

Young People and HIV/AIDS



by Fountainhead Solutions (Pvt) Ltd



**Responding to
Unmet Needs
through
Innovative
Approaches**



**World Health
Organization**

Regional Office for South-East Asia
New Delhi

For further information please contact:

Adolescent Health and Development (AHD) Unit
Department of Family and Community Health

World Health Organization

Regional Office South-East Asia
World Health House, Mahatma Gandhi Marg,
New Delhi 110 002
Email: ahd@searo.who.int
www.searo.who.int
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I. Introduction

I. Introduction

Globally an estimated 39.5 million people were living with HIV/AIDS at the end of 2006. Estimated 4.3 million were newly infected adults. South-East Asia, has the second largest number of HIV infected persons in the world after sub-Saharan Africa⁽¹⁾. The new 2006 estimates released by the National AIDS Control Organization (NACO), indicate that national adult HIV Prevalence In India is approximately 0.36%, which corresponds to an estimated 2 million to 3.1 million people living with HIV in the country. This is likely to impact South-East Asia regional figure. Although the overall HIV prevalence is low, the large population of the Region makes the magnitude of the HIV epidemic huge. HIV epidemic is largely concentrated among populations with high-risk behaviours namely sex workers and their clients, men who have sex with men and injecting drug users. The majority of HIV burden in the region is concentrated in five countries namely India, Thailand, Myanmar, Nepal and Indonesia.

1. HIV/AIDS and young people

Young people account for a large proportion of the population (24% to 35%) in SEA Region and the potential health risks they face is astounding.

Globally estimated 40% of all new HIV infections occurred among young people (15-24 years). In South East Asia the HIV prevalence among the youth ranges from 0.01% to 1.32 % (Figure 1). In countries like India, Nepal, Sri Lanka and Thailand more females than males have been infected with HIV which signifies adverse implications for maternal and child health also.

HIV prevalence is highest among most at risk groups – injecting drug users (IDUs), commercial sex

workers (CSWs) and men who have sex with men (MSM). Large numbers of IDUs, CSWs and MSM are young people. HIV is now spreading through bridge population to general population.

Young people are at the centre of the HIV/AIDS epidemic in terms of transmission, impact and potential for changing the attitude and behaviours that underlie this disease. The importance of focussing on young people has been recognized globally. In recognition of young peoples vulnerability to HIV/AIDS the United Nations General Assembly Special Session on HIV/AIDS outlined a number of goals and targets focussing on young people aged 15-24. These include a pledge to reduce HIV prevalence among young people globally, by 2010. While selected countries have reached key targets and milestones for 2005, many countries have failed to fulfil the pledges specified in the declaration.

2. Risk behaviour among young people

Early sexual debut

Mean age of initiation of sexual activity reported among adolescents is as early as 14-15 years in some countries (Figure 2). In the past few years, surveys examining the risk behaviour of young people have found variable rates of reported sexual activity. Data from the National Behavioral Surveillance of Thailand among secondary school students (2004) indicates that the average age of first sex among sexually active 8th grade students was 13 years for both boys and girls. In Sri Lanka the age of sexual debut was 15.3 years for males and 14.4 years for females.

A survey among young factory workers in Kathmandu revealed that sexual activity among

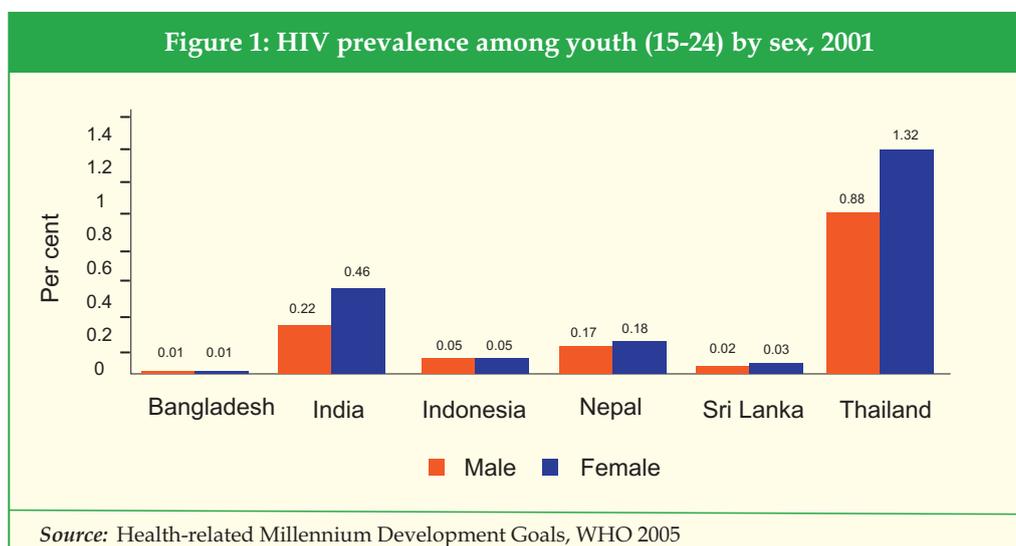
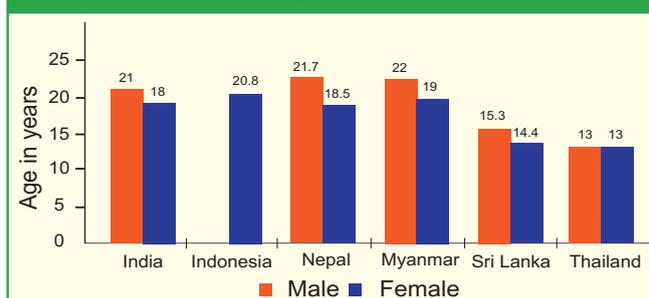


Figure 2: Age at sexual debut



Source: India: BSS general population 2003; Indonesia: DHS 1991; Nepal: DHS 2001; Myanmar: Presentation by Dr. Myint Aung, Divisional AIDS/STD officer, Magway Division, Myanmar; Sri Lanka: National Survey on emerging issues among adolescents in Sri Lanka: UNICEF 2004; Thailand: Bureau of Epidemiology, Communicable Disease Control Dept, Ministry of Public Health, average age of first sex among sexually active 8th grade students, 2004, Report on the HIV/AIDS Situation in Thailand, 2004.

unmarried girls and boys and with non regular partner was common. 20% of unmarried boys and 12% of unmarried girls aged 14-19 years were sexually active. The mean age of sexual debut was 15 years and was same for both boys and girls⁽²⁾.

Knowledge and behaviour aspects

Though majority of young people in South-East Asia region have heard of HIV/AIDS a vast majority do not know how to prevent transmission (Figure 3). Further more, misconceptions about transmission and prevention are widespread. Lack of education and information is one of the main causes of reproductive health problems such as HIV/AIDS and STIs and unwanted pregnancies. In India the BSS (2001) revealed that 84.9% of youth had heard of HIV/AIDS, only about

half of them were aware of two important modes of prevention. In Myanmar more than 90% of youth have heard of HIV/AIDS however only 18% young women and 25% young men knew ABC (A-abstinence, B- being safer by being faithful to one partner, C-correct and consistent use of condom for sexually active young people) of HIV prevention⁽³⁾.

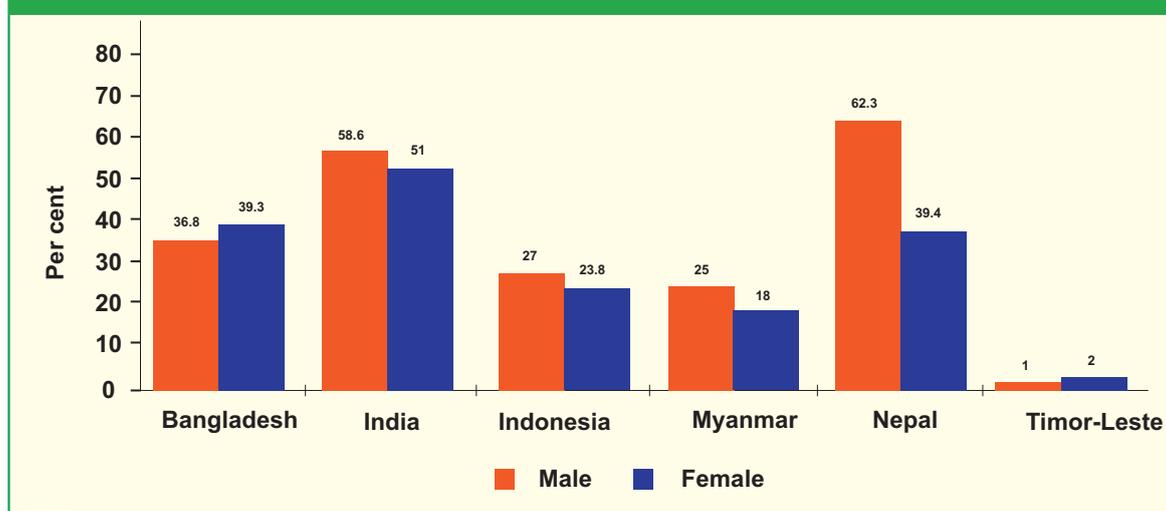
When young people become sexually active, they must have the skills to practice safe sex. Data from surveys show that the proportion of young people using condoms is still quite low even when they have sex with a high risk partner (Figure 4)

The sexual behavioral pattern among young people in Thailand suggests that sexual activity is increasing among adolescents while condom use has remained low. The trend from 1996 to 2004 in Thailand shows that over a period of time condom use by young males have gone down even with high risk partners like female sex workers. While condom use by sexually active male secondary students with female sex workers was 73.9% in 1996, it had come down to 43.1% by 2004. Condom use was less than 40% for all other partner types as well⁽⁴⁾.

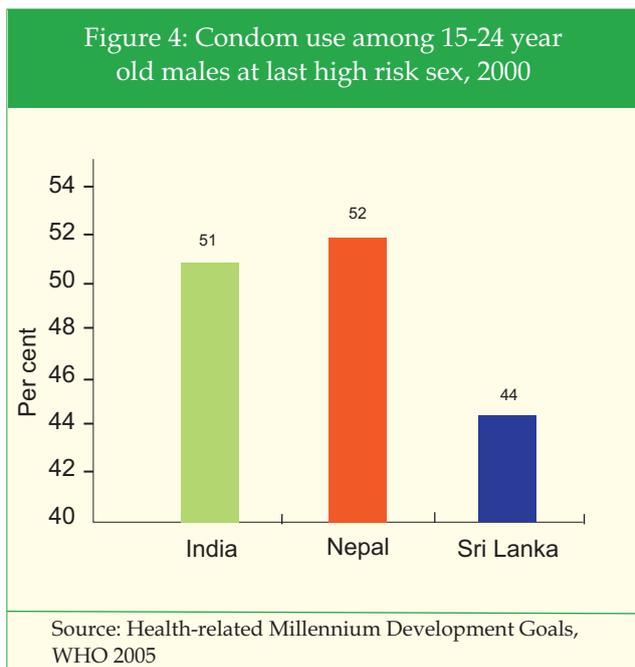
Data from the Nepal Demographic Survey (2001) shows that though a large majority of young people know where to get condoms, there is a major difference between their knowledge and condom use (Figure 5).

It is essential that education for HIV prevention is well tested and evaluated, age- appropriate and relevant to the situation and culture of young people and their families.

Figure 3: Knowledge of youth on two or more methods of prevention of HIV/AIDS



Source: Bangladesh: DHS 2004 (20-40 years); India: Behavioural Surveillance Survey 2001 (for 15-24 years); Indonesia: DHS 2003 (for 20-24 years); Myanmar: Behavioural Surveillance 2003 (20-24 years); Nepal: DHS 2001 (for 20-24 years); Timor-Leste: DHS 2003 (for 20-24 years)



The mass media is becoming increasingly important and excellent channel to reach them with preventive messages. The greatest benefits are gained when young people have access to health services, condoms and social support to follow through on the preventive messages.

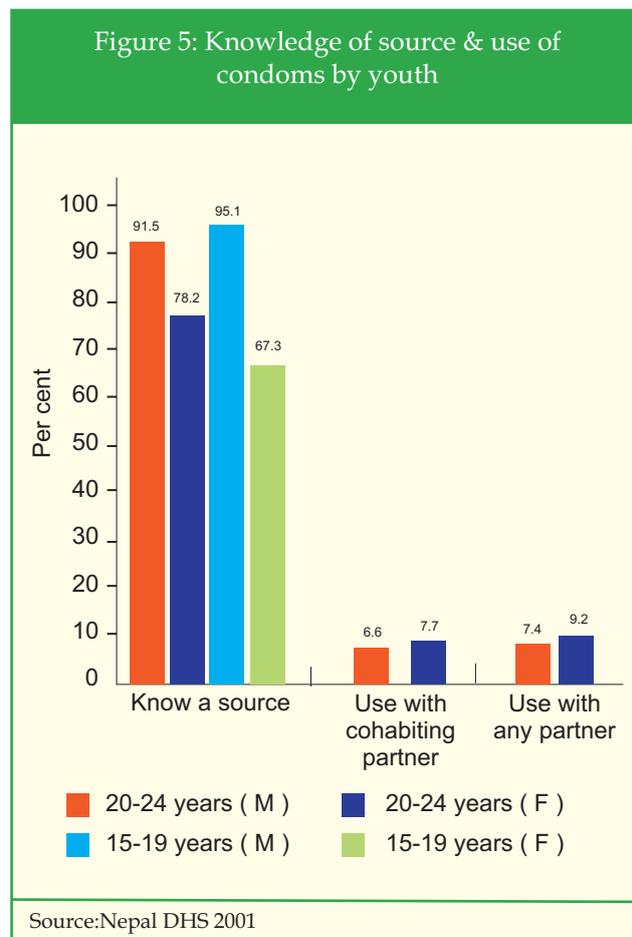
Young girls are more vulnerable

When the primary mode of HIV transmission is heterosexual, young women are the worst affected. For reasons of biology, gender and socio-cultural norms females are more susceptible than males to HIV infection.

Not only do many females marry while still in their teens, they often marry men who are considerably older increasing the likelihood that their partners are already infected. Given the spousal age differences, it is reasonable to assume that many teenage brides have limited capacity to negotiate with their husbands about sex, contraception, and childbearing, as well as other aspects of domestic life.

More monogamous married women are getting infected with HIV. In Pune, India, a study in a STI clinic found that 25 % of the 4000 women attending the clinic were infected with STI and 14% were HIV positive. Among 93% who were married, 91% had only one partner as their husbands⁽⁶⁾.

Soci-economic norms that reinforce gender inequalities are also an important factor that leave girls among young women more vulnerable to HIV. Most women are reported to have experienced coerced and unprotected sex from an early age. Some adolescent



girls are attached to men who support them in exchange for sex. They have little power to negotiate the use of condoms. The myth that sex with a virgin can cure AIDS or STIs further endangers young girls who fall prey to forced or coerced sexual relations, which can result in significant HIV transmission.

Trafficking, migration, sex between young females and older men, coerced sexual relations including rape, lack of economic opportunities, low education level, and cultural attitudes all contribute to the spread of HIV/AIDS among girls.

Injecting drug use: Emerging threat

Needle sharing among IDUs, a high-risk activity coupled with lack of access to HIV information and prevention services, has fuelled the spread of HIV and AIDS in a number of Asian societies. Drug use often starts during adolescence. Over 50 % of injecting drug users in India, Thailand and Myanmar are aged 15-24⁽⁶⁾. More than 40% reported AIDS cases among IDUs in Indonesia were in the 15-24 years age group. In Nepal, where half of the country's 50,000 injecting drug users are 16 to 25 years old, the incidence of HIV among people who inject drugs increased from 2 % in 1995 to nearly 50% in 1998⁽⁷⁾.

Drug dependency increases the likelihood that young people will turn to crime or prostitution to finance their drug habit. When one mixes IDU with prostitution, there is a good chance that the virus will begin to spread to the wider community.

Young Sex Workers

Sex workers constitute one of the core risk groups for HIV infection and transmission because they engage frequently in sexual acts with multiple partners. Data from across the Region suggest that, in most countries, a high proportion of sex workers are young women. In Thailand it is estimated that between 27 000 and 35 000 sex workers are younger than 18 years of age⁽⁸⁾. A study in Pokhara and Jhapa district (Nepal) on female sex workers revealed that 59% and 31% of the sex workers were adolescents aged between 10-19 years respectively⁽⁹⁾.

Young sex workers are also at a high risk of acquiring HIV. In Myanmar almost 36% of female sex workers aged 20-24 years were HIV positive in 2004⁽¹⁰⁾. Driven by poverty and the desire for a better life, many women and girls find themselves using sex as a commodity in exchange for goods, services, money, accommodation, or other basic necessities. Lack of knowledge of condoms and sexual and reproductive health increases the risk among young people.

In Thailand 100% condom program, which enforced mandatory condom use in brothels, played a significant role in reducing Thailand's HIV prevalence. Young men reduced their visits to sex workers by almost half between 1991 and 1995. Their condom use increased from 60% to nearly 95%. The net result was a drop in the percentage of young men infected with HIV from 8% in 1992 to less than 3% by 1997. There was also evidence of a fall in HIV prevalence among 21-year-old conscripts from 3.5% in 1991 to 1% in 1992.

Thailand's success is attributed to an early and sustained multisectoral response with national leadership and political commitment, as well as the availability of good epidemiological and behavioural data for planning and public awareness.

Young men having sex with men

Men having sex with men suffer from social stigma and discrimination and have inadequate knowledge of HIV/AIDS and indulge in unsafe sexual practices. This can result in increased risk taking among MSM. A need assessment study for prevention of HIV/AIDS/STIs among MSM in the age group of 21-30 years

in Dhaka revealed that the mean age of first sex with other male was mostly between 10-12 years⁽¹¹⁾. Studies also indicate increased HIV infection among MSM. An Integrated Bio-Behavioral Survey (IBBS) in Kathmandu Valley, with a large majority of sample representing young MSM (59% MSW and 61% MSM were aged between 16-24 years) showed an HIV prevalence of 4.8% in MSW and 3.6% in MSM. These studies also revealed high risk behaviors by young MSMs. Consistent condom use was low and multiple partnerships were common. A high proportion of MSM reported selling and buying sex. A substantial proportion of these men also reported having sex with females.

3. Young people, HIV/AIDS and the global goals

In recognition of young people's vulnerability to HIV/AIDS, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS on HIV/AIDS) outlined a number of goals and targets focusing on young people aged 15-24. These are based on the core elements of the joint WHO/UNFPA/ UNICEF document 'Action for adolescent health: towards a common agenda'. The goals of UNGASS on HIV/AIDS build on and are reflected in the commitments made at a range of other global fora, including the International Conference on Population and Development's programme of action (known as ICPD+5) and the United Nations Special Session on Children. The goals and targets endorsed during the UNGASS on HIV/AIDS not only focus on decreasing HIV prevalence among young people but also focus on promoting the core elements of the programme framework that is, providing access to information, skills and services as well as decreasing vulnerability. These targets help contribute towards achieving universal access to prevention, treatment and care and Millennium Development Goals that aims to halt and begin to reverse the spread of HIV/AIDS.

Following are the highlights of important goals for young people's health and development, with a focus on HIV/AIDS:

- *The UN General Assembly Special Session on Children*
Develop and implement national health policies and programmes for adolescents, including goals and indicators, to promote their physical and mental health.
- *The Millennium Development Goal on HIV/AIDS*
- By 2015 halt and begin to reverse the spread of

HIV/AIDS (using the prevalence of HIV among pregnant 15–24 year olds as an indicator)

- *The UN General Assembly Special Session on HIV/AIDS*

- By 2005, ensure that at least 90% (and by 2010 that 95%) of young people have access to the **information** they need to reduce their vulnerability to HIV.

- By 2005, ensure that at least 90% (and by 2010 that 95%) of young people have access to the **skills** they need to reduce their vulnerability to HIV.

- By 2005, ensure that at least 90% (and by 2010 that 95%) of young people have access to the **services** they need to reduce their vulnerability to HIV.

- By 2003, develop and/or strengthen strategies, policies and programmes which reduce the **vulnerability** of children and young people.

- By 2005 HIV **prevalence** among young people (15–24 years) reduced by 25% in the most affected countries, and by 2010 reduce prevalence by 25% globally⁽¹²⁾.





II. Innovative Approaches

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1. Youth Action against AIDS: From University Campus to Community

Background and Rationale

The National Service Scheme (NSS) in India launched a campaign on AIDS awareness popularly known as 'Universities Talk AIDS' (UTA) in 1991 in collaboration with the Ministry of Health & Family Welfare in all 174 universities in the country. The programme focuses on young people who are most vulnerable to HIV/AIDS, improving awareness on HIV/AIDS, to help young people resist peer pressure and develop a safe and responsible lifestyle. The programme continues to be the Indian government's largest effort in sensitizing the youth on causes, consequences and prevention of HIV/AIDS.

Objective

1. To discover the extent of students' knowledge about HIV/AIDS.
2. To develop a series of targeted messages in the higher education system.
3. To sensitize and mobilize peer group and community discussion on HIV/AIDS prevention.

Implementation

The programme is run by the Indian government as a strategy to prevent HIV/AIDS by informing students and encouraging discussion about healthy human sexuality. The programme was implemented through the National Service Scheme (NSS) of the Department of Youth Affairs and Sports, in the Ministry of Human Resource Development. UTA began on an experimental basis in 1991, in the first phase, the project was implemented in 59 universities covering 29 states and union territories in India and about 7,000 educators/facilitators were trained. It is a low-cost programme; each college campus received US\$90/year.

To link the awareness programmes on the campuses with communities, in the second phase UTA designed a "Campus-to-community" linkages system called "Concerted Action by Universities upon Silent Emergencies" (CAUSE - 2000). The campus-to-community campaign covered nearly 7,500 colleges affiliated to 158 universities and nearly 75,000 peer educators were trained, generating awareness among 10 million students. The low-cost, UTA project entered into the third phase in 1996, with an objective of training 10 new peer educators per year from each college. UTA

has produced a number of knowledge, attitudes and practices studies, evaluation reports, IEC materials, experimental documents, training manuals, modules and a documentary film. An example of a successful UTA programme is at Kumaon University Campus; Almora. There, the local NSS unit conducted five AIDS education campaigns in its 10-day residential camps, each reaching about 230 students. Activities using participatory group methodologies focused on HIV/AIDS, STDs, preventive measures, peer-group focus discussions and communication skills. After the training camps, intensive orientation workshops were conducted for field officers and selected peer educators from various colleges. They discussed medical facts, global scenarios, human sexuality, misconceptions and beliefs, the growing-up process, responsible sexual behaviour, values and attitudes, prejudice and its impact, the psychosocial and cultural impact of HIV/AIDS, counselling, and attitudes towards condom use. At the end of the workshops, the participants prepared education messages in local dialects for the community at large, using handbills, songs, poems, posters and puppetry. Posters collected through a state-level competition were distributed to the local media and workshop participants. Audio-visual aids were used to make the workshops more interesting.

In terms of functional challenges, strong opposition was faced from some principals while some teachers were reluctant to share the forum with students and condom demonstration was considered anti-culture. There were concerns that UTA might promote promiscuity among students. The project also faced certain organizational issues in terms of NSS officers leaving the organization after completion of a three-year period, provision was needed to retain trained facilitators. UTA also needed more support from field personnel to monitor the programme properly. Maintaining a flow of information and resources as well as feedback to the university and peer educators from the Regional Office needed attention.

Result

- There was an increase in awareness and understanding; peer educators create an environment conducive to discussing sensitive issues such as sexuality.
- The entailing behaviours and statements of the

participants tended to be more 'responsible' and sex tended to be viewed in a more 'positive' manner than it used to be before the intervention.

- Seventeen lifestyle education centres have been established to orient youth towards planned parenthood and healthy lifestyle.
- More than 7,000 NSS programme officers and 55,000 peer educators have been trained on AIDS education.
- 5,820 colleges of higher learning and+ 2 level institutions with over 5.6 million student population have been declared AIDS Aware.
- WHO headquarters, Geneva, has termed UTA as an innovative education intervention. A national-level quarterly Newsletter 'YOUTOPIA', is also published regularly.

Why this became successful

Keeping in view that HIV/AIDS is a delicate issue relating to sex, instead of using traditional pedagogic practices, brainstorming and ice breaking participatory methodologies were employed throughout the training programme. Students could communicate effectively and comfortably on sexual matters, and learn basic counselling skills. Conducive environment helped break the barriers of communication on taboo subjects such as sex, and elicited spontaneous, warm interaction between teachers and students after mutual trust and appreciation was established. The intervention created awareness in the students on HIV/AIDS/STD and other important issues for youth such as drug abuse, relationships, courtship and marriage and developed a responsible attitude towards sex. The key message was to delay the first sexual experience and adopt safe sex practices.

Extracted from: Web link: <http://www.yas.nic.in/yasroot/schemes/nss.htm>,
www.kit.ni/exchange/html/1997_3_india_universities_talk.asp

National Service Scheme

Ministry of Youth Affairs & Sports

Govt. of India.

2. Balbir Pasha Stirs Protection Talk

Background and Rationale

Nearly 5 million people in India are infected with HIV, the second highest figure in the world. Staggering misconceptions about how HIV is transmitted and a reluctance to publicly discuss the disease fuel its spread. From November 2002-February 2003, Population Services International (PSI) executed an aggressive, innovative communication campaign in Mumbai, as part of an integrated behaviour change HIV/AIDS prevention programme entitled, "Operation Lighthouse". The programme is being implemented in 12 major port communities across India with financial support extended by the United States Agency for International Development (USAID) through the AIDS Mark funding mechanism.

Objective

An extensive mass media HIV/AIDS campaign was designed to meet the following key communication objectives:

- To increase perception of HIV/AIDS risk from unprotected sex with non-regular partners by personalizing the message and creating empathy through identifiable real-life situations. (Attitudinal Change).
- To generate discussion about HIV/AIDS among the target populations and opinion leaders in order to facilitate understanding and knowledge acquisition. (Changing Social Norms).
- To motivate people to access HIV/AIDS helpline and VCT services. (Behavioural Change).

Implementation

The campaign was based on consumer research analysis that suggested daunting HIV infection rates coupled with flawed risk perception, especially among the poorest sectors of the population in Mumbai.

Through a mixture of strategically placed outdoor communications, hard-hitting television and radio messaging, and comprehensive newspaper exposure, this character was quite visibly portrayed in various intriguing scenarios, serving as a behavioural model for consumers of Mumbai mass media to relate to, learn from, and empathize with.

In Mumbai, it revolves around Balbir Pasha, a fictional character whom the target audience of young urban men can relate to. Balbir is portrayed in a series of identifiable, real-life sexual situations in which he runs

the risk of contracting HIV. Scenarios concern the use of alcohol and "forgetting" to use a condom, the mistaken belief that having a regular partner (even a prostitute or casual partner) means one is safe from HIV/AIDS infection, and the misconception that if one's partner looks healthy, he or she must be free of HIV/AIDS. Presented in an approachable, familiar manner, Balbir Pasha succeeds in personalizing HIV risk and bringing the topic of HIV/AIDS into the open.

In addition to strategic media creation and placement, the successful integration of support services, promotion of an HIV/AIDS Helpline, promotion of STI and voluntary counselling and HIV testing services, condoms and on the ground interpersonal communications were hallmarks of this campaign. Though subjected to some criticism for its cutting-edge frankness, impact studies and other data show that the campaign achieved phenomenal reach and those exposed to its messages exhibited marked knowledge acquisition and behaviour change with regard to HIV/AIDS.

Results

Increased risk perception among those exposed to the campaign

- Proportion of target audience who have sex with commercial sex workers and who feel they are at high risk for HIV if they have unprotected sex increased from 17% to 43%.
- Proportion of target audience who feel at risk for HIV if they have sex with 'healthy looking' commercial sex workers increases from 39% to 56%, while risk associated with 'expensive' commercial sex workers increases from 50% to 72%.

Increased tendency to discuss HIV/AIDS with others

- More than half of the target audience report having discussed the 'Balbir Pasha' ad campaign with someone.

Increase in number of people accessing HIV/AIDS prevention products and services.

- Increase in number of calls to PSI's Saadhan HIV/AIDS hotline, and shift in types of queries from superficial to more invasive and informed.
- Increase in proportion of individuals reporting last-time condom usage with commercial sex workers from 87% to 92%.

- Retail sales of condoms in the Red Light district, the priority focus area for the campaign, tripled after the launch of the campaign as compared to before it started.

Why this became successful

After an analysis of the process, PSI believes that six main elements of the campaign contributed to its phenomenal success:

1. Consumer insight: The 'Balbir Pasha' campaign was built on the basis of an in-depth study of the target consumer, his behaviour, knowledge, and lifestyle. By developing a character that the target consumer could relate to, the campaign was able to personalize HIV risk, which resulted in attitude shifts among those exposed to the messages.

2. Building of intrigue: Much of the reason the campaign's main messages made such an impact in Mumbai is attributable to the intrigue that was built up by the preceding teaser campaign. This allowed the public to get familiar with the name 'Balbir Pasha' and gave the target consumer the opportunity to form a relationship with this character before the main precautionary HIV/AIDS were introduced.

3. Optimal media mix: a variety of communication media were utilized in order to effectively target the consumer in mind. The use of outdoor media, such as train posters, billboards, etc. was especially relevant to achieving the high visibility of the campaign's messages.

4. Link with on-the-ground activities: Associating each phase of the 'Balbir Pasha' campaign with the promotion of the Saadhan helpline, the themes of interpersonal communications activities, and the provision of voluntary counselling and testing services ensured valuable synergies.

5. Infiltration into popular culture: The infiltration of 'Balbir Pasha' into street-talk, independent art projects, and other advertising campaigns further provided a 'hook' for the target consumer to relate to and personalize HIV risk.

6. Hard-hitting messages: Although criticized by some for their relative frankness, PSI managed to deliver HIV/AIDS messages in a way that spoke directly to the target consumer, rather than attempting to passively persuade the consumer.

Extracted from: www.psi.org/news/india.pdf and www.psi.org/resources/pubs/balbir_case_study.pdf

PSI/India

Modern Mills Compound

Sane Guruji Marg, Mahalakshmi

Mumbai 400011, India.

Phone: +9122-23063187

3. “Chatting with my Best Friend” (“Saathi Sanga Maan Ko Kura”)

Background and rationale

Nepal had, by the year 2000, entered the stage of a concentrated epidemic. With about 36,000 people living with HIV/AIDS. By the end of 2001, this figure increased to 58,000, with a quarter below 25 years. Among injecting drug users, HIV prevalence shot up from 2% in 1995 to nearly 50% in 1998, and a 2002 study revealed a scathing rate of 68% among male injecting drug users in Kathmandu.

In 1999, UNICEF conducted a survey to assess the programmatic response to the HIV/AIDS epidemic in Nepal and to identify gaps and needs. The survey identified the urgent need for a communication strategy targeted specifically at young people, focussing on HIV infection through unsafe sexual and injecting drug use.

“Chatting with my best friend” is the first and so far the only national radio programme in Nepal, which discusses personal issues, affecting young people in a frank and honest manner. The programme is presented in an entertaining way, through lively discussions and short, hard-hitting dramas, interspersed with popular music and song.

Objective

The aim of the programme is to increase young people’s knowledge of issues affecting their lives and to help them deal with the difficult issues through life skills-based education. The specific objective is to prevent HIV infection and injecting drug use through increased knowledge of HIV/AIDS and drug use-related issues.

Implementation

UNICEF launched a national Knowledge, Attitudes, Practice and Skills (KAPS) survey of teenagers to determine their attitude, needs and fears covering 1,400 young people aged between 12 and 18 years in seven districts representing all the country’s geographical areas and development zones.

Findings indicated that young people’s main concerns centred on unemployment, education, family problems, health, money as well as love, sex and marriage. The Survey demonstrated an urgent need for a life-skills based education to address the larger issue of positive self-development among adolescents. Radio was, by far, the most widely utilized mass medium, 86% of respondents said they listened regularly to the

radio, which is cheaper and more easily accessible. “Chatting with my best friend” has three main components, the radio programme, letters from listener and listeners’ club. These are coordinated by a television drama programme and printed material.

Ten broadcast media professionals aged between 19 and 26 underwent a six-month training course in the design and production of entertainment education programmes aimed at young people, with a particular focus on life skills for the prevention of HIV/AIDS, STIs and injecting drug use.

A provisional list of 52 topics to be covered was drawn up, and ten episodes were pre-tested among a randomly selected group of 500 young people. The pre-test found that the format and contents of the programme were popular, and the first episode of ‘chatting with my best friend’ went on the air in April 2001. Radio Nepal broadcasts one-hour programme in the national language, Nepali, every Saturday afternoon. It is then repeated by eight FM stations the following week. It is estimated that over 3 million young people and an unknown number of adults tune in to the programme regularly. It persuades young people to engage in healthy behaviour, by addressing a range of relevant issues, including love, sex, marriage, pregnancy, drug abuse, problems with parents, HIV and other STIs.

In the first two years the programme received almost 15,000 letters from listeners from all over the country. In 2002, the average number of letters per month exceeded 700. In 2002, a local NGO was contracted to respond to the letters. Every listener who writes to the programme receives an individual response. Listeners are also sent one or more booklets and photo novellas relevant to the particular life skills referred to in the letter. These are designed as self-learning tools to help young people and are particularly suitable for use in rural areas with high illiteracy rates.

Ten months after “chatting” first went on the air, listeners were encouraged to form clubs so they could discuss the issues raised and undertake some activities together. This was based on focus group discussions with young people, parents and community leaders in five districts. The suggestions to establish clubs met with an immediate and positive response. Within eight months, over 500 listeners’ clubs had been formed in 61 of the country’s 75 districts. Some clubs were youth groups who added listening to the chatting programme

to their activities. In Palpa district, the listeners' club formed a partnership with the local health centre, and organized a three-day workshop to educate adolescents about sexual and reproductive health. To fund this initiative the members collected donations and obtained funds from the district development committee to start their own newsletter. Clubs also reported collaboration with health centres for condom distribution.

Targeted mainly at young people living in urban areas, especially in Kathmandu, the 'Catmandu' television drama plots depict young people dealing with emotional conflicts, facing tough choices and going through situations which demand empathy, creative and critical thinking, problem solving abilities and other life skills. 'Catmandu', the first television programme acted and directed by young people for young people in Nepal regularly attracts an estimated 50% of the station's viewers.

The quality of the programme is monitored through analysis and discussion of listeners' letters. In December 2001, a focus group survey carried out in five districts showed that 70% of young people were regular listeners of the programme.

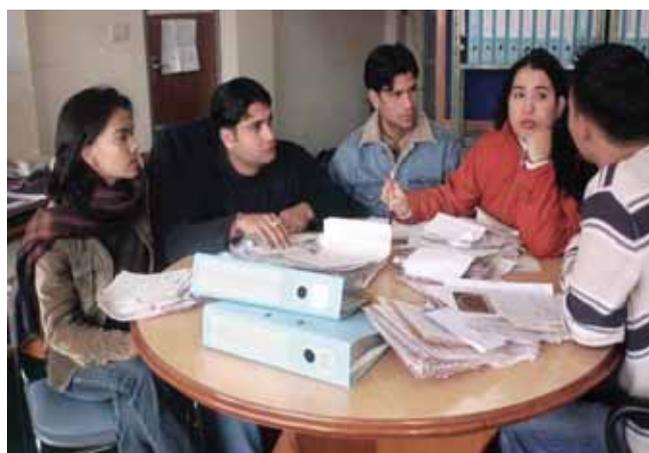
Results

The programme provides accurate and comprehensive information on sex, HIV/AIDS and sexually transmitted infections and pregnancy. The audience is estimated to be more than 3 million young people in 61 of Nepal's 75 districts. Both the radio and television programmes contribute to breaking the cycle of silence and denial. The programme has mobilized young people and created an extensive network of listeners' clubs.

Feedback from listeners has been extremely positive. Over 700 letters are received from listeners each month, and more than 500 listeners' club were formed in 2002.

Why this became successful

A thorough understanding of the audience is the key to the success of the programme. It is the result of two years of research, planning and training carried out by the UNICEF Nepal country office to understand the interests, needs, knowledge, attitude, behaviour and life skills of the target audience, followed by ongoing monitoring and audience research to assess the impact and effectiveness. The frankness and honesty with which the programme addressed the sensitive, but critical issues has appealed to young people and contributed to its success. The producers and presenters



Source: UNICEF

are themselves young and understand the culture of the young people who can easily relate their problems to the presenters whom they regard as friends.

Extracted from: Learning, Sharing to Action: HIV/AIDS Prevention among young people in South Asia, Unicef.

Anand Tamang

Director, Centre for Research on Environment

Health and Population Activities (CREHPA)

Kusunti, Lalitpur, P.O. Box 9626

Kathmandu, NEPAL

Phone: 977-1-5546487, 5521717

Fax: 5522724

E-mail: anand@crehpa.wlink.com.np

Website: www.crehpa.org.np

4. Girl Power

Background and Rationale

Adolescent Peer Organized Network (APON), is a project designed and implemented by one of Bangladesh's leading NGOs, the Bangladesh Rural Advancement Committee (BRAC). The APON project, which started in 1998-99 in 25 regions, is now operational in 58 regions with 6,500 reading centres and aims to reach about 200,000 adolescents, mainly girls.

Objectives

- Empower adolescent girls and develop their confidence and leadership skills.
- Develop adolescent girls' life skills to help them become responsible members of their families, the communities and their country.
- Change the traditional rural perception of the capabilities and value of girls.
- Provide adolescent girls with a network of peer support.
- Encourage adolescent girls to continue their education.

Implementation

The APON project aims to address the problems and needs of adolescent girls, whose health and wellbeing are at risk due to the conservative nature of traditional Bangladeshi society, which keeps them in ignorance about matters relating to sexuality and reproductive health by providing peer education and support, non-traditional vocational training and employment.

The network developed as a conscious response to the needs articulated by young women and girls to have a forum to discuss issues of reproductive health, contraception, sex education and sexually transmitted diseases which are not usually addressed in development programmes. They also wanted to learn about sensitive social issues such as inheritance law, oral divorce, dowry, women's legal rights, nutrition, children's health, physical harassment, acid attacks and how to deal diplomatically with mothers-in-law.

In response to this need, BRAC developed a set of 20 booklets on 40 different social, economic and environmental issues in which adolescent girls had expressed an interest. The booklets not only convey information but also impart social skills to help girls with gender-related issues that constrain their lives in

a conservative society. They also provide information about whom to contact and what actions to take in the event of sexual abuse, symptoms of particular diseases, and how to obtain legal aid.

Reading centres were created where adolescent girls can acquire knowledge and life skills that enable them to make informed choices and to develop their leadership potential. The objectives of the Reading Centres are to empower girls through education and skills development, provision of employment opportunities and increased awareness of sexual and reproductive health and gender issues.

The most innovative feature of this network is the involvement of adolescent girls in the design and implementation of this programme. Peer educators, mostly those in 8th standard, work with groups of girls and young women to study the booklets, develop relevant take-home messages and plan actions within their communities. There are currently 5100 peer educators and nearly 150,000 adolescent girls have participated in studying the booklets between 2000 and 2002. As these peer educators receive a salary for their work, they have become valued income-earners in their families and the pressure on them to marry early has decreased.

Parents and community leaders are often distrustful of initiatives aimed at educating young women and girls on sexual and reproductive health. The APON project however, has been successful in involving them and getting their support, which is critical to reduce young women's vulnerability and risk to HIV infection as well as unwanted and early pregnancies.

Results

The project increased knowledge and strengthened life skills. About 200,000 adolescent girls attended APON training courses between May 2000 and September 2002. Girls trained by APON have been able to use their knowledge and social skills successfully to influence important decisions. There was a change in family and societal attitudes especially for girls who have directly or indirectly gained employment through the project. The project has devised a delayed marriage scheme to enable girls to complete their secondary school education before being married. Through this scheme, the project pays Tk 700 (about 10 US dollars) to girls for their senior school certificate examination provided they do not get married before the age of 18.

By September 2002, a total of 89 girls had received this payment and none had broken their promise not to marry before they were 18. Monitoring has shown that 319 of the girls trained and assisted by the project have been successful in starting a photo, sewing or poultry business, or getting a data entry job in an office.

Why this became successful

Education and skill development through peer education, advocacy to overcome parental resistance and

empowerment through livelihood programmes and opportunities for income generation made it a success. A critical impact of the programme is that young girls are questioning early marriage, affirming their desire for higher education and rejecting violence as inevitable. Moreover, adolescent girls themselves become the main change agents in the process of empowerment, which can also help to protect them from the threat of HIV/AIDS and other STIs.

Extracted from: Learning, Sharing to Action: HIV/AIDS Prevention among young people in South Asia, Unicef.
Programme Coordinator, Education,
BRAC Education Programme
Bangladesh Rural Advancement Committee (BRAC)
75 Mokakhali, Dhaka 1212
Bangladesh

5. Male bisexual behaviour and HIV risk

Background and Rationale

The Humsafar Trust is a male sexual health agency in Mumbai, India which started as a support system for men having sex with men (MSM) in the city as the HIV/AIDS crisis started gathering momentum in the early 90's. The Trust now is a multi-faceted organization serving various needs of the MSM community with several activities to help the community in battling the epidemic

The illegal status and public disapproval of their sexual orientation drives MSM in India underground for their sexual needs. This heightens their vulnerability to sexually transmitted infections (STIs) and HIV/AIDS. HIV can also spread from MSM into the general population. Infection trends indicate that more women are being infected. Because of their marginalized position in society, MSM find it extremely difficult to access the health information and services they need to protect them and their partners from HIV and other STIs.

Humsafar Trust has pioneered a holistic and comprehensive approach to care, support, information and advocacy for MSM. Through the Trust and in collaboration with public and private health institutions, about 8,500 men, mostly in their twenties, have been able to access vital health information care and support, especially with regard to HIV/AIDS and other STIs. In 1998, the Director of Health Services of Maharashtra state agreed to provide funds for the trust to do a sex map of MSM sites in Mumbai. The Trust identified 76 places where men meet either to seek sexual liaisons or simply to exchange information and socialise. Most of these sites were either train stations or bus terminals. Based on the study the Mumbai district AIDS control society gave the Trust funding for an outreach programme for a target population of 1,000 MSM. Based on survey findings, Humsafar programmers drew up plans for a much larger project entitled, comprehensive and holistic care and support project in the sector, to stabilize STI and HIV in Mumbai.

Objective

- To motivate men having sex with men to adopt safe sex practices and to reduce high-risk behaviour.
- To provide high quality STI services at the Humsafar Trust and enable men having sex with men to seek other appropriate services through a system of referral linkages.
- To provide a safe space and a non-judgemental

meeting ground for men having sex with men to participate in group discussions on safe and healthy sexual behaviour.

- To develop a model for continuum of care for those living with HIV/AIDS within this group.

Implementation

Humsafar has good working relations with the state and municipal AIDS societies both of which have provided financial support to its activities. A sensitisation programme was started with doctors, nurses, counsellors and other health professionals especially at Sion Hospital and Cooper Hospital and they in turn did advocacy for Humsafar with their colleagues. Rapport was established with the local police, pan wallahs, the newspaper vendors, the tea sellers and other small traders in the neighbourhood. Advocacy involved giving condoms or referring them for STI/HIV counselling and testing. Humsafar conducts workshops for college and university students, industrial workers, the police, lawyers and journalists. In October 2002, the all women's SNDT University in Mumbai hosted an international gay and lesbian conference organised by Humsafar.

More than half of the 54 people who work for the Humsafar Trust in Mumbai are engaged in outreach activities. Twenty young men all of whom are themselves MSM are the outreach workers of the programme. Based on the Trust reach, the outreach workers are assigned specific beats which they visit six nights of the week from approximately 7 pm until 11 pm. Most beats are located in or near railway stations and bus terminals.

Before setting out on their beat, the outreach workers come to the Trusts' office to write a report on the previous evening's work and to replenish their supplies of condoms and informational material. While on their beats the outreach workers chat informally with individuals and groups about their problems, STI, HIV/AIDS and safer sex. They carry out demonstrations of how to put on a condom with each outreach worker distributing 70-80 free condoms per evening. They also distribute information material and invite people to visit the Humsafar Trust drop-in centre and encourage people to be counselled and tested for STIs and HIV. Between February 2001 and March 2002, Humsafar outreach workers made a total of 50,961 outreach contacts, including 6,949 people who were new to the programme. Each outreach worker tries to meet a target of eight new referrals for STI/HIV counselling and testing per month.

The Humsafar Trust maintains a crisis management cell to act as a rapid response unit to help sort out any problems that may occur at the outreach sites. A monitoring cell also visits sites on a random basis to check on the presence and performance of the outreach worker. In the course of their work outreach workers take part in bimonthly team meetings with project staff to discuss issues and problems and identify possible solutions. They also participate in quarterly refresher training workshops, which serve to update their knowledge, improve their skills and sustain motivation.

Between February 2001 and March 2002 a total of 3365 people visited the Humsafar centre. There are newspapers, pamphlets and magazines to read, health information material to take away and a well stocked library on sexual health, homosexuality, HIV/AIDS and STIs. Visitors can also watch TV or video and listen to music. They can make cups of tea or coffee in the office kitchen. Bottles of filtered water can be collected and taken home, a generally appreciated service because many people do not have access to safe drinking water.

A basket of condoms is conveniently located near the entrance and visitors can help themselves. Both counselling and testing are provided free of charge to the clients. During February 2001-April 2002, a total of 1,308 men having sex with men were counselled and referred for STIs and HIV testing, of whom 289 (22%) tested HIV-positive and 161 (12%) were diagnosed with syphilis. All counselled at Sion Hospital or the

Humsafar clinic receive sexual health education and two condoms. Some of those positive attend Sion Hospital for regular follow-up, health monitoring, nutrition supplements and dietary advice. Sion Hospital provides MSM with free treatment for bacterial STIs, as well as some common HIV-related opportunistic infections such as candidiasis. Antiretroviral treatment is also available, but not affordable to most of Humsafar clients or staff.

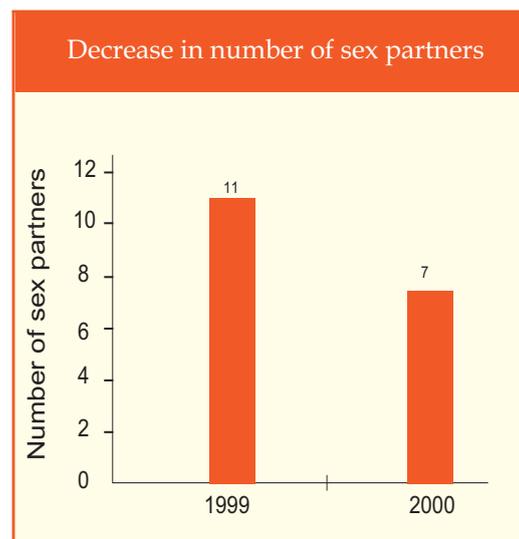
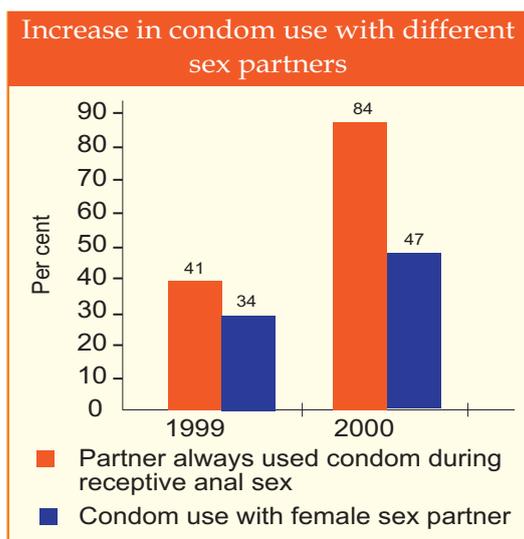
Result

The survey found significant and encouraging changes compared with two years earlier. While 84% of respondents who were involved in receptive anal sex reported that their partners always used a condom, compared with 41%, two years earlier, the average number of sex partners was seven, compared with 11, two years previously.

As in 1999/2000, about half of the respondents also had sex with female partners, but the proportion that used condoms rose from 34% to 47%.

Why this became successful

Continuity in leadership and being grounded in the community they are supporting and support from the government of Maharashtra are major reasons for the survival and staying power of Humsafar. The Trust has created and maintained among its staff and volunteers high morale and ethical standards. The Trust offers an alternative family, providing not only an emotional home but also practical help in times of illness or other need.



Extracted from : Learning, Sharing to Action : HIV/AIDS Prevention among young people in South Asia, Unicef
 Mr. Ashok Row Kavi
 Vakola Old Municipal Building, II Floor, Nehru Road, Santacruz (East), Mumbai, 400055
 Phone: (022)26650547
 Email: humsafar@vsnl.com
 Web Site: www.humsafar.org

6. Youth Ambassadors Fight against HIV/AIDS

Introduction and Rationale

Trends from India's National AIDS Control Organization (NACO) Sentinel Surveillance indicate the shift in the spread of the epidemic from the high-risk groups in urban areas to the general population in rural areas, with an increased number of young people, particularly young women, getting infected. With over 50% of all reported AIDS cases occurring in the 15-24 age group, all stakeholders recognize that mobilizing and partnering with young people is critical. The lack of information and access to services leads to fear, stigma and deep-rooted discrimination preventing young people from adopting preventive strategies such as using condoms, seeking testing for HIV and other STIs, adhering to treatment or disclosing their HIV status to sexual partners. The Parliamentary Forum on HIV/AIDS (FPA) in its 2003 Declaration has committed to take steps to ensure that the response has a concerted focus on youth.

In line with the intent to involve young people as primary stakeholders in fighting the epidemic, it was decided by FPA and UN agencies that motivated and concerned young people from all walks of life and from all corners of the country be brought together on a forum and their opinions and concerns be taken on board while discussing the Draft Legislation on HIV/AIDS. The format adopted was "a representative day in the Indian Parliament."

Key stakeholders, the Parliamentary Forum on HIV/AIDS and the UN Agencies (UNFPA, UNICEF, UNIFEM, UNODC), with the pivotal role of UNAIDS, came together to devise a programme to orient and sensitize youth ambassadors on HIV/AIDS and provide them a platform to discuss the key factors affecting the HIV/AIDS epidemic in the country. In addition to the Prime Minister's Office and NACO, the Ministry of Health, Ministry of Human Resource Development and the Ministry of Youth Affairs were key agencies from the Government of India that participated in the process. The first step was to sensitise and orient the 200 key youth ambassadors on HIV/AIDS. These youth ambassadors were visualized to lead the discussions and debates on HIV/AIDS and later be the focal points for youth leadership in the fight against HIV/AIDS in the country.

Objective

1. To mobilise youth representatives from all parts of the country on the issue of HIV/AIDS.

2. To increase awareness among the youth on HIV/AIDS prevention and care.
3. As young people and representatives of the youth, to reaffirm their roles and responsibilities towards the prevention of HIV/AIDS.

Implementation

Two hundred young people, aged between 20 and 25 years, from Indian Association of Universities, Nehru Yuva Kendra Sangathan, the National Cadet Corps and National Service Scheme were selected through competitive selection. The selections were based on the ability of the candidates to internalize issues and take leadership in addressing issues of concern to young people.

As the first step, the 200 young people were oriented, through a week long programme, on key aspects of HIV/AIDS like its pathogenesis, vulnerabilities of young people to HIV/AIDS, socio-economic impact of HIV/AIDS, various international and national initiatives to fight the epidemic. In addition, they were exposed to parliamentary procedures and various discussions and debates as part of the draft legislation on HIV/AIDS in the country. This was followed by a session on helping them understand their role as youth ambassadors.

The next step was to orient around 4000 youth from all corners of the country to HIV/AIDS. These youth represented all districts of the country and thus had national representation. The 200 youth ambassadors played the role of facilitators during the orientation of the larger contingent.

In addition to the 200 youth ambassadors, an additional 343 young people were chosen from the larger group to match the numbers of elected representatives of the Indian Parliament. The 543 youth were brought together as youth representatives of Indian Parliamentarians to discuss, debate and deliberate on various aspects of the HIV epidemic in the country and suggest a way forward in the form of approved draft legislation by young people.

All this culminated into a parliamentary session of young people, with a selected Speaker of the House, member of Treasury Benches and Opposition. This special session was inaugurated by the Honourable Prime Minister of India, Dr. Man Mohan Singh and addressed by Dr. Ambumani Ramadoss, Honourable Minister for Health. Issues of violation of rights, stigma and discrimination were hotly debated. Other issues

like resource allocation and gender were also well interacted. All this happened in the presence of a gallery of young people and different stakeholders applauding and heckling from time to time. This ended with a legislative Bill taken up for presentation to the Parliament.

The Population Foundation of India, MAMTA Lawyers Collective and some UN agencies, worked closely with the young people in preparing their questions and the relevant answers. The partnership of different agencies like the Government of India, the UN systems, NGOs and individual experts is worth emulating.

More stress need to be placed on follow-up in the states and districts to get value for investments. Change in the legal and regulatory framework should be taken forward as a follow-up.

Results

The event has set the tone for a large youth-developed and youth-oriented advocacy and awareness campaign in the country. As it has a national representation, the key messages on HIV can be expected to reach the farthest corners of the country.

As these young people lead the national campaign, NACO, respective State AIDS control agencies and Youth institutions like NYKS and NSS can now groom the sensitized and motivated youth ambassadors in the fight against HIV/AIDS.

Since its launch in 2003, the FPA has been actively involved in strengthening the Forum at every level from state to the panchayat, to mobilize communities to respond to the growing challenges of AIDS.

There is a need for follow-up action so that such an effort can deal with issues related to legal aspects, rights and removal of stigma. The debates and discussions should probably be extended to the states and local governments to obtain the views and concerns of representatives at all levels.

Why this became successful

The youth convention is a concrete initiative that brings together elected representatives and student leaders on a common platform. It brought the young people closer to the advocacy and awareness campaign in the country for their active involvement in the response to fight against HIV/AIDS.

Dr. Sunil Mehra

B-5, GK-II, New Delhi-48

Phone: (011) 29220210

Email: mamta@ndf.vsnl.net.in

Web Site: www.mamta-himc.org

7. Reducing Girls' Vulnerability to HIV/AIDS: Sema Life Development Project

Background and Rationale

The Sema Life Development project is a project run by the Ministry of Education, Thailand, with a special budget allocated by the Ministry of Finance, and UNICEF with the specific aim of fighting the problem of girls being recruited for prostitution and other hazardous forms of child labour. Poverty, the lack of educational opportunities, broken families and the desire to seek a better standard of living, were the factors in pushing young girls into prostitution. The project aims to tackle the problem of children in prostitution through an education and awareness programme.

The Ministry of Public Health provides support for nursing education for recipients of scholarships who have completed lower-secondary education (Grade 9) and wish to enter nursing college. UNICEF, in collaboration with the Ministry of Education and the Dusit College of the Dusit Thani Hotel, provides support for a two-year training course in hotel hospitality to recipients of Sema scholarships who complete their lower-secondary education. The Institute for Population and Social Research, Mahidol University, is also a participant.

Objective

The objective of the project is to reduce the number of children at high risk of entering the sex trade, by supporting their attendance at school and, in some cases, promoting discussion between their teachers and parents. The project's targets are:

- To prevent girls at high risk from becoming sex workers (SWs), at least 500 girls are provided scholarships for boarding school.
- To provide 4,000 scholarships for day-students to further their education in schools located in their communities.
- To prepare for students scholarships who complete Grades 9 and 12 so that they can attend vocational training.
- To establish 94 Sema Pattana Cheewit centres in 94 districts in eight northern provinces. These centres will provide information and conduct campaigns to prevent girls from becoming SWs.
- To establish a collaborative system for working with other concerned organizations.

Implementation

The Sema Life Development Project is the most broadly implemented of the strategies for eradicating child prostitution. This project was initiated in 1992 to help highly disadvantaged girls from poor families and with little opportunity to continue their education and enrol in secondary school by providing them with scholarships of 3,000 baht (about US\$ 77 in early 1997) per year. This amount was considered sufficient to cover all educational costs and other personal costs during the school year. Eight provinces in the North (Chiang Rai, Lamphun, Phayao, Chiang Mai, Prae, Mae Hong Song, Lamphun, and Nan) were identified as the target areas. They are the parts of the country from which there is the greatest risk of girls being recruited for the sex trade. These provinces also had high HIV/AIDS rates, as well as a high percentage of girls (43 %) who did not continue in school after completing Grade 6.

Following a selection process, some girls are provided scholarships for boarding school. Others receive scholarships as day-students to further their education in schools located in their communities.

Results

In the first three years of implementation, 1994 to 1996, 1,395 girls received scholarships for boarding school and 11,500 girls for day school. Data were collected by the Ministry of Education about what the students who completed Grade 9 did after finishing their education (for the first group of girls receiving scholarships in 1994). However, only data pertaining to boarding school girls are available. This information shows that of 395 girls, who finished Grade 9 in 1996, 320 (81 %) continued their education in some form, two students took short training courses, 47 girls (12 %) began working, and 4 (1 %) dropped out of school.

The high percentage of girls pursuing an education after finishing Grade 9 indicates the measure of success of this project. From focus group discussions with girls who are currently holding scholarships in boarding schools, it appears that the girls want to study when they have a chance. The three-week orientation programme to prepare girls before entering boarding school helps them to adjust to life in school. Moreover, three years in school is long enough to provide knowledge of the dangers of getting HIV from becoming a SW, as well as to provide other means of making a living.

Overall, experience shows that the programme permits many girls to attend schools for a number of years, preventing their being sold into the sex trade. Their opportunities for employment upon graduation are increased by their higher level of education.

The programme staff note a number of lessons learned at the operational level:

- The direct transfer of money to each girl's bank account has been found to be the most appropriate method of disbursement. It cuts out unnecessary steps and shortens the time between approval and transfer of the money.
- The curriculum offered in school should provide a variety of alternatives. Girls from poorer families may be at a disadvantage in terms of their educational ability, and they may not do well in a strict academic environment. Students report that their friends who drop out do so because they were bored with studying and unable to follow classes. If the school offers alternative programmes such as

vocational training and opportunities to acquire important life skills, these may help motivate girls to stay in school.

- Follow-up information about what the girls do afterwards is important, since it serves as an indicator of project success or the need for improved planning and implementation.

Why this became successful

The project has been able to provide the young girls with alternatives, which they previously did not have. The co-operation between the different actors involved in the project has ensured the smooth running of the programme. But the main reason of success has been the teachers' inputs and commitment to the project. Teachers play a major role in setting up a network of communication, co-ordination and co-operation among the different actors involved in the project, such as community leaders, social workers, government officials, the police, educators, and NGOs to ensure the success of the campaign.

Extracted from: <http://www.unaids.org>

UNAIDS

20 Avenue Appia - 1211

Geneva 27 - Switzerland

Phone.: (+41) 22 791 36 66

Fax: (+41) 22 791 41 87

E-mail: unaids@unaids.org

8. Thai Women of Tomorrow Project

Background and Rationale

The Thai Women of Tomorrow (TWT) Project was initiated in 1992 by researchers at the Faculty of Social Sciences, Chiang Mai University. Its premise was that changing the attitudes of girls and parents is the most important factor in establishing successful education programmes. If parents and girls have positive attitudes toward prostitution, it is difficult to convince them of the value of education. Even if the project can compensate families by giving the children scholarships, the children might drop out of school before they finish Grade 9. The project therefore put its efforts into attitude-changing activities, with scholarships and short-course training as supporting activities for those who want to have alternative ways of earning money. TWT focuses on girls who have finished Grade 6 and have not gone further in their education. There is, however, greater emphasis on changing attitudes of girls and their parents against prostitution and towards vocational training as an alternative to school.

Objective

The basic objective is to provide an education for girls in difficult circumstances so that they can develop in maturity, knowledge, and experience. It is hoped that girls can thereby protect themselves from being deceived into prostitution and can find a socially acceptable job. The project also aims to inform parents and girls about the dangers of prostitution, and thereby change their attitudes toward it.

Implementation

The project was initiated by researchers at the Faculty of Social Sciences, Chiang Mai. The Thai Women of Tomorrow proposal was submitted to the Women's Economic and Leadership Development Programme (WELD) under financial support from the Canadian International Development Agency (CIDA). Since the initial stages, the government of Japan, the United States Agency for International Development (USAID) and the International Labour Organisation (ILO) have supported parts of the programme.

The first approved component of the project, entitled Reduction of Child Prostitution by Raising Consciousness and Attitudes among Children and Parents in Rural Society, was started in 1993. This was the TWT's first phase aimed at testing an attitude-changing model. The project targeted rural primary school girls at risk of becoming sex workers in two

districts in Phayao Province, an area with major HIV/AIDS and prostitution problems.

After a test of the model produced satisfactory results, the project moved to Phase II, Providing Educational and Occupational Opportunities through Public-Private Partnership. This phase built a partnership between the public and private sectors to provide opportunities for girls to continue education and training through scholarship funds and skills training. In addition it provided job opportunities for girls after they had finished their training programmes. Two provinces, Phayao and Chiang Rai, were the target areas, and it was planned to expand the project to cover every province in the North and Northeast if the programme proved successful. The project received funding from USAID in 1993, as well as from private donations.

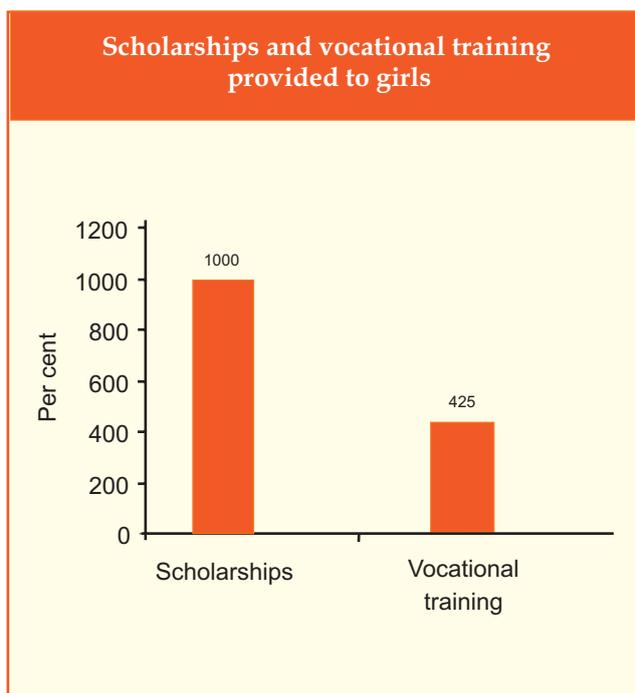
The third phase of the TWT project started at the end of 1994 after support from USAID ended. In order for the project to be sustainable, three activities were initiated:

- Building a relationship with the private sector and other NGOs for long-term support in providing scholarships to the students.
- Transferring the idea and methodology of the public-private partnership to teaching institutions and public organizations, to link both study curriculum and training with the private sector.
- Strengthening capacity for media production and for counselling to change the attitudes of young women and their parents regarding prostitution. This activity received financial support from the government of Japan under the Small-Scale Grant Assistance programme (SSGA).

Results

The project recruited volunteer teachers in six districts of Phayao and Chiang Rai Provinces, trained them, and assigned them the responsibility for changing attitudes among girls at risk and their families.

The project provided more than 1,000 scholarships to girls who finished Grade 6. This means that these girls will not enter the labour market for at least three more years. Another 425 girls participated in vocational training in four areas:



- A six-month Assistant Health Worker training programme was attended by 140 girls at the Thai-Canadian Academy of the Care West Company.

After training, they were employed by Care West and some private hospitals in Bangkok, Chiang Mai, and Chiang Rai with standard wages and benefits.

- Seventy-five girls were trained for 250 hours at the Computer Centre, Chiang Mai University. They were then placed in secretarial positions at several established companies with reasonable salaries and benefits.

- For three months, 150 girls were trained at the Wing Group in Sankanpang, Chiang Mai, and Sahapatana Groups at Lamphun. They were then placed at several garment and leather companies in Chiang Mai with standard wages and benefits.
- Sixty girls were trained in the Gemopolis and the General Diamond Companies, the leading gem-cutting businesses in Thailand. They were then employed as skilled gem cutters in these companies in Bangkok. The career is very promising and the benefits are higher than the minimum legal wage.

Finally, various packages of campaign media and methods were produced. For example, one set of video tapes contain interviews with anonymous girls who are actually working as prostitutes. The girls tell of their suffering, the nature of which is usually unknown to villagers. When the girls and their families learn about how the girls might be abused, their attitude towards prostitution changed.

Why this became successful

The projects efforts in changing attitude with scholarships and short-course training as support activities made it a success. Focus group sessions and home visits were very carefully prepared by TWT staff and delivered to target groups by volunteer teachers. These methods were continued with at-risk families in order to monitor, follow-up, and try to influence decisions about the girls' future. As a result, a large number of girls and their parents changed their minds and decided to either continue schooling or join vocational training programmes.

Extracted from: <http://unaids.org>

UNAIDS

- 20 Avenue Appia - 1211

Geneva 27 - Switzerland

Phone: (+41) 22 791 36 66

Fax: (+41) 22 791 41 87

E-mail: unaids@unaids.org

9. Bringing Comprehensive Reproductive Health Services to the community

Introduction and Rationale

The endorsement by the European Commission (EC) of the results of the international conference on population and development (ICPD) held in Cairo in 1994 provided the spur for the EC/UNFPA initiative for Reproductive Health in Asia. The UNFPA's Reproductive Health Initiative (RHI) in Nepal is aimed at improving the reproductive health status of women, men and adolescents. The programme consists of five innovative community-based projects, which are implemented by national NGOs in partnership with European organizations and in collaboration with the Ministry of Health.

Objective

- Enhancing community-based reproductive health services via NGOs and strengthening linkages between communities, community-based organizations, women's groups, local leaders, the government health system and other appropriate health services.
- To contribute towards reducing delays in seeking reaching and receiving appropriate care.

Implementation

The key strategy to reach under-served and marginalized population groups was to mobilize grass root organizations in support of the RHI. Projects worked with existing networks such as village development committees (VDCs), women's groups, youth clubs and community-based organizations (CBOs) to raise awareness on reproductive health issues and establish linkages and referral networks. To meet people's needs for quality integrated services, projects worked to enhance community-based services. Outreach clinics were set up and high quality services made available through static and mobile clinics. Emphasizing a more holistic approach to general well being led to prominence being given to counselling services. Furthermore, people were empowered to look at psychological, social and gender issues as well as physical health problems and to act upon them accordingly.

Village Development Committees and mother's groups were engaged in project activities as a way of creating community ownership and for mobilizing community volunteers. This project trained almost 1000 community health workers and 2900 community

leaders to become advocates in their communities. More than 2,000 mother's groups with over 24,000 members were trained on reproductive health, gender issues and reproductive rights. In each village a small tin trunk library containing information, education and communication material on both reproductive health and general development issues was provided to support awareness raising activities in the community.

Community leaders and other local representatives were involved in the planning, implementation and monitoring of activities. Regular meetings with community representatives were used to share project progress and obtain feedback on how activities were received by the communities. The feedback provided was used to revise and plan activities to address the shortcomings and specific needs.

Classes were held to reach illiterate people in urban slums with information about reproductive health. As young, illiterate women are especially vulnerable to sexual abuse and exploitation, particular efforts were made to target interventions towards this underserved section of the community. Furthermore, over 7000 young illiterate /semi-literate women benefited from intensive three-month training on basic reproductive health and life skills. These young, rural girls would otherwise have had little or no opportunity to obtain information about their own bodies or to build their confidence to enable them to better protect their sexual and reproductive health.

Communities mobilized local resources to set up Emergency Health Care revolving funds, which helped increase access to transport and health care in case of emergencies, thus reducing dangerous delays. The establishment of health insurance schemes was another strategy employed to improve access to essential health care. Through another project, a subsidized treatment fund was established. These enabled clients, who were otherwise unable to pay to use the services like family planning, antenatal care, diagnosis and treatment of reproductive tract infections, immunization, post-abortion care and other gynaecological problems at the static clinic at subsidized rates or free of charge.

Free services were also offered to remote and marginalized communities through outreach clinics and community health promoters who travelled as far as 60 kms to provide free services and information to poor communities. These initiatives brought quality

health care within reach of a significant number of marginalized, under-served people. For instance, in a remote and conservative muslim community called Ranipur, two years of outreach services and awareness raising activities resulted in women taking up ante-natal care and family planning services, which had previously been almost completely unknown.

The specific needs of young people aged 13 to 24 years were addressed through peer education programmes and Youth Information Centres. Fifteen resource centres in five districts provided a library with information, education and communication materials and games, as well as a training and common room area, where meetings and film shows were held. Counselling and other services were provided at the centres. A total of 216 male, female and mixed peer groups of eight to ten out-of-school youth were formed and trained on sexual and reproductive health and life skill issues. Subsequently, these young people were encouraged to share their newly-gained knowledge among peers in the communities. At the same time the 672 teachers trained in sexual and reproductive health education were able to reach as many as 40,000 students. Moreover, as influential people in the community, they provided significant support to the project. Altogether, the RHI in Nepal reached more than 76,000 out-of-school young people.

Following a social research study to evaluate the information needs and gaps faced by young people, a regular newsletter for them, 'Jigyasa' or 'curiosity,' and a flipchart on young people's reproductive health and developments were produced. Other useful tools were produced by the Umbrella Project to meet the common needs of partners, including a handbook on reproductive health for grassroots workers. Through a joint initiative the project also initiated the use of street drama as an innovative medium for reaching young people and to propagate health messages

Counselling has been emphasized as part of a holistic and integrated approach to reproductive health care, which also includes dealing with psychological, social and legal aspects of sexual and reproductive health care. In Kirtipur, the centre for community-based reproductive health, which was supported by six outreach clinics and a system of home visits, pioneered this approach. The Centre's multi-sector team included a psychologist, a lawyer, a social worker and a male counsellor, in addition to the regular clinical staff and field workers. Through the project, staff from the centre was trained to work as facilitators, encouraging clients to share problems and make informed choices.

Particular emphasis was given to maintain confidentiality. This approach enabled the centre to gain the trust and respect of the community, and it became possible to tackle sensitive issues, such as gender-based violence and issues related to property rights. Clients were referred to other support networks as required.

An important element of this project was geared to improving and adapting to the Nepalese context the contents of a training manual designed by the Regional Dimension Gender Project to tackle Gender-Based Violence through reproductive health programmes. However, gender issues cannot be addressed effectively without the active involvement of men. For this reason, the Centre mobilized 87 male volunteers. As a result, there are positive indications of increased male involvement, with men beginning to accompany their partners to the clinic as well as seeking services for themselves. In another RHI project, male volunteers were trained to raise awareness of reproductive health issues amongst men. An existing clinic under the same project was even extended to include a male counselling centre to better reach men with appropriate services.

Result

The reproductive health and life skills training provided to young women under RHI had a broad impact on their lives. The girls gained knowledge, skills and confidence and were able to approach preventive health services, as well as seek appropriate care when they had health problems. Moreover, as a result of the programme, more than 1000 young women enrolled in formal education and 55 adolescent girls' groups, convened reproductive health activities and decided to enrol in non-formal education. Others sought support to set up income-generating projects. Increased confidence was also demonstrated when the group members played an active role in advocating for their needs and rights during the National Adolescent Girls' Congress.

The Centres which adopted an integrated and holistic approach to reproductive health were able to address a broader range of problems and concerns in a way that took a more realistic account of the context, problems and needs of people's lives. By providing legal and social counselling and psychological support as well as preventive and curative health services, the centres enabled communities and individuals to address sensitive and controversial issues, such as gender-based violence. The success of the RHI project in mobilizing key individuals and social networks and communities in support of reproductive health

activities, demonstrated the potential for poor people to own and sustain reproductive health initiatives. An RHI project that worked in the slum communities in Nepal successfully created local sustainability.

Why this became successful

Participation was a key strategy for RHI in Nepal, It was instrumental in reaching groups that had previously not been able to receive reproductive health information and services. At the same time, active

involvement in projects proved an empowering experience for community members. The project organized various training programmes and exchange visits to build capacity among local partner organizations. An evaluation of capacity building efforts undertaken showed that the institutional capacity of the partners had been significantly strengthened. The levels of competence, confidence and motivation of the staff and volunteers were rated as remarkably high.

Extracted from: www.asia-initiative.org

EU/UNFPA Reproductive Health Initiative for
Youth In Asia

Best Practices: Publications

Learning from Partnerships: RHI 1998-2002

10. Promotion of Contraceptives through Depot Holders

Background and Rationale

Haryana is a small state in India with a population of 21.08 million (census, 2001). The birth rate in the State is higher as compared to the all India average (26.7 in Haryana, 25.4 for India-census 2001). This is despite the higher couple protection rate in the State than for India (CPR in Haryana is 53.3%) while it is 42.3% in India (1998-99). The consistent use rate of oral contraceptive pills (OCP) and condoms has been low in the State and there is stagnation in utilization of contraceptives.

There is a need to explore alternative approaches to popularize the adoption of contraceptives and their correct use. Safe sex behaviour through correct use of condom is one of the most effective methods for prevention of STDs and HIV/AIDS. Meta-analysis to study condom effectiveness indicates that consistent and correct use reduced HIV incidence by at least 80% and perhaps as much as 97% (Weller, S and Davis, K, 2002). Promotion and widespread use of good quality condoms can go a long way in controlling STDs and AIDS epidemic.

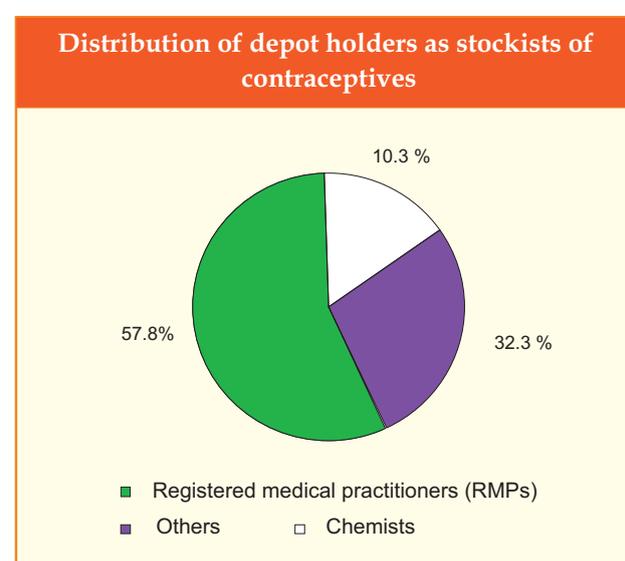
SWACH, an NGO in Panchkula, Haryana, has taken up the challenge to promote the distribution and sale of a variety of condoms and oral pills through the social marketing approach in four districts of Haryana state i.e. Ambala, Yamuna Nagar, Kurukshetra and Panchkula covering a population of 2.3 million. This is a programme sponsored by the Ministry of Health and Family Welfare, Govt of India which is implemented in collaboration with the State and district health authorities of Haryana and number of NGOs. Besides supervisory staff, there are 60 field workers who cover a population of 35,000-40,000 each. These field workers visit each village as per an agreed plan, meet key persons, identify and select depot holders for stocking the contraceptives, motivate the depot holders to continue to participate in the programme, and replenish stocks to the depot holders on a regular basis, organize meetings to generate demand and explain correct use. The supervisory staff provides training, educational material and supportive supervision. Under this social marketing programme, SWACH has established a network of 1976 depot holders in its project area. In addition, another 884 depots managed by women have also been established exclusively for the distribution of oral pills. In order to promote

condoms and oral pills in rural and slum areas, two innovative approaches i.e. social marketing of contraceptives and distribution of contraceptives through depot holders were adopted. This has been summarized, based on experience in the four districts.

Implementation

The traditional distribution system for condoms and oral pills by the government through the network of its health services is inadequate since it does not reach a large proportion of the population especially people at the lower end of the economy. Due to lack of privacy, un-married and married men who indulge in pre-marital and extra-marital sex respectively and are at higher risk of contracting STDs and HIV/AIDS do not avail of the government facilities. The availability of condoms and oral pills through commercial channels was inadequate in villages since these were available only in the shops in the townships or very large villages. The public considered these unaffordable. As a result, the use rate of condoms for safe sex or as a contraceptive has been low. Under the social marketing approach adopted in this project, contraceptives were sold at a subsidized price. Under social marketing, the stockist also gets a small incentive for selling the product. SWACH staff working in the project identified popular providers to act as depot holders and organized a system of regular supplies, providing information and monitoring for social marketing of condoms and Oral contraceptive pills (OCPs).

The depot holders are the stockists for condoms and oral pills in rural areas as well as in urban slums in the



four districts. They include local doctors popularly known as RMPs(57.8%), Karyana (grocery) shop owners(27.3%), chemists(10.3%) and others like panwala, cycle repair shop, tea stall, etc. which constitute only 4.9%. Since these depot holders are mostly males, women feel shy to procure OCPs from them. So, 884 depots exclusively for distribution of OCP, were established.

These depots are run by anganwari workers, anganwari helpers, dais (TBAs) prominent village women, etc. The depots are located within each large village with a population of more than 1000. Many small villages and hamlets with a population of less than 1000 do not have RMPs or grocery shops. Some depot holders who are chemists are located in the townships and are quite popular since their shops are often located on the roadside or near a bus stand.

Key informants at the village level i.e. sarpanch, panch, school teacher and members of “mahila swasth sangh”, or women health group were contacted and apprised of the programme by the senior staff of the project. They were asked to give their suggestions regarding a suitable place and person with whom contraceptives could be stocked so that people could freely avail themselves of the services whenever needed. They identified various people like the local doctor (RMP) Karyana (grocery) shop owner, chemist, etc. After consultations with the key informants, focus group discussions were held with men and women separately which helped build up consensus on the choice of depot holders. In every village, at least one depot holder was short-listed. They were motivated to make them realize the value service they are going to render to the community i.e. saving the life of people from HIV/AIDS and helping them to plan their family. They were informed that the project staff jointly with them would create awareness through publicity activities. It was also explained that people who come to them for medical care or for buying groceries are also likely to pick up condoms or OCPs. When people come to buy the condoms or OCPs they are likely to buy other products from them. This would help to boost their sale and increase their popularity. They were given the supplies without charging the cost. Once they sold the product, the cost was recovered. After they developed confidence, they started to give the money for the condoms and OCPs in advance.

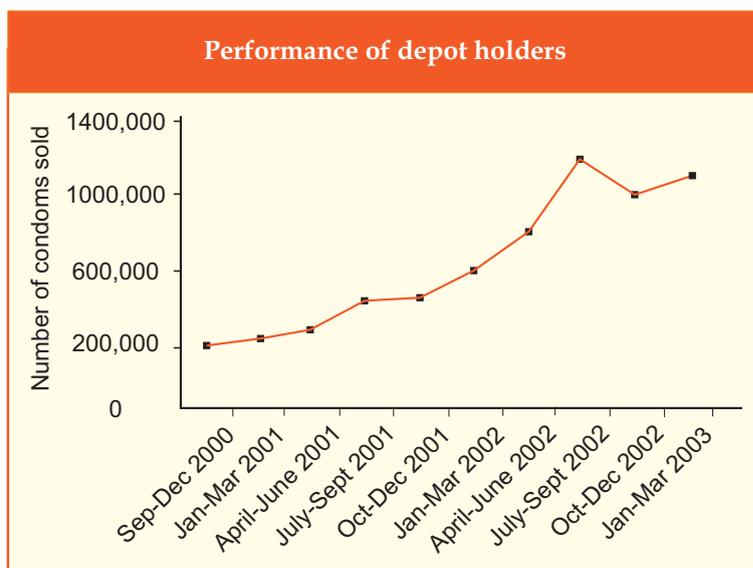
The depot holders participated in the village-level meetings conducted to increase

awareness and to emphasize the importance of condoms and OCPs. Some of the depot holders addressed the meetings since they were quite popular and were also interested in involving the villagers in the promotion campaign. The depot holders recognized that this is a good social cause and it would increase their credibility in the village. The depot holders are acceptable to the clients because of their easy availability and accessibility. People go and procure contraceptives in the pretext of going for advice and treatment of their illness or purchasing grocery items. The confidentiality is fully maintained. Five different forms are used to monitor the progress of the programme. Form 1 is kept with the depot holders. It contains information on the quantity of contraceptives supplied, sold, balance and re-supply. Field workers submit a report to SWACH on Form 2, containing depot holder-wise information regarding sale, supply and balance of contraceptives. This information is entered in the excel programme in the computer and monitored regularly in SWACH. The performance of depot holders who are not able to sell at least 100 pieces of condoms continuously for three months is noted down. This information is shared with the concerned field worker during review meeting, which is held twice a month. The field worker is asked to identify the problem and solve it. In such cases, IEC activities in the form of meetings were organized.

Results

At present there are 1976 depots holders who sell contraceptives. Out of a total of 1835 villages, the depot holders have been established in 1565 villages. Depots could not be established in 270 villages which are hamlets (having a population of 100-150) or where suitable depot holders could not be found. On an average there are 1.6 depots per village.





Getting inspired by the sale of condoms, SWACH launched the sale of OCPs in April 2001. During the period April 2001-March 2003, SWACH distributed 3, 47,980 cycles of OCPs and 3, 35,762 have been sold. The sale figure for one year (January to December, 2001) was analyzed to assess the performance of various categories of stockists. On an average, a chemist sells 695 pieces of condoms followed by RMP (435 pieces), Karyana (425 pieces) and others (256) every month.

Why this became successful

Provision of quality condoms and OCPs in every village from an acceptable provider lead to improve access and coverage.

Availability of supplies without interruption combined with regular ongoing community based interactions increased demand and acceptability by the people. The response has been successful because of wide community support, their role in designing and delivering change, and participation in changing the social environment.

During the period October 2000 - March 2003, 64, 56,287 pieces of condoms (Sawan, Nirodh Deluxe, and Milan) have been distributed. Out of a total supplied, 62, 24,270 pieces of condoms have been sold. There is an increase in the trend over the months except in the quarter July to September 2002, when the sale figure is higher.

P. N. Mohanty, Director.
 Survival for Women and Children Foundation (SWACH)
 Near Sanatan Dharam Mandir, Sector- 16,
 Panchkula, Haryana, India
 Phone: (0172) 2567770
 Fax : (0172) 2566805
 Email: swach@glide.net.in
 Web Site: www.swach.org

11. CHARCA (Coordinated HIV/AIDS Response through Capacity Building and Awareness)

Background and Rationale

India has an estimated 3.97 million people affected with HIV. Globally, young women and girls are 2.5 times more susceptible to HIV than men. Women constitute 21.4% of known AIDS cases in the country. Furthermore, many among those who have heard about HIV do not know how to avoid the infection. In view of the high vulnerability of young women to HIV/AIDS and the difficulty of reaching out to the masses with timely preventive information, an urgent need was felt for building intervention models that addressed women's empowerment, their rights and vulnerabilities in a more effective and expanded response. CHARCA evolved as an answer to this need.

Objective

CHARCA aims at empowering young women by addressing them within the context of their families, partners, immediate community and the society by providing information, and improving skills, to build leadership, increase support networks and create a positive, enabling environment. Through this process, it seeks to reduce HIV/AIDS and STI's among women and to empower them to protect themselves and realize their rights. Project activities will lead to:

- The adoption of improved health-seeking behaviour and positive gender perspectives.
- Skills and leadership, support networks and necessary enabling environments for women.
- Increased community capacity, recognition and response to young women.
- Community-based research, documentation and dissemination of information and best practices in India; and adoption of health-seeking behaviour.
- Increased advocacy, sharing of experiences and networking on issues of HIV/AIDS and women.
- Increased reproductive health services and information.

Implementation

In August 2000, project conceptualization began with consultations with district, state, national and bilateral players. Consensus on the need for CHARCA was defined, and the approaches/guiding principles were developed. Because district ownership, participation, and implementation were identified as

key to the projects success, a true "bottom-up" assessment of all six districts was undertaken. In September 2001, Bellary became the first pilot district where a district assessment and planning took place. Lessons were learned from the initial experience, and the other five districts underwent planning processes that were completed in December 2002. Within the UN system, the Technical Resource Team (TRT), made up of focal points from each Agency, supported project development and provided technical expertise from their respective agencies, throughout conceptualization, development and design. Multi-sectoral stakeholder workshops representing government (district, state and national), NGO, CBO's and the UN, were undertaken in preparation of the logical framework and project principles. Through a planning grant, CHARCA had undertaken systematic efforts in the planning and development phase to:

- Complete the District Situation Assessments (DSAs) and District Strategic Plans (DSPs).
- Draft an integrated inter-agency work plan for project implementation including yearly outputs.
- Determine UN Inter-agency management structures, administration, fund flow modalities and institutional arrangements, and reporting.
- Develop national, state and district structures for implementation and reporting.
- Develop financing mechanisms and flow of funds between various donors, UN, state and district level.
- Recruit project staff.
- Finalize the project document and budget as per the UNF/UNFIP project document format.

National/Government Commitment

The National AIDS Control Organization (NACO) is an important partner in the CHARCA project. NACO representatives are members of both the project management and technical committees. NACO and State AIDS Control Societies (SACS) have been involved in the identification of the project districts and project planning. The SACS have been closely involved in the development of district-level institutional arrangements and implementation modalities for CHARCA, which has underscored the need for such a project at district level. There are several government programmes which are linked with CHARCA activities: The Family health

awareness campaign (FHAC) is looking at reproductive health of women; Education Department at literacy rates and drop-out level of girls; women and child programmes; youth programmes, etc.

NGO and Civil Society Participation

CHARCA, in collaboration with the Government and NGO partners, works extensively with district-level NGO and CBO. This type of partnership is important for capacity building and for the long-term sustainability of the project. NGO selection at district level was based on criteria similar to the ones used for the District Situation Assessments (DSAs) / District Strategic Plans (DSPs). CHARCA, a joint UN programme designed to reduce the vulnerability of young women to HIV is being implemented in the districts of Bellary (Karnataka), Guntur (Andhra Pradesh), Udaipur (Rajasthan), Kanpur (Uttar Pradesh), Kishanganj (Bihar) and Aizawl (Mizoram). ILO, UNDP, UNESCO, UNFPA, UNICEF, UNIFEM, UNODC, WHO and UNAIDS are the UN agencies that have come together in varying capacities to accomplish the objectives of CHARCA.

UNICEF in Guntur and Kishanganj, UNDP in Bellary and Kanpur, UNODC in Aizawl and UNFPA in Udaipur are the lead agencies, while the rest play a supportive role. The UN agencies are implementing the project in partnership with the government departments, local district administration, NGOs and CBOs. The mainstay of CHARCA is its five pillar strategy; 1) Awareness creation, 2) Capacity building, 3) Improving services, 4) Building support structures and 5) Creating an enabling environment. The primary stakeholders are young women in the age group of 13-25 years in the CHARCA districts who are vulnerable because of poor access to resources which include information, education, economic independence and access to health and legal services.

The secondary stakeholders in the project are men, spouses, families, health providers, community and religious leaders, local organizations, media, politicians and policy makers who, at another level, are also the CHARCA outreach partners or stakeholders

Institutional Mechanism

Implemented by the UN system, CHARCA operates under the guidance of the CHARCA Management Committee (CMC). The joint planning process of the project was facilitated by the UNAIDS Secretariat and members of the CHARCA Taskforce.

Programme Activities

The framework of the overall strategy provides adequate scope for innovation and adaptation at district levels. The activities listed below are the direct result of the District Strategic Assessments and Plans

Planning and Initial start up

Needs Assessment, district-level baseline study (gender issues, beneficiary identification, vulnerability factors, violence, services availability and quality, information requirements, existing support groups & infrastructure), district-level planning and assessment with stakeholders, strategy development for 'Telling the Story' and intra-district sharing of case stories and best practices, monitoring and evaluation structures were put in place. For young women & men through: school AIDS education; peer education; out-of-school outreach; formal and informal workplace initiatives; general outreach; mass campaigns; Q&A sessions; group discussions; reaching women's groups and apex bodies where they exist. To increase awareness and build women's leadership.

CHARCA has used innovative and effective strategies for increasing awareness. Use of local folk media like kalajathas (in Udaipur and Guntur), puppetry (in Bellary), street theatre (in Kishanganj and Kanpur), role plays (in Guntur), and village meetings (in Udaipur and Guntur) have helped reach out to the general population. Some of these, for instance, Nama Halli (a two-day village level activity in which a combination of mass awareness methods are used), and Gram Sabha (an introductory meeting with the entire village), are often used as entry-point activities to build rapport with the villagers and to introduce the issue.

Onni sabhas (lane meetings) and meetings of neighbourhood leaders (in Bellary) are other innovative and effective strategies that ensure that the project is reaching out to every household in specific area.



Capacity Building and Skill Development

School-based training; group discussion; training workshops; demonstration; leadership skills; role plays; building and organizing community groups; women's groups; trade unions; worker's associations; and employers' rights help young women build their skills. The awareness, knowledge and information generated by CHARCA is used by the people to enhance their skills at different levels—at the level of peer educators, at the level of community groups, at the level of government functionaries, and at the level of the NGOs working with CHARCA.

Peer Educators - The first level of capacity building takes place with the peer educators who are recruited because of their personal experience with at-risk behaviour. They had their own experiences along the path of empowerment to share.

Districts	Volunteers sensitized	Health care providers trained in AFHS
Aizawl	644	50
Bellary	63,950	-
Guntur	273149	175
Kanpur	181785	650
Kishanganj	11608	-
Udaipur	21285	634
TOTAL	552421	1509

District	Male	Female	Total
Aizawl	-	182	182
Bellary	819	1753	2572
Guntur	1171	5972	7143
Kishanganj	150	139	289
Kanpur	225	266	491
Udaipur	1072	741	1813
TOTAL	3437	9053	12490

Table 3: No of HIV Positive Peer Educators in CHARCA

CHARCA Districts	Male	Female
Aizawl	0	18
Bellary	0	1
Guntur	6	6
Kanpur	2	6
Kishanganj	2	3
Udaipur	0	0
TOTAL	10	34

Community Groups & Women's Collectives: Community groups consisting of women are being used as ways to slowly incorporate normally taboo social topics into a public forum.

Anganwadi workers facilitate discussion on gender and HIV provide information and linkages to services to positive women on issues of nutrition, breastfeeding etc. Women's collectives serve as a forum and take action on issues related to gender, HIV and women's vulnerability

Government functionaries/Gram Sabha/ Panchayat/Urban local bodies: Public forums for advocacy and action help to reduce women's vulnerabilities, stigma and discrimination, promote community-based care and support and provide linkages to services. A vast cadre of trained government functionaries forms the backbone of the CHARCA project. Mandal Level Trainers, who in turn have trained Village Resource Persons (VRP) and Preraks are the grass-roots level functionaries who carry the messages of CHARCA to their existing target groups. Government departments have identified a nodal officer who is responsible for the HIV/AIDS programme in their department.

NGOs Groups: The project is being implemented by NGO partners who bring rich and varied experience



and have an important role in CHARCA. Working on HIV/AIDS with a gender perspective in a general population is a capacity and skill that the NGO functionaries have acquired through their association with CHARCA. Since most of the NGOs are currently implementing targeted intervention programmes supported by SACS, CHARCA adds a new dimension to their programme and to their understanding of the issue of working with the general population and working with a gender perspective.

Improving access and quality of services: Voluntary Counselling and Testing (VCT) and improved SRH Services through Adolescent Friendly Health Services (AFHS), support networks for affected people, SRH services for migrant populations, awareness workshops for women on what services they are entitled to, advocacy workshops to highlight quality of services and women's perceptions; setting up feedback mechanisms which respond to young women's needs; strengthening existing sexual health services, including STD services for men are taken up.

Building support structures: Identify and strengthen existing women's groups and apex bodies. Promoting and setting up new groups (where they do not exist), capacity building exercises such as training, exposure visits for women; setting up interaction fora and strengthening them; promoting youth leaders and youth agenda. Establishment of Women Information Centres (WICs), Sandarbh Kendras, Soochana Kendras etc. is a positive development that contributes towards enabling women to gather and discuss issues on matters that affect them.

Strengthening existing networks of HIV-positive persons and involving them in project planning as resource persons, and as PEs is one way of involving the positive persons and ensuring that the networks of these people carry forward the CHARCA agenda beyond the project period

Creating an Enabling Environment: For Advocacy and awareness raising activities at district and national levels. Workshops, training, information dissemination and regular interaction with police to create space within their own setting where women's issues can be addressed; legal system representatives to create awareness on the rights of women and to facilitate redressal of their problems; employers; trade unions; media and religious leaders, case studies of young women who have solved their issues through support networks.

Media articles that create awareness and sensitive

reporting of HIV and women' related issues; outreach to leaders and policy makers. Bringing together institutions for the benefit of young women, facilitating the formation of support groups for women affected by HIV/AIDS and for discussion for men, especially adolescents.

Results

Two years into its implementation, CHARCA, a joint UN project addressing difficult issues such as gender, women's rights, violence and social norms to reduce women's vulnerabilities to HIV/AIDS has been able to create awareness, visibility and dialogue at every level—among community members, line departments of the governments, NGO partners, outreach workers within the project and various government services, even if the depth and intensity of this dialogue varies considerably between the six CHARCA districts.

One of the most significant outcomes of CHARCA has been its ability to prioritize women's vulnerability within HIV/AIDS programmatically. The project has been able to promote effective networking, establish positive partnerships, organize information sharing to strengthen existing interventions, promote best practices to encourage replication across districts under the guidance and support of the State AIDS Control Societies and the district administrations. Joint UN programming has enabled to reinforce and supplement technical expertise of different agencies at the field level.

As the project progresses into its third year of implementation, it has been successful in taking the message beyond the four modes of transmission to include linking HIV/AIDS to RTI/STD, violence against women, and the practice of early marriage. There has been an increase in the number of men and women coming forward and asking for more condoms. Increased awareness has led to clear behavioural changes like demanding the use of fresh/disposable syringes from the health delivery system. The project has helped reduce stigma and discrimination and among the most significant sustainable outcomes has been the establishment of over 100 Women Information Centre, where women gather and discuss what they feel which they can't in the public domain, and the recruitment and capacity building of an army of 12490 energetic peer educators.

Why this became successful

Strengthening existing networks of HIV positive persons and involving them in CHARCA either as peer educators, outreach workers, or resource persons has

given them a platform to voice their opinions. Working with community elders, religious leaders, PRI functionaries, and the media are some examples of the project to have discerned the major influencing forces within the community, sensitizing them on the CHARCA issues and successfully getting them onboard to discuss and carry forward the CHARCA agenda.

Several challenges, constraints and gaps have been identified in addition to the good work being done and these will feed into strategizing the project for the remaining period. These challenges however should not outweigh the several good practices and lessons that have emerged. Awareness is being raised,

skills are being learned and lasting structures are being created that will, hopefully, continue long past the existence of CHARCA.



Debbie Paul,
Programme Officer,
CHARCA,
UNAIDS,
A2/35, Safdarjung Enclave,
New Delhi 110029
www.youand aids.org/charca

12. The Power of Youth: TANSACS Red Ribbon Clubs

Background and Rationale

Red as a sign of warning is particularly relevant in the context of impressionable youth. At an age when sex is an adventure, an exploration of intrinsic desire, the thought of danger is far, far away. Yet, it is this group, defined by curiosity and boldness that is extremely vulnerable to AIDS. Youth is a nation's future. They are the trend setters, the leading lights of every home and therefore very influential. Target them and you target the nation. The Red Ribbon Club (RRC) is a voluntary on-campus intervention programme for students in colleges and universities in Tamil Nadu. The first RRC was formed in Periyar University, Salem, in June 2005. It has since acquired a momentum that will be a huge resource in Tamil Nadu's and India's fight against AIDS. The programme aims at harnessing the potential of educated youth and helps them to be the educators among their peers in the entire campus and the community at large. The target is to have every college in Tamil Nadu form an RRC club voluntarily, reaching more than 75,00,000 college students.

Objective

RRC's activities are aimed towards five specific targets.

- Opening up a discussion or sexual behaviour change among youth.
- Identifying youth in the high- risk category on campus and transform their behaviour.
- Increasing the perception of risky activities in the youth.
- Creating of peer educators.
- Reaching out to non-RRC youth, non-collegiate youth and the general public.

Implementation

The ideation and administration of the programme are done by the Tamil Nadu State AIDS Control Society (TANSACS) and the Centres for Disease Control and Prevention, USA (CDC). A state RRC coordinator supervises the programme in all its aspects. The core team is made up of five regional managers, each in charge of five to six districts in Tamil Nadu, depending on the concentration of colleges. They, in turn, send out 24 field officers who directly interact with the colleges. From the college, an internal programme officer, usually a professor in charge of National Service Scheme (NSS) becomes the RRC officer. This officer guides the students in all activities of the club. The most important aspect of RRC is that it is voluntary. The RRC is a forum for



students to learn and discuss issues relating to sex and sexuality.

The atmosphere and the activities are kept extremely informal and warm. This means while some level of training is given to representatives of professors and students of the college, each college is encouraged to work on its own ideas and activities that will carry the message across to fellow-students and to the community.



For RRC members almost all work is play! They interact within as well as outside their campus. The programmes include exposure visits, awareness campaigns, public meetings, intra and inter-university competitions, cultural programmes, (folk art, street plays, etc.), debates, workshops, seminars, exhibitions, rallies, road shows, use of local cables (talk shows, phone-ins etc.), news letters and, of course, training on leadership and communication skills.

The RRC members are encouraged to develop various information materials like CDs, poster messages, Video on Wheels, wall paintings, radio jingles and identify and use any other media vehicle they may find appropriate giving vent to individual thinking and creativity.

Every idea mooted by an RRC group that TANSACS



find meritorious is supported financially for execution. It could be a cycle rally or an educational bike tour across Tamil Nadu. Co-operation and joint efforts amongst NGOs is also encouraged for cross pollination of ideas and greater reach.

The entire efforts now are geared towards linking the students with NGOs (who will be the knowledge resource). Finally, corporates are involved to raise funds to give the activities inspired coverage, that will, in turn, keep motivation levels high.

RRC is envisaged as a space for the students for the following:

- To develop natural, healthy and clean attitudes on relationships between the sexes.
- To enable them to discuss sex and sexuality, calmly and without shame or shyness.
- To enable them, especially the female students, to identify and understand situations of exploitation and abuse.
- To educate them with correct, concise and adequate information and heighten their level of awareness about STI/HIV/AIDS.
- To make them understand about the need for care and support for affected persons and instill in them the spirit to help and support people living with HIV/AIDS.
- To create counseling and supportive channels in each institution and help solve problems relating to sex, sexuality, STI/HIV/AIDS.
- To train the students to network with governmental and non-governmental agencies and community

based organizations to develop a safer and responsible life style.



Rs 70 lakhs has been released so far for formation of clubs in colleges. Apart from this, TANSACS, with help from the Centre for Disease Control and prevention (CDC) supports the personnel who work for the effective implementation of the programme.

Results

The rate at which the programme is gaining ground and the high level of motivated involvement of the entire team it guarantees a movement that will probably be a landmark in the global efforts to prevent AIDS. Significantly, in the early stages of the campaign, there is a marked involvement and participation from economically backward students. A fallout of the programme is that students gain organizational and networking skills which will be a great strength in any career they choose to pursue. Besides, of course, gaining much needed knowledge on health-related issues, sex and sexual behaviour and the impact of HIV/AIDS.

Why this became successful

The programme gives youth freedom to choose their path, because youth cannot be commanded. The programme is basically dynamic and individualistic. It allows each college to discover their own means to pass on the message. Naturally then, the role of regional managers and field officers is critical as they have to keep motivation in top gear and foster a high level of participation and creativity. They have to keep the programme on track and give it good momentum. The entire programme hinges on the drive of the team and the sense of responsibility that it helps create amongst the participants.

Dr. P.Kuganatham,
 Programme Officer(ICTC)
 SMO-CD
 Tamil Nadu State AIDS Control Society,
 Chennai-8

13. HIV/AIDS Prevention and Care project (IHPCP) For Young IDUs

Background and Rationale

The first case of AIDS in Indonesia was recorded in 1987 and the prevalence increased dramatically by the end of the 1990s. By 2002, the government estimated that there were between 90,000 and 130,000 people living with HIV/AIDS, of a total population of more than 210 million. The percentage of age groups of adolescents (10-19 years), youth (15-24 years) and young people (10-24 years) are: 20%, 18.4%, and 28.9% respectively (IDHS 2002-2003)

Up to the mid-1990s the main mode of HIV transmission was sexual intercourse but it slowly shifted to IDUs (Injecting Drug Users) transmission. Indonesia is now classified as a country with a concentrated epidemic, primarily among its injecting drug users.

The highest cumulative number of AIDS cases up to 31 March 2006 by age among the young productive age group (20-29 years, 54.27%), indicate that the infection could have started during the adolescent years.

In recent years, the mode of transmission by IDUs has increased significantly, the highest age brackets of IDUs transmission is among the 20-29 age group (71.33%). For this reason, prevention and care of HIV infection among young people remains a key component of the effective response to HIV/AIDS in Indonesia. Furthermore IDUs are the main contributors to HIV transmission, and are mostly young people.

HIV/AIDS prevention efforts in the mid 1980s began with the formation of a Commission on AIDS at the central level through a Presidential Decree issued in 1994. By the end of 2004, Provincial AIDS Commissions had been set up in many of the country's provinces and districts, particularly in the six provinces with the greatest number of people at risk: Jakarta, Bali, Papua, Riau, West Java and East Java.

At present, to fulfil the needs of basic health care, there are more than 7000 health Centres but only around 100 have youth-friendly services. In addition, there are many non governmental clinics and health centres. There are four grades of public hospitals. Grade A and B hospitals and many private hospitals have skills and ability to take care of people living with HIV/AIDS and are equipped with laboratories to support prevention and care of HIV/AIDS persons and surveillance activities.

With the current HIV/AIDS situation and conditions related to young people in Indonesia, Harm Reduction is an appropriate programme to reduce HIV/AIDS transmission. A good example of partnership in harm reduction program is the Indonesia HIV/AIDS Prevention and Care project (IHPCP), a partnership between the Government of Indonesia and the Government of Australia. IHPCP aims to maximize the use of its resources by collaborating and coordinating with other bilateral, multilateral and international NGOs. The ways in which IHPCP provides support to its partners include technical assistance, capacity building, and partner grants.

IHPCP's national counterpart is the Office of the Coordinating Minister for People's Welfare, where the National AIDS Commission is located. This office works closely with the Governors' Offices and the Provincial AIDS Commissions in the provinces where IHPCP is implemented. IHPCP currently works in six provinces: Bali, South Sulawesi, East Nusa Tenggara, DKI Jakarta, West Java and Papua. IHPCP also coordinates and collaborates closely with other donor organizations and programme including the USAID-funded Aksi Stop Aids (ASA) Programme, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the



World Health Organization (WHO) and the United Nations Development Programme (UNDP).

Objective

To support the efforts of the Indonesian Government and civil society to control the spread and impact of HIV/AIDS, including activities aimed at reducing new infection through sexual transmission and injecting drug use, enhancing access to quality care, support and treatment services.

Implementation

The core of the harm reduction activities are Needle and Syringe programme, Oral Substitution Therapy and HIV/STIs prevention, detection and management. Harm reduction activities link with three other programmes Policy Development and Planning; Reducing Sexual Transmission of HIV; Care, Support and Treatment.

In the service sites, close partnership and collaboration between NGOs (youth centres) and government institutions (health centres) is a fundamental principle. This is based on the fact that: (1) youth-friendly services have already been established by some NGOs (e.g. PKBI/IPPA, and Pelita Ilmu Foundation) (2) Outreach is easier by NGOs with their field workers, especially to locate IDUs (3) Voluntary counselling and testing (VCT) is provided in NGO's centres (4) Condoms for adolescents are available at NGO centres. NGOs should be in the front line. They screen the target in community, providing a package and refer to health centres as needed. The health Centres cover clinical aspects such as oral substitution therapy for drug abuse and STIs management.

In this project, this NGO is working with health centres and hospitals for HIV/AIDS prevention and care through harm reduction. Its activities includes peer education, basic health care, comprehensive health care, oral substitution therapy, rehabilitation service

for drug users, IEC, access and assistance, counselling and harm reduction, VCT, prevention of infection, needle exchange programme and the clean up the used syringes/needles programme

Results

The project has achieved the following:

- Increased awareness about HIV/AIDS among IDUs and the community.
- Brought back ex-IDUs to their community after improving their quality of life.
- the number of IDUs has been reduced.
- New cases of HIV transmission through IDUs has been suppressed.
- Condom use for prevention of STI/HIV infection has been increased.
- Sustainable local government support (budget plus policy) for HIV/AIDS prevention, care, and treatment of IDUs in community.
- Increased accessibility of health services for IDUs.
- Early detection and care of STIs/HIV infection among young IDUs.
- Proper oral substitution therapy for IDUs

Why this became successful

Local government and community commitment on prevention and care of IDUs, flexible approach to planning support for local activities to ensure that the scale and type of programming is matched to the needs of local young people played a key role in the success of the project. Partnership at all levels of administration and implementation, collaboration, clear responsibility and role of each party, youth-friendly services and comprehensive capacity building (providers, communities, NGOs, private sector) were some of the other important factors that contributed to its success.

Dr. Enny Setiasih,

Bina Mulia I, Floor 9. Jl. HR. Rasuna Said Kav.

10-11 Kuningan Jakarta 12950

Phone: (62-21) 520 4349

Fax: (62-21) 520 1164

Email: who@who.or.id



III. Lessons Learnt

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The case studies presented here illustrate innovative approaches on HIV/AIDS among young people in South-East Asia. These approaches indicate potential for operationalising interventions by the health sector in co-ordination with other sectors. Some of these experiences can be scaled up with monitoring of quality and coverage of health services.

1. Advocacy

The support of the health ministry and other officials and policy makers is critical for the success of HIV prevention programme for young people. Without the understanding and support of these officials it would be impossible for these programmes to be planned and implemented. Youth Convention was an effective way of creating awareness and sensitizing people on issues relating to HIV/AIDS among young people. It played an important role in bringing together elective representatives, UN leaders, ministers and student leaders on a common platform. This Youth Parliament is highly commendable as it is aiming at training young people to be ambassadors in the fight against HIV/AIDS.

2. Successful responses to the epidemic have their roots in the community

The involvement of the community has been key to the success of the projects in reaching young people. Community members such as parents, teachers, and religious leaders have been crucial in reaching adolescents in creating an enabling environment in models like the University talk AIDS programme in India and the Thai women of tomorrow programme in Thailand. The RHI project in Nepal created local sustainability by working in communities. Training of service providers, making improvements to facilities, informing and mobilizing communities generates demand and community support.

3. Involving young people

The active involvement of young people in planning implementation and evaluation ensure relevance of programme activities to the real needs of young people, commitment to programme objectives and significantly contributes to the development of those young people who are actively involved. “Chatting with my best friend”, has proven to be an effective in meeting young people’s need for emotional support and guidance about critical life choices.

4. Peer education

Peer-to-peer education, often coupled with a life skills approach, has proven to be an important component of effective HIV/AIDS prevention interventions. By utilizing peer-to-peer education as well as partnerships between adults and youth, more creative and effective programme can be implemented.

Peer-to-peer education is important for special target groups such as IDUs, sex workers, and their clients as well as MSM. Peer-to-peer education may be useful especially where adult-adolescent communication on sexual health issues is a taboo or is limited. The ‘Humsafar’ youth project validates that young people are capable of reducing their risk of HIV infection, through behaviour change. Peer education was an important component for this change as well as access to condoms and drug treatment facilities. UNFPA-supported RHI projects has involved young people in developing training modules, training, counselling and setting up rural and urban youth information centres. These activities have contributed towards building the capacity of organizations working with young people. Universities and schools have the potential to provide an excellent base for a large scale programme and high coverage of young people in countries. They can play a role in addressing issues in communities and help forge links with the families of young people and strengthen the capabilities of families to help young people.

5. School and Educational Institutions

The Universities Talk AIDS (UTA) and Red Ribbon Club programme in India was able to reach out to a large number of young people and promoted the development of positive attitude and skills in them. Evidence suggests that open and frank discussions on sex and sexual health at an early age delays the onset of sexual activity and encourages the adoption of responsible and safer sexual practices as well as consistent and correct use of condoms.

Support should also be provided for out-of-school youth and youth in difficult circumstances to empower them and to link reproductive health and HIV prevention with livelihood opportunities, skill building and vocational training. ‘Sema Life development project’ and ‘Thai women of tomorrow’ have been able to provide girls with alternatives to sex work with scholarships and short training courses. The girls now

took leadership roles and could address sensitive issues. There was a change in family and societal attitude after the girls gained employment through the project and pressure on them to marry decreased.

6. Media

The mass media is a powerful force with a large number of households now having access to radio and /or TV. Radio and television can be used to broadcast information designed to influence social norms and attitudes about adolescent health topics. It can provide great potential to communicate and mobilize community support on selected adolescent health issues and influence these attitudes and opinions to help modify social norms and promote healthy behaviours. The 'Balbir Pasha' campaign in India sought to dispel HIV/AIDS myths, increased risk perception, generated discussions and motivated people to access HIV/AIDS hotlines and voluntary counselling and VCT services. The programme showcases an advertisement campaign with 'Balbir Pasha' which youth and urban men could relate to, learn from and empathize with.

7. Access to services, testing and treatment

Knowledge alone is not effective until it is accompanied by adoption of healthy practices and access to supplies and services to make a difference. Programmes that stimulate demand must ensure that his demand can be met. Hamsafar center was a useful approach to reach young MSM. The facility was equipped with condoms and basics as bottles of filter water as many did not have access to safe drinking water.

Survival for Women And Children Foundation (SWACH) used an innovative approach of social marketing to promote the distribution and sale of a variety of condoms and oral pills in four districts of Haryana .It was backed by knowledge regarding the corrective use and utility of the condom. Popular providers were identified to act as depot holders and organize a system of regular supplies, providing information and monitoring for social marketing of condoms and OCPs.This resulted in increased awareness of safe sex and condoms use.

8. Involving men in reproductive health issues

Experience from the RHI suggests that where men are targeted and involved in services, their wives and

partners feel more secure, confident and comfortable in using services. Psychosexual counselling enhances confidence and satisfaction of both men and women. Providing specialist services, including counselling for men is one of the innovations of the RHI. However, extra and consistent efforts are needed to engage men in reproductive health issues and attract them into clinics, participating in radio programmes, newsletters etc. However, long-term commitment is needed in order to break down the perception that family planning and reproductive health are women's business only. The gender differences that characterize social and economic life heighten young women's vulnerability to negative health consequences. Programmes must be gender sensitive so as to ensure that the needs of girls and boys are addressed with a view to empower girls.

9. Empowering young women

The reproductive health and life skills training provided to young women under RHI in Nepal had a broad impact on the lives of young people. The girls gained knowledge, skills and confidence, and approached preventive health services when they had health problems. Moreover as a result of the programme more than 1000 young women enrolled in formal education and 55 adolescent girls groups were convened for reproductive health activities to enrol in non-formal education. Increased confidence was also demonstrated when the group members played a vocal role in advocacy for their needs and rights.

Another unique programme that is making a difference in the lives of young people is the 'Adolescent Peer organized Network (APON)' in Bangladesh. The most innovative feature of this network is the involvement of adolescent girls in the design and implementation of the programme. A critical impact of the programme is that young girls are questioning early marriage, and expressing their desire for higher education. Moreover, adolescent girls themselves became the change agents in the process of empowerment, which helped to protect them from the threat of HIV/AIDS and other STIs.

10. Adolescents are empowered by enjoyable activities

Initially, young people may be shy or hesitant about getting involved in the HIV/AIDS and reproductive health activities. However, projects like 'Chatting with Best Friends', 'BRAC's Adolescent Peer Organized Network' and 'Humsafar Trust' have provided young

people with a comfortable venue like resource centres, clubs, reading centres, libraries and have won the support of their parents and peers. These centres gave young people a place to socialize and organize their own activities as well as provided access to reproductive health information and services. Some centres also organised training sessions for income generation and community work. These opportunities increase young people's confidence and enable them to develop new skills.

11. NGOs can work effectively as a team with the government

Successful projects have demonstrated that all NGOs can provide critical support to AIDS control programmes for young people, because they are people-oriented and more sensitive to their needs. They can raise awareness among parents, groups and communities about HIV/AIDS prevention, care and treatment and become effective partners in national response and participate fully in planning, implementation and evaluation of programmes for young people.



IV. WHO Strategy for HIV in Young People

WHO Strategy for HIV in young people

WHO is working to strengthen and accelerate country-level health sector action in relation to young people and HIV/AIDS, and thereby enable a range of actors to maximize their contributions to an expanded response for achieving the global goals. The strategy for prevention treatment and care of HIV/AIDS among young people encompasses the following “4 S” .

- **Strategic Information** : strengthening capacity in countries to collect, analyze and disseminate data necessary for programmes, policies and advocacy focusing on HIV and related domains (sexual and reproductive health, alcohol/drugs, violence) through biological, behavioral, determinant and programmatic indicators.

- **Services and supplies**: Increasing young people’s access to information and counseling about HIV/AIDS, reducing risk through condoms and harm reduction in injecting drug users, providing early diagnosis (testing) and treatment/care for STIs and HIV/AIDS through trained service providers working in a variety of settings in a strengthened health system, with the involvement of young people and the engagement of the community and including a focus on all young people, particularly vulnerable groups and settings.

- **Supportive policy environment**: ensuring that the health sector is able to provide the evidence base and example 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.

- **Strengthening action in other sectors**: mobilizing and supporting other sectors to contribute to HIV prevention and care. These include- Education (school health services, information about the availability of services); NGOs/CBOs (reaching vulnerable groups at high risk of HIV/AIDS); Youth (service provision, information and mobilization); Criminal justice (reaching vulnerable groups at high risk of HIV/AIDS); Media (information about the need for and availability of services) and Labour (work place interventions and information).

Addressing needs of young people: Progress so far

To develop linkages between HIV/AIDS and adolescent sexual reproductive health programmes WHO/SEARO organized a Regional consultation on HIV/AIDS among young people, in Chiang Mai, Thailand, in October 2005. Programme Managers from HIV/AIDS and Adolescent health and development agreed on development of a common framework for implementing activities at country level and reviewed and provided feed back on Draft Regional Strategy on HIV and Young People.

Technical assistance was provided to Bangladesh in developing national Standards for Youth friendly health services (YFHS) as a part of programme on HIV/AIDS among young people funded by GFATM. Technical assistance was also provided to Sri Lanka in developing national Standards for youth friendly health services. In India the Adolescent Reproductive and Sexual Health (ARSH) strategy under RCH-II has been accepted. National standards, adaptation of packages for Medical officers and health care workers and implementation guidelines have been finalized in collaboration with Ministry of Health and Family Welfare, WHO and UNFPA. Implementation guidelines and training packages have been finalized and disseminated to all the states.

Under Strategic Partnership Project (SPP) supported by UNFPA, a meeting of UN regional focal persons from South Asia was organized to agree on a joint framework for action at regional and country level. South Asia, UN inter-Agency task team (UN-IATT) on health sector response to HIV/AIDS for Young people was formed in August 2005. This was followed by a capacity building meeting of UN country teams and experts in March 2006 to strengthen consensus between UN partners in the SPP focus countries about priorities for health sector action for the prevention and care of HIV/AIDS among young people. Guidelines for UN country team (UNCT) for joint country level action are being finalised in collaboration with UNICEF and UNFPA. Under the strategic partnership project (SPP), a compendium of institutions working on HIV/AIDS among young people and ASRH in four focus countries (Bangladesh, India, Nepal and Sri Lanka) was completed.

Fact sheets, HIV/AIDS among young people and Adolescent Health in all eleven countries have been developed. Advocacy booklet is also being finalized. Recognizing the vital role of prevention, documentation of innovative approaches in relation to HIV and young people and Adolescent sexual and reproductive health (ASRH) issues the present document "Young people and HIV/AIDS, Responding to unmet needs through innovative approaches" has been compiled.

Increasing access to health services for young people is one of the UNGASS goals for HIV prevention. To take forward this objective it is therefore necessary to measure the coverage of health services for young people at the global, national and sub-national levels. To meet the needs of global monitoring for achievement of the UNGASS goals, WHO has developed tool for assessing coverage of health services for HIV prevention for young people based on indicators agreed at an international technical consultation that was organized in Geneva in April 2006.

In order to understand the existing laws and policies affecting young people access to health services and to strengthen the evidence base for policies and programmes consultation was held with partners International Paediatrics Association (IPA) International Planned Parenthood Federation (IPPF), International Association for Adolescent Health (IAAH) on issues relating to consent and confidentiality in July 2006.

Meeting identified strengths and weaknesses with current policies and practices and identified priorities for action. WHO is in the process of developing guidance for service providers and mid level managers to assist them to respond more effectively to the specific needs of adolescents in relation to consent and confidentiality.

To build the capacity of program managers in South Asia region WHO has supported development of regional training course on programming for HIV/AIDS and Reproductive health of young people in joint collaboration with UNFPA. The pilot course was conducted by Institute of health management research (IHMR) Jaipur, India. It is proposed to identify national institutions in other member countries to implement the distinct programme manager's course.

To review the progress and to look at the evidence for effectiveness of interventions to prevent the spread of HIV among young people, WHO in collaboration with UNAIDS Inter-agency Task team on Young People, UNFPA and UNICEF have published a joint technical report series on preventing HIV/AIDS in young people, a systematic review of the evidence from developing countries. The report provides systematic reviews of the evidence for policies and programmes to decrease HIV prevalence among young people, as a contribution towards achieving universal access to prevention, treatment and care and attaining the global targets set by the world leaders.

References

1. WHO, Regional office for south-East Asia: HIV/AIDS in the South-East Asia Region March 2007.
2. Puri, M. (2001): "Sexual risk behavior and risk perception of unwanted pregnancies and sexually transmitted diseases among young factory workers in Nepal", CREHPA, Kathmandu)
3. Bureau of Epidemiology, Department of Communicable Disease Control, Ministry of Public Health, Report on the HIV/AIDS Situation in Thailand, 2004
4. Second Generation Surveillance 2003, MOH, Myanmar
5. UNFPA, Making one billion count, investing in adolescents health and rights, State of world population 2003.
6. United Nations ESCAP, June 2006, Socio-Economic Policy Brief, Issue No.5
7. National AIDS and STD Control Centre, Kathmandu. 2001
8. Steinfatt T. Working at the bars: sex work and health communication in Thailand. New Haven, CT, Greenwood, 2002.
9. Family Health Division (FHD), MOHP 'Adolescent Health and Development in Nepal- A Country Profile 2005'
10. HIV Sentinel Surveillance (HSS), NAP, Department of Health, 2004.
11. HIV/AIDS/STI intervention among MSM, An Experience from ODPUP. HIV/AIDS and STD Alliance Bangladesh, December 2003
12. WHO, Technical Report Series 938: Preventing HIV/AIDS in young people; A systematic review of the evidence from developing countries, UNAIDS Inter-agency Task Team on young people, UNAIDS, UNFPA, UNICEF and WHO 2006.

