¹⁶ See annex for details. Although systematic data is lacking, project reports in various formats suggest that at least twice as many have been reached since 2003 when the JIC first began to be used with German support as part of development cooperation efforts.

■ **Build strong management and quality assurance systems**

Implementing the JIC on a large scale in a consistent, high-quality manner is no easy feat. In recent years, it has become abundantly clear that achieving this requires a strong project management model, including dedicated personnel, and a robust and multifaceted monitoring and evaluation system. The day-to-day implementation of the JIC – as well as longer-term planning for its use – is greatly enhanced by a regular flow of information from participants (e.g. how they experience the JIC; what they are learning as a result of their participation) and facilitators (e.g. the challenges encountered during JIC runs, insights into participants’ concerns and questions), as well as administrative data which provide breakdowns of the audiences reached (by type and setting), geographical areas covered, the uptake of testing and other linked services, and costs per implemented JIC run.

Facilitators are the heart and soul of the JIC. Well-trained and motivated young people who are able to talk in a relaxed, caring and informed way about sexual and reproductive health topics can quickly create a safe atmosphere, where participants feel comfortable asking questions and sharing concerns. By the same token, without good quality facilitators, the JIC can easily falter. Through high-quality

trainings, comprehensive resource manuals, regular supervision, feedback and refresher trainings, implementing organisations can ensure a qualified, knowledgeable and motivated facilitator team. Retaining talented facilitators will always be a challenge, but experience shows that facilitators feel greater ownership of the JIC when they are given opportunities to share insights, to reflect on the results of their efforts (e.g. opportunities to discuss project achievements), and to learn from one another’s experiences.

■ **Sustainability must be planned for and pursued from the very start**

Over the past decade GDC has amassed a rich body of experience with different models for institutionalising the JIC in partner countries. The overarching lesson is that the process of handing over the JIC to a national partner or partners is a complex and lengthy one: GDC-supported programmes should think about an ‘exit strategy’ early on and work steadily towards its realisation, prepared for setbacks along the way.



■ *Energetic, confident and well-trained facilitators, such as this one in Mozambique, are key to the JIC’s success.*

In countries like Zambia and Zimbabwe where the JIC has been implemented in partnership with local NGOs, it has taken significant time to identify suitable partner organisations, to plan and undertake a handover, and to provide continued support as the new host assumes responsibility for coordinating the JIC. In both cases, GDC-supported programmes have provided organisational development support during this phased transition. For example, development advisors have been placed at the new JIC coordinating organisations to (among other things) work alongside partner staff to establish the systems and procedures necessary to implement the JIC successfully and to ensure its financial sustainability.

An alternative approach is to institutionalise the JIC in national structures, as is currently being pursued in Kyrgyzstan, with the Ministry of Health and Ministry of Education and the involvement of several youth NGOs. The success of this approach depends upon a careful and long-term process of consensus-building among multiple institutions, and the development of operational plans which outline roles, responsibilities, communication and coordination channels, as well as financial obligations. Here, GDC has also played a critical role in bringing together key stakeholders, facilitating expert workshops to work through details of the implementation design, and providing support at each stage of the planning and handover process.

Scientifically establishing the benefits of the JIC will greatly increase prospects for the tool's long-term sustainability. In an effort to focus their investments and ensure 'value for money,' many development partners only consider approaches with strong evidence of effectiveness. NGO implementing partners will find it easier to build the JIC into funding proposals, and ministries of education will be more likely to consider integrating the JIC into curricula and to allowing its widespread use in schools, if the approach has undergone robust evaluations.

■ Time to reconsider the JIC's 'theory of change'?

With its integrated approach to addressing HIV and sexual and reproductive health, and its interactive, youth-friendly methodology, the JIC is just as timely and relevant now as it was when it was first developed in the early years of the HIV epidemic. Yet despite its enduring popularity, important questions are being raised about the potential of the JIC, as a one-time intervention, to bring about sustained attitudinal and behaviour change.

There is strong evidence that the JIC improves young people's knowledge of sexual and reproductive health topics, including HIV, and encourages greater communication on these issues. However improved knowledge and greater openness will not, in and of themselves, lead to improvements in protective behaviour, such as consistent condom use, or to greater health service utilisation by young people. Economic, socio-cultural and structural factors – from cultural norms which equate unprotected sex with faithfulness, to the availability, quality and accessibility of health services and the perceived acceptability of young people accessing these services – are of equal or greater importance.

The mixed results generated by the recent impact study in Zimbabwe suggest that there may be a need to re-calibrate expectations for what the JIC can realistically achieve in terms of changing individual behaviours, without discounting the JIC's many strengths and its powerful resonance with audiences around the world. The study may provide an opportunity to rethink the JIC as a popular intervention which can be used to build knowledge and promote the uptake of health services alongside parallel efforts aimed, for example, at reforming health systems and transforming community-level attitudes towards young people and their sexual and reproductive health needs.

There is much that current and future JIC implementers can learn from both the recent experience in Zimbabwe and from one another's diverse applications of the JIC. The time may be ripe to bring together JIC practitioners, behaviour change experts and specialists in sexual and reproductive health programming to revisit the JIC's objectives, to reconsider the role it can and should play in comprehensive sexual and reproductive health strategies, and to discuss how its contribution to high-level programme goals can be appropriately reflected in results-based monitoring and evaluation frameworks.

Peer review

To be included in the German Health Practice Collection, a project or programme must demonstrate that it comes close to meeting a majority of the Collection's criteria (see Box 11).

In reviewing this publication, two experts in behaviour change communication and adolescent sexual and reproductive health have agreed that the experience of the Join-In Circuit is worth documenting and sharing widely. They offered the following reflections on the Collection's specific criteria:

Effectiveness

Peer-facilitated dialogues like the Join-In Circuit are an effective way of reaching young people on sensitive topics, such as sexual and reproductive health and HIV. The JIC has succeeded in recruiting and reaching tens of thousands of young people across multiple countries with its engaging methodology. As actual behaviour change is influenced by multiple factors at individual, family, community and societal level, there can never be a linear chain of events which explains behaviour or behaviour change. This is a general limitation of behaviour change communication and is not specific to the JIC.

While JIC implementers should be commended for reaching so many young people, it is also important to ensure equity in access. More attention may need to be paid to ensure that young people who are not in school, or affiliated with certain institutions (e.g. churches), have the opportunity to participate.

Transferability

It has already been demonstrated that the JIC is a transferable approach. The adaptation of the JIC to various socio-cultural and socio-political contexts is noteworthy. A cross-national evaluation of JIC implementation could provide valuable insight into how successfully the JIC performs in different national settings.

Participatory and empowering approach

Evidence shows that the JIC empowers young people, providing them with knowledge about sexual and reproductive health, including HIV, through an engaging and participatory learning format. Peer-facilitated dialogues are a good approach for ensuring that young people internalise key messages. However, the success of this approach ultimately depends on the skill, experience and knowledge of the facilitators themselves.

Gender awareness

Both reviewers felt that the JIC is implicitly gender sensitive, but that efforts could be intensified to make this more explicit.

Quality of monitoring and evaluation

The implementation of the JIC, particularly in Zimbabwe, has benefited from a robust approach to monitoring and evaluation. Monitoring data and evaluation results have been used by the programme, for example, to improve geographical coverage and to redouble efforts to reach young women. An impact study undertaken by an independent institution has provided new insight into behaviour change programming.

Innovation

Two aspects of the JIC are seen as particularly innovative. First, the JIC is unique in the way it brings together an educational approach with access to sexual and reproductive health services (i.e. HIV testing and counselling, referrals). Second, the efforts to ensure sustainability are commendable: this includes not only building the capacity of local NGO partners to assume responsibility for the JIC, but also ongoing efforts to mainstream the JIC into education systems.

Comparative cost-effectiveness

There is not enough evidence to assess the JIC's cost effectiveness.

Sustainability

The investments made to secure the JIC's sustainability – through partnerships with local NGOs and demonstrated efforts to engage governments at multiple levels – are noteworthy. For long-term sustainability, efforts to mainstream the JIC into school systems and government programmes are promising. Ultimately the success of this approach will depend on the willingness of governments to underwrite implementation costs, which may be more possible in some countries than in others.

Box 11. Publication process of the German Health Practice Collection

In response to annual calls for proposals, experts working in GDC-supported initiatives propose projects that they regard as good or promising practice to the Managing Editor of the GHPC at ghpc@giz.de. All proposals are then posted on the [Collection's website](#) to allow GDC experts and the interested public to compare, assess and rate them. The proposals are also discussed in various technical fora in which German experts participate.

Informed by this initial peer assessment, an editorial board of GDC experts and BMZ officers select those they deem most worthy of publication. Professional writers then make on-site visits to collect information, working closely with the local partners and GDC personnel who jointly implement the selected projects.

Each report is submitted in draft form to independent peer reviewers who are acknowledged internationally as scholars or practitioners. The reviewers assess whether the documented project represents 'good or promising practice,' based on eight criteria:

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

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Annex: GIZ-supported applications of the Join-In Circuit since 2011

Table 2. Annex: GIZ-supported applications of the Join-In Circuit on AIDS, Love and Sexuality since 2011

Country and time period*	GIZ programme	Implementation arrangements	Target groups and estimated reach**	Special features
Bosnia and Herzegovina 2009 to 2011	Promotion of Sexual and Reproductive Health and HIV Prevention for Adolescents	Partners: Municipalities, local health centers, youth centers, youth NGOs Settings: Schools, youth centres	Target groups: Young people aged 15-24 Reach: Over 3,500 young people in 20 youth centres in 14 municipalities (October 2010 - November 2011)	Strong links established with local health stations Youth-Friendly Corners (info points) in youth centres As of 2015, info points continue to be used in 13 youth centres; JIC is still used in 5 youth centres
Kyrgyzstan 2008 to present	System development in sexual and reproductive health and rights (SRHR) – Central Asia	Partners: Ministry of Health/ Republican Centre for Health Promotion; Ministry of Education; NGOs Settings: Schools	Target groups: School pupils, aged 15-18; parents of school pupils Reach: Over 20,000 young people reached between 2011 and 2014 in 657 schools in rural areas, small cities and Bishkek	Information about and referrals to HIV and SRHR services provided to participants at JIC runs Stations added on HIV and drug use, and on sexual and reproductive rights Special version of JIC developed for use with parents
Mozambique 2006 to present	Programme for basic and technical education and vocational training (Pro-Educação) N.B. From 2003 to 2008, the JIC was used widely by German-supported health programme in Mozambique	Partners: Ministry of Education, Provincial and District Education Departments Settings: Teacher training centers	Target groups: Student teachers, aged 16-20 Reach: Over 6,400 participants between 2011 and 2014	Faculty and student teachers are trained as JIC facilitators JIC runs are carried out at health fairs, where health information, as well as counseling and testing services for diabetes, high blood pressure and HIV, are offered
Nepal 2008 to present	Nepali-German Health Sector Support Programme	Partners: Ministry of Health and Population; Family Health Division; National Health, Education Information and Communication Centre; National Centre for AIDS and STD Control; Ministry of Education; NGOs Settings: Schools, youth clubs and factories	Target groups: Young people, aged 15-19, both in and out of school Reach: Over 36,000 young people between 2013 and 2015 in several districts in Mid-West and Far-West Regions	JIC in Nepal is known as 'SangSangai' The five SangSangai stations cover a wide range of issues including gender, HIV, sexual health, sexual and reproductive health and rights, and contraception

Country and time period*	GIZ programme	Implementation arrangements	Target groups and estimated reach**	Special features
Tajikistan 2012 to present	Regional programme: Health in Central Asia	Partners: Centre for Health Promotion, Ministry of Health and Social Protection; State committee on youth, sports and tourism of Tajikistan Settings: Schools	Target groups: School pupils, aged 16-18 Reach: Over 6,000 schoolchildren reached between 2012 and 2014 in 74 educational institutions, including vocational schools	Information about HIV and SRHR services provided to participants at JIC runs
Uganda 2012 to present	HIV mainstreaming in various GIZ programmes	Partners: German Foundation for World Population, DSW (until 2013); local NGOs; African Prison Project (since 2013) Settings: Community settings, prisons	Target groups: Young people aged 15-24; adults at the workplace; male and female prisoners Reach: Over 2,800 people between 2012 and mid-2015	In 2013, GIZ introduced the standard JIC to support the functional adult literacy curriculum of the African Prisons Project (APP) In 2014, four new stations were developed on water and sanitation, domestic violence, parenthood, and anger management and control
Ukraine 2011 to present	HIV/AIDS advisory services and institutional capacity building	Partners: Ministry of Health, Ministry of Education, NGOs, youth organisations Settings: School, summer camps	Target groups: Young people aged 15-24 Reach: More than 47,000 young people between 2011 and 2014	The Ministry of Education has recommended the JIC for use in schools The JIC methodology has been used by the Peace Corps and by a European Union-funded teacher capacity building project
Uzbekistan 2006 to 2008 2012 to present	Regional programme: Health in Central Asia	Partners: Ministry of Health, Republican Centre for Reproductive Health Settings: Colleges and lyceums	Target groups: Young people aged 16-20 studying in colleges and lyceums Reach: Over 6,000 young people reached during 2013 and 2014	Information about HIV and SRHR services provided to participants at JIC runs Revised, Uzbek version of the JIC in use since September 2014 The Government of Uzbekistan has agreed to cover the administrative costs of JIC implementation in all vocational educational institutions (1555 colleges and lyceums) nationwide

Country and time period*	GIZ programme	Implementation arrangements	Target groups and estimated reach**	Special features
Zambia 2005 to present	Multisectoral HIV Programme	<p>Partners: NGOs</p> <p>Afya Mzuri manages JIC implementation through a network of local NGOs</p> <p>Settings: Public and private sector workplaces, schools, community settings</p>	<p>Target groups: People of reproductive age (15-49), including: high-risk populations (sex workers, mobile populations); young people (in and out of school); parents and teachers; students; salaried employees; community leaders and members</p> <p>Reach: More than 60,000 people countrywide between 2011 and mid-2015</p>	<p>HIV testing and counselling available at many JIC runs; referrals made to Youth-Friendly Corners. Information about other services and resources distributed to participants</p> <p>JIC runs conducted for parents of school pupils</p>
Zimbabwe 2005 to present	HIV Prevention Zimbabwe (HPZ) project	<p>Partners: NGOs. Family AIDS Caring Trust (FACT) manages JIC implementation through a network of local NGOs</p> <p>Settings: Schools, tertiary education institutions and community settings</p>	<p>Target groups: Young people aged 15 to 24 (both in and out of school)</p> <p>Reach: More than 31,000 young people reached between June 2011 and September 2015 in Manicaland and Mashonaland West provinces</p>	<p>Mobile HIV testing and counselling available at most JIC runs. Referrals to clinics and Youth-Friendly Corners for adolescent sexual and reproductive health services, including voluntary medical male circumcision</p> <p>40% of female participants and 33% of males go for HIV testing and counselling immediately following JIC run</p>

* The time period refers to the overall duration of GIZ support, including the time required to adapt the JIC before the start of implementation. Some JICs continue to be used after the end of GIZ support.

** Reach refers to the number of participants during the indicated time period only. In some countries, the total number of JIC participants (i.e. including reach prior to 2011) is significantly larger. Reported figures based on information available as of October 2015.

Note: In addition to the countries listed in this table, GIZ supported the implementation of the JIC between 2003 and 2010 in the following countries: Bangladesh, Democratic Republic of the Congo, Ecuador, Ethiopia, El Salvador, Kazakhstan, Kenya, Latvia, Lithuania, Mongolia and the Russian Federation.

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Friedrich-Ebert-Allee 36
53113 Bonn, Germany
Tel. +49 228 44 60 - 0
Fax +49 228 44 60 - 1766

German Health Practice Collection
ghpc@giz.de
www.health.bmz.de/good-practices

Writer

Karen Birdsall

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Addresses of the BMZ offices

BMZ Bonn
Dahlmannstraße 4
53113 Bonn
Germany
Tel. +49 228 99 535 - 0
Fax +49 228 99 535 - 3500

BMZ Berlin
Stresemannstraße 94
10963 Berlin
Germany
Tel. +49 30 18 535 - 0
Fax +49 30 18 535 - 2501

poststelle@bmz.bund.de
www.bmz.de