HIV and Young People

Report of the Regional Consultation
Chiang Mai, Thailand, 11-14 October 2005

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Executive summary

Young people (10-24 years) are at centre of the HIV/AIDS pandemic in terms of transmission, impact, vulnerability and potential for change. The WHO South-East Asia Region has 6.7 million people living with HIV/AIDS of which nearly 1.9 million are young people (15-24 years). HIV has affected most of the countries of the Region. Though the affected countries have a prevalence rate of less than 1% there are areas in Thailand, India, and Myanmar where the HIV prevalence is higher than 1%, indicating that the epidemic has spilled over to the general population. The HIV prevalence among the youth ranges from 0.01% to 1.32%. In countries like India, and Thailand, more females than males have been infected with HIV which signifies an adverse impact on maternal and child health.

Global goals and targets pertaining to HIV/AIDS among the 15-24 years-age-group provide direction in relation to impact, the coverage of key interventions and decreasing Young People's vulnerability to HIV/AIDS. These goals have been endorsed at the International Conference on Population and Development +5 (ICPD+5) by the UN General Assembly Special Session by the (UNGASS) on HIV/AIDS and UNGASS on Children, and are reflected in the Millennium Development Goals. There is a clear need for an expanded response to achieve these ambitious goals and targets and will necessitate the involvement of different sectors strengthening their own specific contribution.

WHO is working to strengthen and accelerate country-level health sector action in relation to young people (YP) and HIV/AIDS, and thereby enable a range of actors to maximize their contributions to an expanded response for achieving the global goals. This includes a focus on the 4 "S" strategies comprising Strategic information, Services and Supplies, Supportive policy environment and Strengthening action in other sectors.

The regional consultation on HIV/AIDS among Young People was held from 11-14 October 2005 in Chiang Mai, Thailand to review and obtain feedback on the recently-developed draft Regional Strategy on HIV and Young People; to develop and agree on a common framework for implementing activities related to HIV among Young People; to orient participants to the use of the monitoring and evaluation guide for national HIV/AIDS prevention programmes for Young People

and to share evidence-based technical updates with participants on Adolescent Health and Development (AHD) and HIV/Young People.

A number of interactive training techniques were used during the consultation. These included group discussions, plenaries, case studies and a field visit. The global and regional scenarios on HIV/AIDS and young people were presented. Specific country presentations from Indonesia, Myanmar and Sri Lanka focused on sharing of experiences in implementation interventions particularly targeting high risk groups such as sex workers, men having sex with men and IDUs. The programme development tool, Mapping Adolescent Programming and Measurement (MAPM), was introduced to the participants to assist in design, review and measurement of programmes to improve adolescent health development. Application of the MAPM framework allows programme managers to specify which behaviour and their determinants they are addressing or intend to address through intervention activities.

Through group work, the MAPM process for HIV/AIDS and maternal mortality was used to bring about an understanding of the importance of linking HIV to other priority adolescent sexual and reproductive health problems and programmes. Participants also had an opportunity to use the MAPM framework and strategic information to review selected national HIV/AIDS plans.

Experiences from countries on provision of Youth Friendly Health Services (YFHS) were shared to focus on the role of health services. The evidence base for action was presented and the importance of standards for delivery of quality health services were discussed. Bangladesh and India shared their experiences on the development of national standards. An orientation programme package developed for health care providers was shared with the participants. One module from the orientation package was used to demonstrate the methodology used in the package and highlight important issues related to adolescents. A presentation on supportive evidence-based policies was made and discussions were held on some of the policy issues impacting provision and utilization of available health services by young people.

A draft regional strategic framework on control of HIV in young people was presented and discussed. To plan for future actions at country level, participants from countries were divided into groups and were asked to list 2-3 activities to work on during the next six months as a follow-up of the consultation and 2-3 areas for which technical assistance or capacity development will be required.

Conclusions and Recommendations

Based on discussions, a consensus was developed on the core elements for regional strategies for health sector response to achieve the global goals on HIV/AIDS among young people. The approach on how countries could strengthen strategic information, services and supportive policy for young people in relation to HIV/AIDS in their countries was accepted. There was common understanding on the needs for capacity development, technical assistance and networking for youth-friendly health services (YFHS) and related activities in countries of the Region. The health ministries in Member countries should set a national policy and strategy for adolescent health and development, promote an integrated approach and a better understanding of adolescent needs. They should initiate age and sex disaggregated data on young people to serve as an evidence base. Within countries, there is a need to strengthen action in other sectors and to mobilize and support other sectors to contribute to HIV prevention and care in young people. Examples include education, NGOs/CBOs, youth, criminal-justice, media, labour and the armed forces.

Countries should analyze the available innovative and successful initiatives on HIV/AIDS and young people and the information should be fully utilized and shared. To improve the quality of health services and their utilization, countries should develop guidelines, tools and standards and expand the coverage of quality services. International agencies including WHO and UN agencies should provide financial and technical support in the areas of policy, research, evidence, standards and quality for successful implementation of HIV/AIDS programmes for young people.

1. Introduction

A Regional Consultation on HIV and Young People was organized from 11-14th October, 2005 at Chiang Mai, Thailand by the WHO Regional Office for South-East Asia (SEARO). The participants included HIV/AIDS focal persons and adolescent health focal persons from ministries of health (MoH) and selected NGOs from nine countries of the Region (except DPR Korea and Timor-Leste), WHO staff from HQ, the Regional Office, staff from three country offices (Bangladesh, India and Myanmar), and representatives from the UNFPA and UNICEF regional offices. In addition, participants included MoH and WHO–country office staff from Vietnam/ Western Pacific Regional Office (WPRO). A list of participants is given in Annex. The focus of the consultation was on joint actions to be carried out by both the HIV/AIDS and Adolescent Health and Development (AHD) programme managers for prevention of HIV among young people.

1.1 Objectives

(1) To review and obtain feedback on the recently developed draft Regional Strategy on HIV and Young People

(2) To develop and agree on a common framework for implementing activities related to HIV among YP

(3) To orient participants to the use of monitoring and evaluation guide for national HIV/AIDS prevention programmes for YP

(4) To share evidence-based technical updates with participants on AHD and HIV/YP

1.2 Inauguration

The inaugural address of the Regional Director was delivered by the Regional Adviser, AHD/SEARO. According to the Regional Director, young people who constitute a significant number of the population of Member countries, are vulnerable to HIV and are at the centre of the HIV epidemic.

Certain systems-related issues like paucity of disaggregated data pertaining to YP, and lack of access to Youth Friendly Health Services (YFHS) were hampering the health sector's response to the epidemic. The strategies need to focus on reduction of vulnerability of the YP by obtaining strategic information, strengthening of health services and supplies and by building supportive policy environment. The draft Regional Strategic Framework developed by SEARO on control of HIV in YP was to assist countries in developing a health sector response. WHO, through its "3 by 5" and other strategies, was committed to play its strategic role to assist the countries in meeting the UNGASS and MDG goals. Other sectors needed to play an important role in improving access to condoms, de-stigmatization of condom usage, sexuality education, life skills education, and development of age appropriate methods to address myths and misconceptions related to HIV/AIDS.

Dr Pongsak Angkarith, Vice President, Chiang Mai University (CMU), highlighted the recent increase in prevalence of HIV in YP. He said that the success of Thailand in reversing the trends may have led to complacency in relation to YP. This group should be the focus of the programme now. He thanked the Regional Director and the Faculty of Nursing, Chiang Mai University, for having organized this important consultation. Dr Wipada Kunaviktikul, Assoc. Prof and Dean, Faculty of Nursing, CMU, welcomed the participants and thanked WHO, SEARO for organizing the regional consultation.

1.3 Expectations from the consultation

The participants expected that the consultation would help them in developing a common understanding on increased risks and vulnerabilities of YP to HIV and help them develop operational plans for country implementation and develop a monitoring and evaluation (M&E) framework focusing on country-specific indicators to monitor HIV/YP programme. Participants expected to learn about HIV/YP strategies that are practical and realistic, linked and integrated to national plans and policies. Some participants wanted to learn ways to strengthen action in other sectors to contribute to HIV prevention and care. Others wanted to share lessons learnt, "best practices" and challenges, develop consensus on the Regional Strategic Framework, and carry out advocacy for control of HIV in YP in the countries. The agenda is in Annex.

2. Overview

2.1 Why focus on the health sector response to HIV and young people and what are the priorities for action?

Dr Bruce Dick, WHO/HQ, identified the age groups for adolescents (10-19 years); youth (15-24 years), and young people (10-24 years) as the focus for the consultation. Young people are different from each other and adults in many ways. What happens in this period is of crucial importance for them now, and in their future, for their children and the development of nation. Young people are also at the centre of the HIV epidemic. The programme need to focus on adolescents because of the public health importance, the implications for the economic development of the country, poverty reduction, human rights, and for achieving the international goals adopted by countries of the Region.

Young people require access to information and skills, health services and counseling, a safe and supportive policy environment, so as to be empowered to make the right choices for themselves. Keeping the rights perspective and the various global goals and targets, the countries need to focus on HIV/YP for an effective response to the epidemic.

In addition to the "technical reasons" there are also cogent "strategic reasons" for adopting HIV/YP as an entry point for focusing on their health and development. This also provides an opportunity to focus on sensitive issues –like sex and sexuality and vulnerable and marginalized groups of YP who are most at risk. The countries need to have great commitment and allocate resources, to achieve the goals of improving the access of the YP to information, skills and services. Though many sectors need to play their roles, the health sector needs to chart out its crucial course. The health sector needs to mobilize and strengthen other related sectors.

2.2 Discussion points

Psycho-sexual development in YP is important and needs to be provided a better focus in the health sector strategy. In some countries, it is difficult to talk about sexuality and this may prove to be a constraint. Parents and other gatekeepers play a vital role in the education of young people about

sexuality and making decisions related to health. Other departments/ ministries too should contribute towards preventing HIV in the YP in the country.

2.3 HIV/AIDS in South-East Asia: Issues and challenges

Ms Laksami Suebsaeng, Technical Officer, HIV/AIDS Department of Communicable Diseases, WHO/ SEARO, highlighted the diversity in the prevalence and severity of the infection in SEAR countries. HIV/AIDS is a growing epidemic in many SEAR countries and co-exists with RTI/STI. Almost 99% of the HIV-positive persons live in four countries of the Region–India, Thailand, Myanmar and Indonesia. Unprotected heterosexual intercourse and Injecting Drug Use (IDU) remain the leading routes of transmission. In many countries in the Region, epidemics are concentrated among key vulnerable populations, such as sex workers and their clients, IDUs, men who have sex with men (MSM), and certain mobile populations. The epidemic is likely to spread to the general population unless determined action is taken now.

Though in some countries the percentage of infected persons may be low, it translates into huge numbers in the context of the Region. The number of cases in India (5.1 million) is almost equal to the numbers in South Africa even though the prevalence in South Africa is much higher. The epidemic is concentrated among the high risk groups but could spread into the general population unless appropriate corrective steps are taken now. HIV prevalence in Sexually Transmitted Infections (STI) patients and commercial sex worker (CSWs) ranges between 5-25% in India. HIV prevalence among Female Sex Workers (FSWs) is also increasing in Indonesia and Nepal. There are rising trends in the incidence rate in the IDU population and MSM. In Nepal, Myanmar, India and Thailand, young people contribute to about 50% of new HIV infections globally every year. Nearly 70% of IDUs in Nepal are < 25 years of age. Migrant populations and persons in professions that involve mobility (truck drivers and helpers) are at most risk. A survey in southern India in 2002 found that 16% of truck drivers on a specific route were HIV positive. About 54% of truck drivers in Bangladesh reported recent contact with sex workers which increase their risk of HIV. There are increasing trends in risky behaviour among young people. Sexual behaviour among students shows rising trends in sex with CSW. In addition to this trend, the age at sexual debut is falling. There is a need to better understand the sexual behaviour of Young People.

At present, coverage of preventive interventions in targeted groups like CSW, IDU, and MSM is low. Only 5% of IDU are reached by such programmes. Most vulnerable populations have minimal levels of accessing voluntary testing and counselling compared to the general population – partly due to fear of discrimination and the absence of appropriate services. Antiretroviral treatment (ART) costs remain high and the capacity of communities / NGOs to support treatment of the TB/HIV dual epidemic remains limited. There are weaknesses in the surveillance system as well. The "key lessons" are that focus is required on prevention to reduce prevalence and the treatment burden, along with improved coverage for care and treatment, strengthen the health information systems and create an enabling environment.

2.4 Regional overview of HIV/YP

Dr Neena Raina, Regional Adviser, Adolescent Health, WHO/SEARO presented the regional overview. Though, with progress of time, more data related to age and sex are available, there are still crucial gaps. Young people (10-24) constitute 24-36% of the total population of the Region**.** There are an estimated 1.9 million young people (15-24 years) living with HIV/AIDS in the Region. Females are predominantly affected, especially in India and Thailand. In Thailand, about 70% of young people (15-24 years living with HIV/AIDS are females).

Many factors like poverty (commercial sex, trafficking of women), low literacy, gender inequality, migration, stigma and discrimination and low access to health services act as risk factors. In addition, factors like experimentation with sex and drugs, lack of information and skills, poor health care seeking behaviour, lack of age and gender-appropriate sexuality education; impaired risk perception, biological factors like immaturity of cervical mucosa, contextual factors, like being out of school, peer pressure, makes the adolescents and young people more vulnerable to HIV. Gender bias and low social status of adolescents, health care providers and health services' biases, and convergence of risk behaviours and habits add to the vulnerability of adolescents. Young people who share needles and syringes, young sex workers, victims of trafficking and forced sex, and those living in difficult circumstances or situations of conflicts, being most vulnerable are at very high risk of contracting HIV. A large number of children live or work on the streets of three major cities of India, and in Nepal. They are likely to

exchange sex for money, goods or protection, and are also subjected to rape. They are more prone to develop HIV.

Though national data on premarital sex is limited, the trends reflect that the age of sexual debut is decreasing especially for the marginalized groups. The mean age for first sexual debut was 15 years for boys and girls in Nepal (UNAIDS and UNICEF 2001). In addition, the types of partners are usually from high risk group and coercive sex is reported by Young People. Mostly, sex is unprotected in these situations. The available data on sexual behaviour reflects the trend of young men visiting CSW and then acting as the "bridge population". In urban and rural Thailand, 61% of currently single men and 81% of ever married men had sex with sex workers. In regions of India, 19-78% of males reported having sexual relations with a sex worker (Jejeebhoy 1996). As many as 82% of young men visiting border towns of Nepal report recent relations with a sex worker. Though early marriage is common in some countries, it does not provide safety from HIV to young girls, largely due to the age differentials and premarital sexual experience of the husbands.

Lack of knowledge of the status of HIV in the most vulnerable YP is a matter of serious concern. About 50% of CSWs returning to Nepal from Mumbai who had been trafficked earlier are HIV positive. In Nepal, 50% of IDUs were HIV positive; half of them aged 16-25. HIV prevalence among IDUs in Kathmandu is 68% and is as high as 50% in the IDU population of states like Manipur, Mizoram and Nagaland in India.

Low prevalence rates of HIV can not be a reason for complacency in SEAR countries because this does not necessarily mean a low risk. For example, data from Bangladesh, a low prevalence country, reflect the complex web of factors and behaviours that fuel HIV since 46% of MSM are married and 34% visit FSWs. Similarly,76% of "rickshawallahs" are married and 69% of them visit FSW. A significant proportion of these are IDUs.

Member countries in the Region face numerous challenges. Young People lack information not only related to HIV but also related to sexual and reproductive health. They also lack skills to negotiate and decide. Thus, it is important that their information levels, including information about the availability of services and life skills, are enhanced. National representative data on age at sexual debut is not available and data on vulnerable boys and girls are also limited. The VCTC, wherever available, suffer from low utilization.

Despite the existing constraints, the countries in the Region have a tremendous opportunity. They need to reinforce advocacy and leadership for multi-sectoral HIV/AIDS control programmes. Prevention, treatment efforts and care of PLWA should be synchronized. Strengthening of health information systems will help policy makers in making the right policy and programme choices. Creating an enabling environment will help marginalized and hard-to-reach populations to have access to interventions

3. Country presentations

3.1 Srilanka: Adolescents and young people

Dr Deepthi Perera, Director, Elderly, Disabled & Displaced Persons-"Suwasiripaya", Colombo, Sri Lanka, said Young people constitute around 28% and adolescents about 19.7 % of the population of Sri Lanka. Eight percent of the total pregnancies occur amongst adolescents and 22% of out-of- school YP have had sexual experience before marriage. Age of sexual initiation is 15.3 yrs for males and 14.4 yrs. for females .Studies on sexual behaviour of YP show that 43% of the sexual encounters occurred with girl / boy friends, and 11% with CSW. Only 39% reported the use of condoms**.** Sexual abuse is quite worrisome as 3-14% of adolescents experienced forced sex. Approximately 60,000 – 200,000 new episodes of STI occur annually, many of them in YP. Though abortion is illegal in Sri Lanka, 15% of total abortions occur amongst YP. At present, YP have poor knowledge regarding STI and HIV. Majority of CSWs are in the 15-24 years group. A strategy for control is to reach out to adolescents and Young People through schools, universities, as well as technical and vocational training institutions. Teaching modules on HIV/AIDS in the student curricula have been introduced.

3.2 Myanmar: Focusing HIV/YP initiatives among sex workers

Dr Myint Aung, Divisional AIDS/STD Officer, Magway Division, Myanmar said that Adolescents constitute 19.1% and YP constitute around 28% of the population. Age at sexual debut is 22 years for males and 19 years for females. Though 91% of YP have heard about HIV/AIDS, only 25% of males and 18% of females know the basics of HIV prevention, 27% were able to correctly reject common HIV/AIDS misconceptions and 2.8% reported

seeking VCTC services. About 110 townships are participating in the 100% Targeted Condom Programme (TCP). The review of the 100% TCP highlights encouraging signs of effectiveness of this intervention to reduce HIV transmission among female sex workers and their clients. It enhances condom acceptability and condom access in the community. Government and NGO programmes are providing effective interventions for CSWs (including young CSWs), but there is a need for expanding coverage of interventions targeting CSWs. Strengthening of outreach activities and peer group education to empower sex workers, including collaboration with NGO programmes is envisaged.

3.3 Indonesia: HIV/Young people among injecting drugs users

Anasrul SR, Fonny S Ministry of Health of Indonesia said the country at present has a concentrated epidemic. A majority of HIV transmission is due to IDUs (47%) and sexual transmission. Nearly 54% of cumulative AIDS cases belong to the 20-29 year age group. HIV prevalence was > 5% in sex workers in Riau, Papua, West Kalimantan and 27% – 53% in IDUs in DKI Jakarta, Bali, West Java and East Java. Nearly 40% of CSWs in West Java are less than 18 years old. Behavioural surveillance surveys reflect that YP are well informed about HIV prevention, but only < 10% are using condoms consistently. More than 60% ever shared needles and syringes when using drugs. In a survey of high school students (16-18 years) it was observed that 12% of males and 6% of girls had sex in the last year, 39% cited “love”, 33% “curiosity” and 14% “peer pressure” as the reasons for indulging in sex, 78% boys and 23% girls (both 15-19 years) smoke, and 44% of men (20-24 years) drink, 69% of boys and 28% of girls were reported to be “drunk”. The level of information on HIV/AIDS is low in the 20 –24 year age group. Only 23.8 % of females and 27.0% of males had knowledge of at least two ways of prevention of HIV.

3.4 Discussion points

- YP are vulnerable, non-homogenous and have specific needs and rights.
- What happens in this period is of crucial importance for them now, their future and for their children, as well as for the development of nations.

- There is a paucity of data related to HIV/YP but still enough is known to base initiatives on it.
- There is a gap between knowledge and condom use – only 10% of those practicing high risk behaviour used a condom.
- HIV/YP is a good entry point for focusing on YP health and development and, an opportunity to focus on sensitive issues – like sex and sexuality, to focus on vulnerable and marginalized groups of YP and for providing commitment and resources.
- Sexual initiation starts early, thus, sexuality education needs to start earlier for safer sex.
- A better focus on the Life Skills Education (LSE) programme in various settings is required.
- The focus needs to be on prevention so that the burden of ART and management can be reduced in future.
- There is a need for synchronization of prevention, treatment and care activities.

4. Mapping Adolescent Programming and Measurement (MAPM)

Dr Krishna Bose, WHO/HQ provided an overview of Mapping Adolescent Programming and Measurement (MAPM) a tool for strengthening and rationalizing programme implementation and monitoring. This was developed by WHO and UNICEF after multi-country trials and feedback. It has been used with programme managers and researchers in 20 countries to strengthen programming for adolescents. Though designed in the context of adolescent programming, it has wider application in programme planning for HIV/YP. Interventions to improve health outcomes need to take into account that there is a "bunch"

MAPM – the key steps

Step 1: establish what the desired health outcome is

Step 2: identify and select important behaviours to change/encourage that underlie the health outcome

Step 3: identify and select determinants of each of the behaviours to change

Step 4: design intervention activities to change the selected determinants

of behaviours and not necessarily a single behaviour or determinant that impacts the outcomes. There are 'risk' and 'protective' factors that impact health outcomes. MAPM benefits the programming in many ways. MAPM can assist with defining desired results, reduces pressure to just focus on changing health outcomes, provides a rational, stepwise basis for selecting interventions to implement and makes explicit the importance of risk and protective factors in mediating behaviour change. MAPM helps to identify gaps in the available information needed to either develop an effective programme or review existing programmes.

4.1 Group work on MAPM

The participants were divided into four groups. Two groups were given the task of utilizing MAPM for HIV and STI reduction, and the other two groups dealt with reduction of maternal mortality rate (MMR), abortion and reduction of early and unwanted pregnancy. The groups went through the four key steps of MAPM. The presentations using Visualisation in Participatory Programmes (VIPP) methodology were made to the plenary. The synopsis of the group work is given in Annex 3.

An exercise was carried out to trace the common behaviours, determinants and interventions. Both risk and protective factors were considered for influencing the health outcome. An increase in the use of condoms will also reduce unwanted teenage pregnancies in addition to reducing STI and HIV transmission. Thus, the exercise reinforced the concept that it makes great programmatic and economic sense to have combined interventions for HIV / STI reduction and reduction in maternal mortality.

4.2 Discussion

There are many common determinants which should be understood and incorporated into programming. At the moment there is a lack of communication. To strengthen communication, messages need to be clear and comprehensive. Key areas need to be identified so that the strategies could address these at the country level.

5. The health services response to the prevention and care of HIV/AIDS among young people

Evidence-based package of services

- Information and counseling
- Risk reduction
- Condoms promotion and access
- Harm reduction interventions for IDUs
- Diagnosis, treatment and care of STIs and HIV/AIDS

Dr Bruce Dick, WHO/HQ emphasized the role of the health sector in reducing the incidence of HIV amongst YP. There is an evidence-based package of services available. The priorities for the health sector are to : collect, analyse and disseminate the data required for advocacy, policies and programmes; provide services that include a focus on prevention and treatment; develop and implement evidence-informed policies and strategies that provide vision and guidance and mobilise and support other sectors. Most of the member countries need to go a long way to achieve the UNASS goals. They should accelerate the process to achieve the goals.

There is enough evidence to show that the use of health services by YP can be improved. Many studies document the factors that make the services more accessible and affordable and lead to improved usage. Since large numbers of adolescents go to traditional healers and "quacks", they need to be included in programming. Harm reduction is a package of interventions in which the evidence base for needle exchange is strong. Three areas i.e., the health system, providers and the community need to be involved and quality dimensions kept in view to improve utilization of health services. All the experiences with increasing access to health services indicate that demand creation is essential.

Improving the accessibility of services for YP

- Make services more affordable
- Make working hours more convenient
- Inform adolescents about the range of health services available
- Obtain the support of community members including YP.
- Involve a range of outreach workers to take health services to young people in the community
- Link health services with other interventions (schools, media, social marketing)

Involving parents and other community members is important because they need to support YFHS initiatives, and involving young people and peers is important because they contribute to the development of the services.

Barriers to YP accessing services for HIV

Dr Patanjali Nayar, temporary adviser, and Dr Arvind Mathur, WHO Country Office, India, briefed the participants regarding the objective of the session and the expected outcome of the group work. The participants were divided into seven groups and asked to identify five aspects that act as barriers for accessing the HIV services. The VIPP methodology was utilized. A brief discussion took place in which the implications of various barriers and the interventions required to overcome them were discussed. The groups highlighted the lack of policy on services for adolescents, limited mobility of females, and lack of privacy and confidentiality while dealing with adolescents, as prominent reasons for low utilization of services. Groups also highlighted the long waiting time, restrictive attitude of parents due to social norms, lack of faith of adolescents in health facilities, religion and tradition as constraints.

6. Development of standards for Adolescent Friendly Health Services (AFHS)

6.1 India: Development of standards for AFHS in the context of RCH II

Mr Chaitanya Prasad, Deputy Secretary, IEC, Ministry of Health and Family Welfare (MOHFW) Government of India (GOI) provided an overview of the policy environment in India. The National Population Policy 2000 recognizes adolescents as an 'underserved group', with regard to their health needs. The Tenth Five Year Plan identifies adolescents as a distinct target group for policy and programme focus; the National Rural Health Mission (NRHM) provides the overall framework for health sector response that includes HIV/AIDS as a target; In RCH-II, a special focus by the department of Family Welfare has been given to meeting the health service needs (especially SRH) of adolescents. The focus of programmes of other departments is on improving knowledge and skills (e.g. life skills) of adolescents; and the overall objective of the Adolescent Sexual and

Reproductive Health (ARSH) strategy is to contribute to the RCH-II goals of reduction of infant mortality rate (IMR); maternal mortality rate (MMR) and total fertility rate (TFR) and promoting ARSH.

Draft national standards

- Service delivery points provide the specified package of health services for adolescents, effectively.
- Service providers are sensitive to the needs of adolescents and are motivated to work with them.
- Adolescents are well informed about the availability of quality health services from the service-delivery points.
- An enabling environment exists in the community for adolescents to seek the health services they need.
- Service delivery points are accessible to adolescents.
- Adolescents feel at ease with the surroundings and the ambience of the service delivery points.
- Management systems are in place to improve/sustain the quality of health services.

Dr Arvind Mathur, WHO Country Office, India, outlined the process of development of national standards for ASRH. A National Consultation on development of standards and operational guidelines for AFHS was held with the collaboration of MoH, WHO and UNFPA in September 2005. The health issues and problems to be addressed as part of the RCH-II ARSH strategy were discussed. The quality dimensions were recognized and their determinants identified. Consensus on seven draft standard statements was obtained. (See box for draft national standards).

6.2 Bangladesh: Development of design and standards for YFHS initiative

Dr Salim, Dr Lima Rahman and Dr Diana outlined the GFATM-supported project on HIV/YP and the basis for YFHS. The levels of providers and facilities for these services were identified. HIV/AIDS is an entry point for YFHS to provide a package of interventions on reproductive health, nutrition and STI. In Bangladesh, YFHS is not about adding new services, but about making existing services more responsive to the specific needs of young people. There is a need to focus on the health system, the service

providers, and the beneficiaries/ families/ communities. A national consultation to finalize the key issues and for setting standards for YFHS (service providers, facilities and community) to focus on quality of YFHS was held. The standards for YFHS were identified (see Box).

Standards for YFHS

- Gate keepers promote and support the use of YFHS by all young people
- Young people know where they can get YFHS
- Young people feel comfortable with the surroundings and procedures of the Health Service Delivery Points (HSDPs)
- All young people visiting HSDPs receive services that are provided in a respectful manner
- All young people who visit HSDPs are dealt with in an equitable manner irrespective of their status
- The privacy and confidentiality of all young people who visit health service delivery points is maintained
- Service providers are motivated to provide health services to young people in a youth-friendly manner
- HSDPs provide appropriate services to all young people
- HSDPs deliver effective services to young people
- HSDPs collect, analyze and use data on young people to improve the YFHS

7. Orienting the health care providers to AFHS: WHO's orientation package

Dr Neena Raina, WHO/SEARO introduced the topic and the package of materials (Facilitator's Guide, Handbook, CD) developed by WHO. The focus of the Orientation Package (OP) is on addressing the special needs of adolescents and not on building clinical skills. She introduced various modules on adolescent growth and development, adolescent pregnancy, safe abortion and contraception. The intended audiences of the modules are the health care workers who provide clinical services for children and adults and the NGO sector that provides prevention and curative services. The orientation programme package spells out the how to, who to, why to, what to and when to in practical terms: targeting adolescents and youth.

7.1 Panel discussion on the orientation programme package (adaptation process)

Two countries, India and Bangladesh, have adapted the generic OP developed by WHO. In addition, Vietnam has adapted some sections from the OP. Dr Bruce Dick and Dr Neena Raina moderated a discussion on the adaptation process and the lessons learnt. Participants from India, Bangladesh and Vietnam participated in the discussion.

7.2 Discussion points

The target audiences varied with the country. While Viet Nam targeted the public sector only, India and Bangladesh targeted all health care workers (HCW) in the public sector, NGOs and the private sector. India also involved professional bodies like the Indian Medical Association (IMA), Indian Academy of Paediatrics (IAP) and the Federation of Obstetric and Gynecological Societies of India (FOGSI).The package of interventions was different for different HCWs. Viet Nam adapted the package for targeted young sex workers and IDUs, explicitly putting together a 1-2 day small package to integrate into the existing training programme. India defined and designed a different package for each cadre of provider and developed a separate module for the programme managers which emphasised operationalizing the strategy. Some sections were strengthened or added, for example, nutrition and adolescents, HIV/AIDS. Viet Nam has already translated the OP into Vietnamese while the other countries are contemplating translations. In India, a technical core group worked on the modules and a technical agency was asked to design the curriculum. The adapted OP was field tested by expert trainers and based on the findings from the field, the package was revised. The OP will be utilized in 75 pilot districts of the country. Bangladesh is in the midst of adapting the OP and has held a national meeting to train trainers and carry out adaptation. The cascade method of training and the difficulties it entails in maintaining the quality of training were addressed.

8. Field visit

A field visit was organized for the participants to MPlus+ Clinic in Chiang Mai, Thailand that serves the gay, lesbian, and transgender communities. The clinic is funded by PATH and Family Health International (FHI).

MPlus+ has undertaken innovative approaches to identify MSMs in their 'hide-outs' like parks, clubs, public toilets, etc. They take condoms and safe-sex information to these places to make it more acceptable and less stigmatized. MPlus+ have identified various locations where MSM meet/gather such as karaoke bars, brothels, discotheques, massage parlours, cinemas and streets.

MPlus+ has established a drop-in centre and clinic where its target group can be tested and treated for STIs or referred for treatment. The clinic was well equipped and the focus was on provision of quality services to MSM. The gay, lesbian, and transgender communities are comfortable using the centre where health educators, with accurate information, and counseling services are available. Most employees in the clinic were MSM themselves. Participants interacted with MSM, volunteers and doctors and learnt more about the sexual behaviour and needs of MSM

9. Generating demand for health services: Myanmar

Dr Aung Tun, National Adolescent Health Programme Manager, Myanmar spoke about the implementation and linkages of SHAPE (school-based healthy living for adolescents' prevention and education) with other programmes. For sustainability, national and township ownership has been encouraged for developing the curriculum and implementing the training programme.

In Myanmar, 'Shape Plus' has been developed for "Out of school" youth. Shape Plus is carried out by the community. Expenses for transport and for services rendered by the providers are a constraint.

10. Providing services for HIV prevention: Using peers to link with health services/community

Dr Warunee Fongkaew, Associate Professor, Youth Family and Community Development (YFCD), Faculty of Nursing, Chiang Mai University, Thailand shared the lessons learnt on HIV/AIDS prevention among YP from previous studies on adolescents with sexual risk behaviour (1997-2005). The use of peer groups in adolescents is useful since peer pressure is a major factor for

adopting certain behaviors in YP. Peer groups can act as role models, to facilitate positive change in adolescent behaviour. School health programmes need to include adolescent health and development in HIV/AIDS prevention programme and encourage change in the school environment that facilitates continuous development. There is a need to change the paradigm of persons who work with adolescents encouraging them to be 'partners in thinking and taking action'. Early adolescence (9-10 years) is the best time for providing sex education since attitudes and values are being formed at this age. Advocacy, behaviour change communication (BCC) and education can be complementary in HIV prevention. A short video film was shown on the project.

11. Thailand: Experience in providing counseling, care and treatment for young people living with HIV/AIDS

Dr Nopparat Plitakul, Bureau of Health Promotion, Department of Health, Thailand, explained the utility of counseling to assist YP living with HIV/AIDS. Young People (YP) may lack maturity, be extra sensitive and may show poor decision-making because of lack of skills and experience. Most of them are unmarried and have no experience with family planning or condom use. Counseling can help them with learning to live with others, improve the quality of life, communicate their HIV status to others, deal with complications and adverse drug reactions, and provide them with basic elements of sexuality education.

12. Challenges of engaging young people: UNICEF presentation

Mr Greg Carl, Regional HIV/AIDS Project Officer, UNICEF, said that there is no single solution for the numerous challenges that HIV poses in YP. Multiple strategies are desirable and a focus on both in-school and out-of-school adolescents is required. The majority of adolescent's programmes in the Region concentrate on IEC alone and do not provide services and supplies. He gave examples of condom social marketing, Sunshine clinics are increasing focus on VCTC that provide synergy to the initiatives. The SHAPE- PLUS programme in Myanmar keeps the YP and peer educators at the centre. School-based care and support systems are dependent upon

teachers' involvement in training, home visit, assessment and preliminary screening. The teacher/counselor is also available for referred cases. There is a need to provide greater access to information through hotline/phone, and to provide a special focus and targeted interventions for population at most risk.

UNFPA presentation: Putting it all together

Dr Peter Chen, Adviser on ARH, UNFPA country support team, Bangkok, demonstrated that different people follow instructions differently. When YP are given instructions, some would follow them while others would follow what they think is right and what they usually see. The generic and specific approaches to control HIV/AIDS and the key components of successful ARH programming were discussed. The role of AFHS for providing information, counseling and commodities was highlighted and the comparative advantage of various UN agencies discussed. The lessons learnt are summarized in the box.

UNFPA: Lessons Learnt from HIV Programming for Young People

- Take diversity of youth into account
- A comprehensive approach works better
- Focus should be on health promotion and prevention
- Integrate HIV services with RH services
- Keep gender considerations in view
- Encourage youth participation
- Involve parents, teachers and community leaders
- Bring about inter-departmental convergence

13. "The Meaning of Adolescence" – Module from the orientation programme package

Dr Neena Raina, Dr Patanjali Dev Nayar and Dr Arvind Mathur facilitated the module on "The Meaning of Adolescence" for the participants. Positive and negative experiences during adolescence were recalled. Some of them were turning points in life. There are differences in experiences now as compared to the past. This is a result of exposure to media, information and money. In the session on "Sequence of changes of adolescence" the participants worked in groups to identify the physical, mental, emotional

and social changes, and their impact on the adolescents**.** The participants were able to connect the special characteristics of adolescence like smoking, and alcohol use. They were able to link "feeling of being invincible", being closer to peers than parents for some of the risk behaviours and adverse health implications. Sexual experimentation, when combined with innocence and ignorance, can lead to STI/HIV and expose them to the risk of unwanted pregnancy. The public health impact of behaviour can be adverse. This is illustrated in the table below.

Characteristics of adolescence and its implications on public health

Characteristics	Implications-public health
Peer pressure	Leads to unsafe sex, substance abuse, violence, injuries, criminality
Curiosity	STI/HIV, early sex, unwanted pregnancy.
Closer to peer than parents	Substance abuse
Overconfidence	Easily misled, risk taking
Innocence	Risky behaviour (drug, sex, violence)

Discussion points

Adolescents are quick and good learners and can change their behaviour if and when necessary. Although most adolescents go through this phase of life without major problems, it is difficult to recognize those that may have problems. There needs to be consistency about the messages for general population and those for the targeted, vulnerable group of YP. Even though YP have many concerns, the channels are limited to talk to adults. Gender differentials are also highlighted especially in Viet Nam where girls (85%) have talked to their families about first menses whereas boys (only 15%) have talked to their families about their first problems.

14. Why invest in adolescent health?

Adolescent mortality is much less than the "Under-five mortality". This could be a possible reason for the countries allocating larger resources for

child health and not AHD. The challenges and their adverse health impact in adolescents are different, they need to be addressed. The country-specific data could help in building a case. The participants were split into two groups and were asked to debate "for and against" investing in adolescent health (Annex 4). Two of the participants were asked to "judge" the debate. YP are a part of the community/society and have specific rights. However, there are concerns on duplication of funds and personnel for the same programme

15. Using the guide: The experience of Nicaragua

Dr Krishna Bose explained that WHO has developed an Monitoring & Evaluation guide to provide indicators and methods for measurement in planning and monitoring HIV prevention programmes for young people for

Step-by-step use of HIV/YP guide in Nicaragua

Step 1: The available data and indicators for HIV/YP were compiled

Step 2: This list was checked against the list of indicators in the HIV/YP guide

Step 3: Identified the relevance of the indicators from the HIV/YP guide *which were not* already being collected

Step 4: Compiled a list of national-level indicators for HIV/YP in Nicaragua

Step 5: Organized a meeting of stake-holders to develop consensus on a final list of national-level indicators for HIV/YP

Outputs:

- Consensus document with final list of national indicators for HIV/YP
- National monitoring and evaluation plan for HIV/YP in Nicaragua

programme managers at national and sub-national levels. The guide can be used to measure quality, coverage as well as costs. The guide provides indicators for quality of AFHS. It lists: programmatic indicators, determinant indicators (including protective and risk factors), behavioural indicators and impact indicators (i.e. health outcomes). It has been field-tested in Russia and Tanzania to provide indicators and methods for measuring the HIV/UNGASS goal on access (measuring coverage) from the perspective of the young people in the community. The WHO M&E guide is being used in Mongolia, Russia and Tanzania. It is being field-tested in Costa Rica and Thailand and is proposed to be field tested in South Africa. It is proposed to

add an estimation of costs during the field testing of the tool in Vietnam and India. Without knowing costs it is not feasible to expand services .The step-by-step approach taken in using HIV/YP guide in Nicaragua was explained.

Most people in countries are overwhelmed by data collection and in general, there is reluctance to adopt a new guide with more indicators. To start with the countries are encouraged to analyze the information that is already collected at the country level.

15.1 Country presentation: Thailand country profile

Ms. Yupa Poonkhum, Reproductive Health Division, Department of Health, Thailand, presented the country profile. Data collected from M&E: Reporting System, HIV Sentinel Sero surveillance, and Behaviour Surveillance survey (BSS) help to identify many cases that are underreported. The reported number of AIDS cases between 1994-2005 among YP was 10.23%. Sexual transmission is predominant (83%). The average age of sexual initiation is 16 years. The average age of first sex among sexually active 8th grade students, (2004) was 13.1 yrs. More than 20% of sexually active 8th grade students had exchanged sex for money in 2004. Nearly 51% of 8^{th} grade females reported coercive/involuntary sex. While 43% of males and 30% of females reported alcohol consumption, 40% of males and 15% of females reported alcohol consumption before last sex. Of the sexually active 8th grade students, 15% reported drug and substance use before last sex (2004). Only 16.1 % of males and 19.2% of females (8th grade) students could answer all questions about HIV/AIDS correctly. Among sexually active 2nd year male vocational school students in 2004, 54.3% used condoms with CSW, 31% with “other women”, and 10% with girlfriends.

The most common concern reported by YP is unwanted pregnancy (50.7%) followed by HIV (31.4%). Many reported feeling awkward about carrying a condom. They had low self-risk perception (67.4%). Among the military recruits, there is a downward trend related to 100% condom use programme.

15.2 Discussion points

Amongst YP, information collected and analyzed has been useful to change policy and to increase condom availability for youth and strengthen sexual education to make it compulsory in future. Prior to 2003, occasional research studies were reported covering YP, organized by Thai universities. These studies have increased since then. The importance of having different sources for the data was stressed.

15.3 Country presentation: "Prevention of HIV/AIDS among YP in Bangladesh"

Dr Lima Rahman, Deputy Programme Manager, Health Service & Life Skills Education, HIV/AIDS Project (GFATM) Save the Children, Dhaka, Bangladesh explained that a national M&E plan is being developed in Bangladesh. The M&E plan aims to serve as a management tool for the project to monitor the GFATM HIV/AIDS project activities. It will be used to monitor the project activities, evaluate progress made in achieving key operational indicators, and provide performance information to country cooperation mechanism (CCM), DGHS, National AIDS/STD Programme (NASP) and other UN bodies such as UNAIDS. Example list of Outcome/coverage indicators used:

Bangladesh: Performance monitoring tools

- Detailed workplan and M&E framework developed in consultation with SRs and partners.
- Quarterly progress reports measured against the work plan
- Submission of periodic financial statements.
- Internal review to evaluate progress against indicators and modify work plan if required
- An annual financial and management audit

- % of YP aged 15-24 who correctly identify one or two ways of preventing HIV transmission
- % of YP aged 15-24 who say they can access a condom if they need it.

15.4 Group work: Utilizing the M&E guide

Participants were divided in to two groups to discuss the presentations on the experience of M&E in Thailand and Bangladesh. Participants were requested to categorize the indicators provided in the country experiences and assess whether: the health impact, the behaviour outcomes, the determinants indicators and the intervention indicators have been measured (Annex 5). The HIV/YP M&E guide was used as reference material for group work.

15.5 Measuring quality and coverage of health services for adolescents: The services access goal

Dr Krishna Bose highlighted that what is being currently measured often relates to absolute numbers of utilization rates. The quality, coverage and cost also need to be measured. An example from Russia was presented where clinics were assessed for quality by client satisfaction. Client satisfaction criteria included confidentiality and privacy, clients' confidence, availability of information, affordability and accessibility.

Another example, from Mongolia, illustrated conducting of quality surveys. It measured facility observation, staff interview and client surveys. Questions included referral and follow-up advice provided or the convenience of services provided, as reported by both the clients and staff of the clinics. It showed many differences of opinion between YP and staff about services.

Coverage is a key indicator to be measured. This can be measured by mapping service provision in geographic areas. Accessibility coverage would mean how many YP report going to those services. Simplified tools have been used for measuring/scoring:

- Contact coverage
- Acceptability coverage
- Accessibility coverage
- Availability coverage

The examples of Tanzania and Russia where WHO has supported analysis of coverage and quality were presented. In these countries, WHO

and partners reviewed epidemiological and socio-demographic data. Mapping of service provision points and use of services in those areas and survey at facilities were also used for assessing quality. Further analysis will be carried out for vulnerable groups, specific service/disease (STI). Costs too need to be measured. Without knowing costs it is not feasible to expand services. The estimation of costs is fundamental for quality and coverage. Viet Nam is also expected to test the methodology developed by CAH/WHO.

15.6 Role play

Participants were asked to review national HIV/AIDS strategic plans using tools/indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people. Participants were divided into four groups. Each group was given the task of reviewing the national HIV/AIDS strategic plan of the country assigned. Groups were requested to review the national HIV/AIDS plan as a WHO consultant and make recommendations to the government about how to strengthen the plan in terms of the strategic information that is included in the plan relating to young people with particular reference to the health sector. Participants structured their review to include the following key issues:

- Data disaggregated by age and sex
- Specific attention to adolescents/YP
- YP groups most at risk
- Determinants to be influenced by the programme to achieve behaviour impact
- Inclusion of indicators recommended by GFATM,UNAIDS,WHO
- Method of data collection, analysis and feedback.

Participants were requested to present their findings to the Ministry of Health, and a meeting has been organized with the Secretary for Health, the Director of the HIV and the Reproductive Health Departments and staff of the government statistics office.

Groups structured their recommendations in terms of what could be done immediately, and what would take longer to implement.

Indonesia

The Indonesian group found some data on young people segregated by age and sex. Data on sexual behaviour activity was available from a 1999 study in two big cities, Jakarta and Surabaya. It showed that 22% of male senior high school students ever had sex. In Indonesia, very little information was available regarding the absolute number of IDUs, sex behaviour was permissive and condom use was low.

Giving new sterile syringes to IDUs is being tried in the form of pilot projects in Jakarta and Bali, through cooperation between the local health services, NGOs, the Ministry of Health and various donor agencies. Sex workers, IDUs and migrant workers have been identified as populations at risk needing special attention. However, there is no evidence to support the policy recommendations.

Due to religious sanctions, any efforts in education are being challenged by the community. A talk on sex to school children is still a taboo. Although it is packaged in reproductive health, displaying models and pictures of reproductive organs is considered as a bad influence on adolescents. Greater support for programming is required at the religious level, from school teachers and stakeholders. Based on determinants there is a need to develop and prioritize the key messages.

The component of monitoring and evaluation is not reflected clearly in the national plan. Another problem is that UN agencies present a different mandate from time to time. This needs to be resolved to simplify the M&E framework. The country is committed to UNGASS goals and the MDGs. Involvement of YP is necessary to achieve these goals.

Myanmar

Since HIV/YP is an urgent issue, planning and monitoring should be discussed and prioritized. UNICEF and UNFPA have collected data. In the HIV/STD programme, MSM are not included. There is a need for age and sex disaggregated data for young people. All targeted interventions do not focus on young people. While surveillance data for 1992 are available, there is no analysis. Though, MSM is a small group, it is significant in relation to the HIV epidemic. This should be included in the surveillance system. The following three activities are proposed.

(1) Determinants need to be specified

(2) Determinants need to be linked with interventions

(3) Youth-friendly health services need to be established, based on determinants and needs of YP and those at most risk.

Funds should be available for adolescents' health care services to support integrated programmes in townships and link them with sectoral supporting agencies. Models of health services should be designed to meet the needs of young people and specific high-risk groups like MSM. The key aspects should be incorporated in the five-year strategic plan.

Bangladesh

The national strategic plan 2004-2010 has a vision statement of an 'HIV/AIDS-free society' and a mission to reduce the spread of HIV and improve the quality of life of PLWA. Adolescents and young people have been identified as those at risk, together with CSWs and IDUs. Age and sex disaggregated data are lacking for strategic planning. Though young people are identified as a high contributing factor, a situational analysis covering young people, especially those most-at-risk, should be undertaken to bring about a greater focus on YP.

Sri Lanka

There is a need to develop a specific young people's approach and include key indicators on STI management, reporting and establishment of youth-friendly centres. It will take a lot of manpower effort and budget to carry out the task. In the programme, IDUs and CSWs are not explicitly covered.

15.7 Discussion

The role-play session was thought provoking; it acknowledged the process of development of a strategic plan although there is scope for improvement. All countries should work to improve country strategic planning. The segregation of data may be difficult in high-risk groups. Efforts are needed at regional, global and country level in term of advocacy. MAPM approach should be considered. The discussion highlighted the opportunity to determine how different sectors and population groups,

including YP can come together. All need to work together and avoid duplication. The existing adolescent health plans, adolescent strategic plans, reproductive health strategy and family planning plans should be used to build operational plans for YP.

16. Policy issues in HIV/YP perspective in SEAR

Dr Bruce Dick said that policies broadly cover an "expression of intent" that provide the basis for legislation, standards and strategies. They could be explicit or implicit and provide the space for things to be done i.e. either sanction or regulation. Examples of policy issues include:

- Access to condoms for unmarried adolescents
- Consent and confidentiality for testing and counselling for minors and
- Access to harm reduction among drug users.

The concept is also valuable for advocating adolescents' right to quality health services.

HIV/YP and policy challenges

- Policies are political, and are strongly influenced by the socio-cultural context
- The evidence base is only one of the factors that influences policies
- It may be most strategic to focus on a few specific policy issues of particular relevance to programming for HIV/YP
- Policies can be changed (even though they take long time to implement)
- There is often a gap between what is said and what is done!

A variety of evidence is available to base interventions for prevention of HIV amongst YP. The research to date could be categorized as (1) **'GO'**: these interventions could go on scale immediately while monitoring their coverage and quality e.g. skills-based education in schools. There is enough evidence that this actually has an impact on behaviour, (2), **'Ready':**

Interventions for which there is good evidence to be used in countries but should continue to be evaluated and, (3) **'Steady'**: Promoting interventions that require further evaluation before recommending them for wide use. This strategic approach could be used for developing a policy framework. It may be possible to do well despite "obstructive" policies. One of the best examples is of abortion, as in most countries some measure is being taken to provide some services relating to abortion.

17. Draft regional strategic framework on HIV and young people

The Adolescent Health and the HIV units of WHO/SEARO have jointly developed a draft "Regional Strategic Framework for control of HIV in Young People". The draft was distributed in advance to the participants.

Challenges for control of HIV in young people

The challenges include:

- Non – recognition of health and development needs of adolescents and YP
- Lack of sustained policy support for the control of HIV/AIDS in young people
- Lack of co-ordination between HIV programmes and ADH and amongst different stakeholders at the country level
- Lack of age and sex disaggregated data pertaining to behaviour and HIV/STI
- Prevailing negative socio-cultural norms, gender considerations and taboos, and barriers to accessing appropriate information, skills and services
- Lack of AFHS and sensitized health workers
- Lack of capacities on Adolescent Health and HIV/Young People.

Dr Patanjali Nayar, presented an overview of the draft regional framework. The strategic framework was prepared taking into consideration global meetings on the issue. The Goals and objectives, the guiding principles, priority strategies and interventions and the format adopted in the strategy were summarized. The HIV/YP strategy requires a synergistic effort by relevant programmes like reproductive health, MCH, health promotion, nutrition etc. for value addition.

Since advocacy continues to be one of the main requirements, the introductory remarks in the strategic framework highlighted the need for

raising awareness and creating high level, evidence-based advocacy. In this context, simplicity, do-ability and country adaptation were kept in view. While developing the regional strategy, a conscious effort has been made to develop synergy between various programmes, within the health sector, strengthen partnerships, with other sectors and achieve a balance between efforts targeted at prevention and those relating to care and support.

The core elements of the Regional strategy are i) Strategic information, ii) Strengthening of health services and supplies, iii) Supportive policy environment and iv) Sustaining partnerships. The regional strategic framework describes details on the above core elements. It clearly identifies core work within the health sector and coordination with other sectors for a public health impact on HIV/YP. The following are the guiding principles for the draft regional strategy:

- HIV control in YP is an integral part of the national AIDS control programme.
  - Target young people within the existing national programmes for reproductive health, safe motherhood, control of STIs, adolescent-friendly health services and skill-based health education.
  - Strike a balance between WHO's "3 by 5" initiative and HIV control in young people.
- Address the issue of where the virus is and where it is going.
  - Reduce vulnerability amongst young people and involve young people in planning, and programming of the operational plan.
  - Promote positive behaviour and behaviour change wherever required as an integral part of the strategy.
  - Address the rights and equity issues relating to young people.
  - Involve all stakeholders in the health sector and outside, according to their comparative advantage.
  - Include the focus groups most at risk.

A challenge for HIV/YP is to increase the utilization of health services by YP. This is proposed through YFHS, integration with other existing national programmes, establishing outreach services and introducing social marketing, social franchising and voucher schemes. The participants were

requested to critique the framework and provide valuable inputs for strengthening the framework so that it could be finalized.

Dr Neena Raina underlined the importance of critically scanning the regional strategy because it is proposed to place the revised strategy to the AHD and HIV/AIDS technical advisory group for their advice and guidance. She said that the idea is to help develop operational and implementation plans for HIV/YP at the country level.

Role of WHO

WHO will provide technical assistance and enhance the capacity in the following key areas relating to health sector response:

Strategic information – strengthen the capacity in countries to collect, analyze and disseminate the data necessary for programmes, policies and advocacy focusing on HIV and related domains (sexual and reproductive health, alcohol/drugs, violence) through biological, behavioural and programme indicators.

Services and supplies – increase young people's access to information and counselling or HIV/AIDS, reducing risk through condom-use and harm reduction in IDUs , and providing early diagnosis (through testing) and treatment, support and care for HIV/AIDS through trained service providers working in a variety of settings in a strengthened health system with the involvement of the young people and the engagement of the community, including a focus on all young people, particularly groups at most risk in different settings.

Supportive policy environment – ensure that the health sector is able to provide the evidence base and examples of good practice in relation to issues which promote or obstruct the development and implementation of effective policies and programmes for the prevention and care of HIV/AIDS among young people in a sustained manner.

Strengthening actions in other sectors – mobilize and support other sectors to contribute to HIV prevention and care.

18. Feedback on the draft regional strategic framework

The participants were divided into groups and requested to provide inputs regarding format, content, data, layout, etc. of the strategy. The majority of the participants appreciated the diagrammatic and visual presentation of the important points and the general layout. It was suggested that the countries be asked to present recent disaggregated data particularly in relation to gender, vulnerable high risk groups, and ongoing initiatives. It was suggested that, keeping in view the importance of the strategic framework, endorsement by all UN agencies be sought. The regional flavour, especially the best practices for YP and HIV/AIDS need to be highlighted in the document. More focus is needed on high risk groups and a section on difficult policies and programme issues should be added. Contributions required by other sectors to complement the efforts of the health sector (the fourth "S" of the strategy) should be brought upfront.

It was suggested that WHO be positioned as the technical agency in the Region for HIV/AIDS and YP. The timeframe for launching the document was discussed .The launch should be high profile and linked to a theme event. Dr Neena Raina acknowledged the support of Ms Laksmi Suebsaeng and informed the group that fact sheets are being developed for HIV/AIDS and YP for 3-4 countries to provide the disaggregated data and evidence base needed for operational planning.

19. Feedback on the consultation

The participants were divided into country groups and asked to respond, utilizing VIPP cards, to the following queries.

- What were the 2-3 most useful things that you learnt during the consultation?
- What 2-3 activities will you work on during the next six months as a follow up to the consultation?
- What are the 2-3 areas for which you require technical assistance or capacity development?

The consolidated response from the countries is summarized in Annex 6.

WHO/HQ shared their experiences and appreciated the countries' focus on doable actions. It provided an opportunity for representatives from different agencies and country staff to work together on HIV/YP. The MAPM framework and the four strategic principles provide a simple way of articulating issues to the policy makers.

20. Follow-up actions by WHO

(1) The draft 'Regional strategic framework on control of HIV among Young People' will be finalized after incorporating feedback from the meeting. Action: WHO-Regional Office.

(2) The regional strategic framework will be finalized after consultation with experts from RTAG-AHD and RTAG-HIV/AIDS and UN co-sponsors. Action: WHO-Regional Office.

(3) Technical assistance needs be provided during national workshops on HIV among young people to develop operational plans in focused countries. Action: AHD/AIDS/Country Offices

(4) WHO should provide technical support to Member countries (based on their request) in the adaptation of the orientation package for health care providers for provision of YFHS. Action: AHD/AIDS/Country offices

Annex 1

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Annex 2

Agenda

Day 1, 11 October 2005

Day 1 am	Chair: Mr Chaitaya Prasad Rapporteur: Dr Arvind Mathur	**Day 1 am**
0830 – 0915 hrs	Opening ceremony	
0930 – 1015 hrs	Introductions of Participants	Dr Neena Riana
1015 – 1030 hrs	Overview of the Meeting	Dr Neena Riana
1030 – 1115 hrs	Participant Expectations	Dr Bruce Dick
1115 – 1130 hrs	Why focus on Young People: The goals, the evidence base and the Opportunities	Dr Bruce Dick
1130 – 1150 hrs	HIV/AIDS situation in South-East Asia Region	Mrs Laksami Suebsaeng
1150 – 1210 hrs	Regional overview of HIV/AIDS and young people	Dr Neena Riana
1210 – 1220 hrs	Country Presentation: Sri Lanka	
1220 – 1230 hrs	Country Presentation: Myanmar	Dr Myint Aung
1230 – 1240 hrs	Country Presentation: Indonesia	
1240 – 1300 hrs	Buzz group discussion: What we know ? What we don't know?	Dr Bruce Dick
1300 – 1400 hrs	Lunch	
Day 1 pm	Chair: Dr Fonny Silfanus Co-chair: Dr Aung Tun Rapporteur: Mahbub Islam	**Day 1 pm**
1400 – 1430 hrs	Introduction to MAPM	Dr Krishna Bose
1430 – 1600 hrs	Group work: HIV and young people: similarities and differences	Dr Krishna Bose

1600 – 1645 hrs	Plenary feedback, discussion, refinement	Dr Krishna Bose
1645 – 1700 hrs	Re-clustering the cards: The same	
1700	Discussion, synthesis and implications for action	Dr Krishna Bose

Day 2, 12 October 2005

Day 2 am	Chair: Dr Sujatha Samarakoon Co-chair: Dr Gampo Dorji Rapporteur: Dr Po-Lin Chan	**Day 2 am**
0830 – 0845 hrs	Flash, Admin, etc	Dr P.N. Nayar
0900 – 0920 hrs	Setting the scene: the evidence base, the health system, health service providers, and the community component	Dr Bruce Dick
0920 – 1000 hrs	Barriers to young people accessing services for HIV (Condom, Clean needles, etc)	Group Work Dr P.D. Nayar/ Dr Arvind Mathur
1000 – 1020 hrs	Standards: country presentation India	Dr Arvind Mathur Mr Chaitanya Prasad
1020 – 1040 hrs	Standards: country presentation Bangladesh	Bangladesh
1040 – 1110 hrs	Tea/Coffee	
1110 – 1200 hrs	Panel Discussion on the Orientation Programme Introduction to the Orientation Programme The Bangladesh experience The India experience The Viet Nam experience	Dr Neena Raina
1200 – 1220 hrs	Country presentation: Generating demand: Myanmar	Dr Aung Tun
1220 – 1240 hrs	Making the linkages with the community : peer educators: Thailand	Dr Warunee Fongkaew
1240 – 1300 hrs	Challenges of engaging young people and communities	UNICEF
1300 – 1400 hrs	Lunch	

Day 2 pm	Chair: Dr Jafar Hakim Co-chair: Nuntawaun Yuntatilok Rapporteur: Dr Sumit Kapoor	**Day 2 pm**
1400 – 1600 hrs	Orientation Programme module on "The Meaning of Adolescence"	Dr N. Raina Dr P.D. Nayar
1600 – 1620 hrs	Tea/Coffee	
1620 – 1650 hrs	Putting it all together: the UNFPA perspective	UNFPA
1650	Discussion and synthesis	Dr Bruce Dick

Day 3, 13 October 2005

	Strategic information: Available tool	
0830 – 0845 hrs	Administrative matters and flash	
0845 – 0915 hrs	Introduction to the guide to indicators for monitoring and evaluating national HIV/AIDS prevention programme for young people	Dr Krishna Bose
0915 – 0930 hrs	Using the guide: The experience of Nicaragua	Dr Krishna Bose
0930 – 0945 hrs	Country presentation focusing on M & E for HIV/YP	Thailand
0945 – 1000 hrs	Country presentation focusing on M & E for HIV/YP	Bangladesh
1000 – 1015 hrs	Tea/Coffee	
1015 – 1045 hrs	Discussion	All/Plenary
1045 – 1100 hrs	Experience in providing counselling, care and treatment for young people living with HIV/AIDS	Dr Nopporn Patanapornpundh
1100 – 1130 hrs	Measuring quality and coverage: The services access goal	Dr Krishna Bose
1130 – 1215 hrs	Measuring costs	Dr Krishna Bose
1215 – 1300 hrs	Discussion	All/plenary
1300 – 1400 hrs	Lunch	
	Strengthening strategic information	
1400 – 1530 hrs	Review of national HIV/AIDS strategic plans using tools/ discussed during the morning presentations	Group Work

1530 – 1545 hrs	Tea/Coffee	
1545 – 1645 hrs	Feedback from groups	
1645 – 1700 hrs	Discussion and synthesis	

Day 4, 14 October 2005

Day 4 am	Chair: Dr Deepthi Perera Co-Chair: Dr Rameez Co-Chair: Dr Arvind Mathur	**Day 4 am**
	Strategic information: Available tool	
0815 – 0845 hrs	Supportive evidence-based policies: introduction	Dr Bruce Dick
0845 – 0900 hrs	The Regional Strategy Framework: What and why?	Dr Neena Raina/ Dr P.D. Nayar
0900 – 1000 hrs	Review of the Regional Strategy ➢ Structure ➢ Content ➢ Use	Group Work
1000 – 1030 hrs	Plenary feedback and synthesis	Plenary
1030 – 1100 hrs	Tea/Coffee	Bangladesh
1100 – 1230 hrs	Next steps ➢ How will the consultation influence action in countries? ➢ Priorities for technical support and capacity development	Country Teams
1230 – 1330 hrs	Lunch	
1330 – 1430 hrs	Feedback from country teams and peer review	Plenary
1430 – 1500 hrs	Conclusions and follow-up	Dr Neena Raina/ Ms Laksami Suebsaeng

Annex 3

Synopsis of the group work on MAPM

Group 1 and 2: Reduction of HIV and STD

Intervention	Determinants	Behaviour outcomes	Health outcomes
Advocacy	Measurable indicators in terms of Knowledge, Aptitude and Perception (KAP)	Increase use of AFHS	Reduction of STI in YP
Awareness raising activities in vulnerable groups (out of school/ gender discrimination)	Increase access to youth friendly health service	Be faithful	Reduction of HIV
Social marketing of condoms	Policy & legal support for condom promotion	Increase condom use	
Establish drop-in centre	Attitude of key adults	Increase in use of services	

(Group 3 and 4)-: Reduction in MMR Abortion, early and unwanted pregnancy

Intervention	Determinants	Behaviour outcomes	Health outcomes
Quality training programme for health service providers	Increase technical skills of health workers	Increased use of obstetric care	Reduction of MMR
Regular contraceptive supply	Availability of contraceptives (condom)	Delay sexual initiation	Decrease early and unwanted pregnancy
Life skill education	Skilled and friendly providers	Use of contraceptives	Decrease unsafe abortion
Provision of AFHS	Cultural & religious norms & values of community	Delay sexual initiation	
Policy/advocacy for legal abortion	Increased knowledge of contraceptives	Going to formal & qualified service providers	
Supportive national policy for condom & abortion	Protective factors	Increased use of emergency contraceptives	
Safe blood transfusion facility at all service facilities	Maternal literacy		

Annex 4

Group work: Why invest in adolescent health

Against	For
Adolescents are healthy in general – there are other groups more in need, for example, children.	Future maternal mortality, communicable and noncommunicable diseases, for example, tobacco-related diseases, 50% of HIV infection will be in adolescents – investment for the future
Adolescent mortality rate is less than IMR, MMR	Globally there is commitment to MDGs unless we invest in adolescents, Goals will not be met.
Health Service Delivery Points (HSDPs) are not in place for this new programme- no outcome, no ground reality for MDGs of the lofty goals (not one UN resolution has succeeded). Adolescents are a new initiative, it needs a gestation period, and resources need to be invested in critical and immediate areas.	Not to develop new services. Building and improving the services and building the capacity of current providers in adolescents.
Other sectors (education) should invest in adolescent health – reallocation of resources. – everyone is investing in the same issue with duplication of efforts There are several other stakeholders – same public health system has to do the job but the system is crippled and over burdened, unless we create a parallel system for adolescent, health. Lofty goals for MDGs – only on paper.	Optimal returns for the money invested-economic development in adolescent health. Biggest returns for the future investment.
Neo-imperialist desire – new international boutique shops by public health. Every 3 years a concept surfaces that is fashionable. Investment into the same persons, same organizations, same programmes, duplication.	Confusing terminology for age. In SEAR, 1/3 of population is 18 to 25 years.
Since the inception of the UN and the Convention of Human Rights we have not been able to translate this to the ground reality. Stand-alone boutiques/models which will take years to establish a launch.	Fundamental right of the child and adolescents: right to the 'boutiques'
	Adolescents are future adults and parents and will impact the future generation.

Annex 5

Group work: utilizing the M&E guide

Interventions		Determinants		Behaviour outcome		Health outcome	
Thailand	**Bangladesh**	**Thailand**	**Bangladesh**	**Thailand**	**Bangladesh**	**Thailand**	**Bangladesh**
Thailand has indicators that measure coverage (local and national) Of services such as VCT coverage.	Bangladesh is measuring coverage for the GFATM programme.	Examples were presented: Knowledge of HIV prevention. Many are not included in the presentation but are measured	Examples: Percentage of secondary school teachers who approve of HIV/AIDS education. Percentage of parents who will allow children to attend sex/ HIV education Percentage of gatekeepers who support condom use Percentage of self-risk perception of HIV risk	Thailand provided examples of behaviour outcome indicators: Safe sex among YP	Several examples of behaviour outcomes were included in the presentation: Percentage of YP using condoms	HIV prevalence in sentinel groups is measured in Thailand and it can be analyzed by age dis-aggregation.	It wasn't in the presentation but it's being measured by the programme

Annex 6

Consolidated response from SEAR countries on monitoring & evaluation framework on HIV/YP

Countries	Learning	Activities	WHO technical assistance
Bhutan	How to use M&E operational protocol for HIV/AIDS	Initiate a concept of adolescent health programme with strategic framework	Overall framework using MAPM
	Youth issues and Three Ss of HIV/YP strategy		Orientation Programme package for youth and training of trainers (TOT).
Bangladesh	MAPM for M&E	Development of National M&E Plan	Continuation of YFHS support
	Importance of age and sex disaggregated data	Operationalizing national strategic plan.	Development of National M&E plan
	Documentation of best practices for HIV/YP strategy	Formation of Coordination body for linking HIV and adolescent programme	Developing a roadmap for HIV/YP strategy.
India	MAPM for M&E		Technical assistance for incorporating Mapping adolescent programming and measurement (MAPM).
	Strategic directions in the Regional Strategic Framework on HIV and Young People	Coordination with HIV programme to develop a roadmap for HIV/YP	Technical assistance for developing the road map for HIV/YP
	Disaggregated data		Capacity building on Quality Assurance approach
Indonesia	MAPM	Arrange meeting to socialize the result of the consultation	Workshop on strategic framework for control of HIV in YP
	Why focus on YP for control of HIV	Disaggregate the existing data of STI, HIV/AIDS and YP	Integrated operational plan on HIV/YP
	Setting the scene		
Maldives	Monitoring protocols	Joint framework with other sectors for establishing YFHS in the capital city	Develop strategic plan for child and adolescent health
	Importance of designing right intervention for right audience in the HIV/YP context	Sensitize other sectors on the issue of HIV/AIDS and YP	Training of Trainers (TOT) for YFHS
		Develop adolescent health strategic framework	
		Review the national workplan in the light of the regional framework	

Countries	Learning	Activities	WHO technical assistance
Myanmar	Programming like MAPM and OP	Report workshop recommendations to Ministry of Health (MOH).	Orientation Package (OP)
	Regional strategy for HIV/AIDS and YP (Country AHD and AIDS programmes can be adapted)	Review and revise five year plan of HIV and adolescent health	National Aids Programme (NAP) strategy plan
			TOT for OP and for HIV/YP
Nepal	MAPM	Work plan of other programmes and consensus drawn on common activities	Comprehensive strategic framework design using MAPM concept
	Why focus on YP for control of HIV/AIDS	Strengthen the regular reporting system	Capacity development for TOT regarding ART
Sri Lanka	Reinforce the need of working in partnership for HIV/YP	Advocacy to policy and programme for optimizing the benefits for collaborative programmes	Capacity development in M& E of YP and HIV/AIDS
	MAPM to develop the collaborative programme	Effective mobilization of resources for expanding the YFHS to include RTI/STI services	
		Joint programme for HIV/AIDS in YP	
Thailand	Review of strategic plans especially looking through the other countries	Stakeholders meeting inside the ministry and inform them about indicators, monitoring etc. and discussion of MAPM could take place	Development of M& E plan
	MAPM: Logical tool and existing intervention could be re-designed and new interventions could be planned and monitoring could be planned	Existing data on HIV/YP shall be reviewed	Linking with national reporting system
	MAPM and 3 S's of the Regional HIV/YP strategy	Organise an inter-sectoral meeting on HIV/AIDS and RH (Several organizations are working and need to be brought together)	M&E and MAPM AFHS standard development
	Use of tools for developing M&E framework	Introduce MAPM and 3 S's either separately or integrating with workshop	Master Trainer training Capacity development: TOT (Many specialists may be involved)
	Participatory approaches and methods	Continue to develop the OP, specially focusing on IDU	Bi- regional workshop in Vietnam

Annex 7

List of working papers/documents used for this meeting

(1) HIV/YP Monitoring and Evaluation Guide

(2) Measuring Adolescent Programming and Measurement – Draft

(3) Orientation Programme for Programme Managers

(4) AFHS – Agenda for Change

(5) Draft Regional Strategic framework on HIV/AIDS among young people

World Health Organization

Regional Office for South-East Asia