

Summary

Booklet

of

Best

Practices

Table of Contents

Introduction: Best practices and HIV/AIDS	5
What is meant by “best practice”?	5
Why document best practice?	6
Where do best practices come from?	6
Using the summary booklet	7
We welcome your proposals	7
Access to HIV/AIDS-related drugs	11
National Medicine Fund for High Social Impact Diseases (Colombia)	13
Antiretroviral therapy	17
Online Conference on ARV Treatment in Developing Countries (International)	19
Netherlands–Australia–Thailand HIV Research Collaboration (Thailand)	22
Children and young people	27
Field Experiment: The Better You Know Yourself, the Better You Are Protected (Belgium)	29
Women/Life Collective (Brazil)	32
Yunnan/Australian Red Cross Youth Peer Education for HIV/AIDS Prevention Project (People’s Republic of China)	35
Peer Educators for Young People (Denmark)	38
Save Your Generation Association (Ethiopia)	40
Umbrella Project (Germany)	42
Asian Red Cross/Red Crescent Youth Peer Education Programme (International)	44
Mathare Youth Sports Association (Kenya)	46
Red Cross Youth Peer Education Programme (Myanmar)	48
Sexplain: Peer Education on Sexual Health for Young People (Netherlands)	50
Sema Life Development Project (Thailand)	53
Youth Career Development Programme (Thailand)	55
National Strategies to Reduce Vulnerability of Thai Girls (Thailand)	57
Thai Youth AIDS Prevention Project (Thailand)	59
Thai Women of Tomorrow Project (Thailand)	61
Education Loan Fund Project (Thailand)	64
HIV Prevention in First Year of Secondary School (USA)	67
Wan Smolbag Theatre: Popular Theatre for Health Education (Vanuatu)	69

Communications programming	73
The Red Ribbon of Solidarity (Japan)	75
Safe Sex, My Choice (Russian Federation)	77
Community mobilization	79
Project Hope (Brazil).....	81
Diocese of Kitui HIV/AIDS Programme (Kenya).....	84
Drug User Project, Ikhlas Community Centre, Pink Triangle (Malaysia).....	87
National Meetings for People Living with HIV/AIDS (Poland)	91
Tateni Home Care Services (South Africa)	94
Sanpatong Family Care Project (Thailand)	98
Chirumhanzu Home-Based Care Project (Zimbabwe)	102
Counselling and voluntary counselling and testing	105
Effects of HIV Counselling on Sexual Behaviour of Men Attending STD Clinics (India).....	107
Demetra Social Diseases Consultation Centre (Lithuania).....	109
Wandzin: A Village for People Living with HIV/AIDS (Poland).....	111
Health system personnel and training	115
Integrated Pilot Project for Prevention of STDs and HIV/AIDS among Rio's Low-Income Population (Brazil).....	117
Health Promotion in Action (Canada).....	120
Support to Antenatal Clinics (Uganda).....	122
Human rights, ethics, and law	125
The Canadian HIV/AIDS Legal Network (Canada).....	126
Republic of the Philippines AIDS Prevention and Control Law (Philippines).....	128
Injecting drug use	131
National Action Plan on HIV/AIDS and Injection Drug Use (Canada).....	133
HIV/AIDS Prevention among IDUs (Ukraine)	136
Male condom	139
It Takes Two: Pill and Condom (Canada)	140
Men who have sex with men	143
MSM Outreach Programme (Hong Kong)	144
Project MSM (Switzerland).....	147
Mother-to-child transmission	149
Short-Course ZDV to Prevent Mother-to-Child HIV Transmission during Routine Health Care (Thailand)	151

National strategic planning	155
National Consultation to Renew Canada's Strategy for HIV/AIDS (Canada)	156
Prisons.....	159
Sustainable HIV/AIDS Prevention Activities in Prisons (Ukraine).....	161
Religion.....	163
Madarasa AIDS Education and Prevention Project (Uganda).....	164
Community Action for AIDS Prevention (Uganda)	166
Family AIDS Education and Prevention through Imams Project (Uganda)	167
AIDS Education through Imams (Uganda)	171
School-based interventions and services	173
Skills for Healthy Relationships (Canada).....	174
Intersectoral STD and HIV/AIDS Prevention through Training of Secondary School Leaders (Colombia)	177
Sex workers.....	181
Study in Social Organizations of Three Illegal “Red Light” Districts (People’s Republic of China)	183
Wanchai Night Club Outreach Programme (Hong Kong)	186
TADA: Prevention of HIV and STDs among Sex Workers (Poland)	189
Sexually transmitted diseases	193
Training and Promoting Syndromic Management of Sexually Transmitted Diseases (Philippines)	194
Surveillance and reporting (epidemiology)	197
Data Collection and Analysis (Uganda)	199
Vaccines	203
Thailand's National Plan for HIV/AIDS Vaccine Development (Thailand)	204
Workplace.....	207
Raising HIV/AIDS Awareness among UN Employees and Their Families (Azerbaijan).....	209
PHILACOR Corporation: Private Sector HIV/AIDS Response (Philippines)	211
ANNEX 1: Making a proposal for the Summary Booklet	213
INDEX.....	217

Introduction: Best practices and HIV/AIDS

One of UNAIDS' main tasks is to identify practices around the world that work in responding to the HIV/AIDS epidemic, and to examine how and why they work. Once these practices are identified, UNAIDS and its cosponsors promote the sharing of these practices, including through such means as documentation and widespread distribution of the lessons learned. This summary booklet is part of that effort.

What is meant by "best practice"?

The concept of best practice is not reserved only for "ultimate truths" or "gold standards." For UNAIDS, best practice means accumulating and applying knowledge about what is working and not working in different situations and contexts. In other words, it is both the lessons learned *and* the continuing process of learning, feedback, reflection and analysis (what works, how and why, etc.)

At its most basic, best practice suggests a simple maxim: *Don't reinvent the wheel: learn in order to improve it, and adapt it to your terrain to make it work better.*

The process of best practice is manifested in three ways:

- ◆ exchange of experience, including sharing between individual experts and Technical Resource Networks (TRNs)
- ◆ pilot testing, operations research, and other projects and programmes
- ◆ documentation (however, it is important to remember that best practice is not limited to documentation).

Identifying best practice that provides useful lessons learned means making judgements. To arrive at such judgements, two approaches may be used, each reflecting a different level of analysis.

The first approach is based on simple description of the practice's accomplishments. From this point of view, best practice can be anything that works, in full or in part, and that can be useful in providing lessons learned.

The second approach is to carry out a thorough analysis using specific, established criteria that look at strengths and weaknesses as well as successes and failures. UNAIDS uses a set of five criteria as a guide: effectiveness, efficiency, relevance, ethical soundness, sustainability. While candidate best practices should meet one or more of the criteria, they do not need to meet them all.

- ◆ In summary, the best practice process helps to identify and describe the lessons learned and the keys to success of any given project, programme or policy.

Why document best practice?

Our UNAIDS cosponsors, in-country staff, and Secretariat in Geneva are constantly asked to provide brief and up-to-date information – “snapshots” might be a good description – about the constructive and creative things that people and organizations around the world are doing about HIV/AIDS. This is a practical illustration of one of the main reasons we document and disseminate best practice. Without access to existing knowledge and experience from the field of things that work, whether fully or in part, mistakes may be repeated and valuable time may be lost. Lessons learned must be widely shared and adapted to local conditions in order to enable an effective response to the epidemic.

The formal objectives of best practice are:

- ◆ To strengthen capacity to identify, document, exchange, promote, use and adapt best practice as lessons learned within a country and inter-country as a means to expand the national response to HIV/AIDS.
- ◆ To promote the application of the best practice process for policy and strategy definition and formulation.
- ◆ To collect, produce, disseminate and promote best practice.

In this Summary Booklet, UNAIDS attempts to capture details of a range of best practices in order to provide useful lessons and offer references for those working in HIV/AIDS-related activities.

Where do best practices come from?

Sources of best practice are wide. They include UN system staff, non-governmental organizations (NGOs), government representatives and agencies, community groups, and individuals. Sometimes best practice is identified through small or mass media. UNAIDS gratefully acknowledges the work of its staff, but especially acknowledges the diligent efforts of the field staff of its cosponsors (UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO, and the World Bank), the chairs of the United Nations Theme Groups on HIV/AIDS and other partners to provide the lessons learned for the summary booklet.

Submissions usually arrived in electronic files, often with detailed supporting documents. Others, sometimes handwritten, came to us in the mail from non-governmental and community organizations and from independent researchers – that is, from people working on the front lines of the response to HIV/AIDS. Still others have been gleaned from journals, project reports, and even from newspapers and magazines.

Some have been accepted for publication almost verbatim. These include some of the better-known projects that are often held up as examples of best practices. Others, generally less well known, have been judged promising but not published in this first issue because further information is needed to confirm or clarify the proposal. Surprisingly few have been rejected outright, probably because almost all efforts to respond to the epidemic have something to teach us.

While some of the practices have been the subject of formal evaluation processes, most have not. This may seem odd in a publication devoted to best practice, but there is a reason for it that is based solidly in the reality of the HIV/AIDS epidemic.

Formal evaluation of the type practised by academic and government institutions is often a slow, complicated, and expensive process that can take more professional time and cost more than the actual process being evaluated – and that should be planned as part of a practice's life span. The majority of practices detailed in this summary were oriented towards action rather than methodological “purity”; many were formed by grassroots organizations and individuals, few of which have the resources or in-house expertise for formal evaluation.

For this reason, many of the practices do not present evaluation information *per se*. In all cases, however, the outcomes and lessons learned provide whatever information is available on outputs and impacts.

In this first issue, readers will find a preponderance of examples that deal with children and young people, community-based care, and vulnerable populations such as sex workers and injecting drug users. There is a simple reason for this: these are among UNAIDS' five priority themes (the other two are the more technical fields of vaccine development and mother-to-child transmission), and we have a great deal of information on them that is solidly documented, well understood, and worth sharing.

Using the summary booklet

Currently, UNAIDS collects and publishes information on 50 topic areas related to HIV/AIDS. The practices described in this summary are organized, first, according to their main topic areas. Each practice is preceded by a brief introduction to the topic. Since most practices are relevant to more than one topic area (for instance a national fund for high-cost drugs would be categorized first as a practice related to access to drugs, but it is also related to human rights, ethics, and law), an index is provided at the end of the summary so that practices can be found by their secondary topic areas, as well as by country.

We have tried to provide complete contact information so that readers can get additional information on practices that interest them. Where possible, each practice contains a section called Further Reading, in which readers will find bibliographic references for obtaining more information (some of this is available on the Internet, and full electronic "addresses" are provided).

In addition to the printed issues of this booklet, which we hope to update with new practices regularly, an electronic version will be available on UNAIDS' Internet web page at <http://www.unaids.org/highband/bpc/introduction.html>. This will provide access to practices as soon as they are added to the database, and allow them to be downloaded and printed as needed. This, we hope, will further increase the Summary's usefulness to the many people who can benefit from such information.

We welcome your proposals

The entries in this booklet represent only some of the many reports and suggestions that we received. We thank all those who submitted proposals, whether they were included in this issue or not. Your efforts, and your willingness to share lessons learned, are the hope of the worldwide response to HIV/AIDS.

This publication includes a proposal submission form at the end, which readers can use to propose other practices. The form can also be downloaded from the UNAIDS' web page and submitted electronically – undoubtedly the cheapest and fastest

method. As well, UNAIDS welcomes any comments and suggestions that will help us make this summary better and more complete. Please address these to the Best Practices Coordinator, PSR, at the UNAIDS Secretariat in Geneva, or to programme advisers in your country.

Best Practices

Access to HIV/AIDS-related drugs

While people living with HIV/AIDS may live many years before their HIV infection leads to secondary diseases and eventually AIDS, survival with advancing HIV infection is complicated with symptoms and medical conditions. Many of these symptoms and conditions, and the advance of HIV itself, are manageable with drugs. However, access to even the most basic of drugs is seriously lacking in many parts of the world.

The classes of drugs most important to persons living with HIV/AIDS are: *anti-infectives* to treat or prevent opportunistic infections; *anti-cancer drugs* to treat tumours such as Kaposi sarcoma and lymphoma; *palliative drugs* to relieve pain and discomfort, both physical and mental; and *antiretrovirals* to limit the damage that HIV does to the immune system.

Improving access to drugs for people living with HIV presents challenges on a variety of levels. Most countries face the following challenges to some degree: limited financial resources; problems with prioritization of drug needs; inadequate health care infrastructure; and inadequate distribution and administration systems.

Responses that are proving useful in various parts of the world include:

- ◆ Making care of persons living with HIV/AIDS a part of national strategic planning
- ◆ Improving methodologies for rational selection of HIV/AIDS-related drugs, including creation of national essential drug lists
- ◆ Improving affordability through actions such as negotiation with pharmaceutical companies for better prices; competitive procurement through generic tendering and therapeutic class tendering; local production; working with private-sector drug distributors to reduce the price markup between the supplier and the consumer
- ◆ Ensuring physical availability of drugs through actions such as group purchasing arrangements by groups of people living with HIV/AIDS; facilitating supply of priority HIV-related drugs through non-governmental organizations (NGOs); involving local associations of pharmacists and licensed drug-sellers in promoting safe dispensing; strengthening regulatory control of drug registration, quality assurance, and drug outlets

Ensuring better access to drugs on a global level demands new relationships and alliances at international, country, and local level. While responsibility for deciding how to allocate public funds rests with governments, based on the public health and economic context of the country, experience shows that the challenges of access to HIV/AIDS-related drugs can best be met when the government enters into partnerships with other sectors. Strengthening the role of persons living with HIV/AIDS in care partnerships is of central importance. Their role includes advocacy for building political commitment, providing information to aid in the process of prioritization, and advising on delivery and administration of drugs.

At the same time, strategic partnerships are necessary at the international level. UNAIDS is currently working with WHO and UNICEF to make generic drugs more

available. It has also set up pilot projects in several developing countries to assess how recently developed (and therefore expensive) proprietary drugs can be made more widely available.

National Medicine Fund for High Social Impact Diseases (Colombia)

Starting Year: 1996

Main Topic Area: Access to drugs

Other Topic Areas: Human rights, ethics, and law

Contact Person:

Luz Stella Vargas

Phone: +571 222-6818 or 222-6799

Fax: +571 222-6818 or 222-6799

Email: redsalud@multiphone.net.co

Address:

Red de Cooperativas de Hospitales de Colombia (REDSALUD)

Calle 55 No 35-46

Santa Fe de Bogotá

Colombia

Luis Angel Moreno

Ministerio de Salud, Programa ETS/SIDA

Carrera 13 No 32-76, Piso 11

Santa Fe de Bogotá

Colombia

Implementers

The National Medicine Fund for High Social Impact Diseases was implemented by a general directing council composed of representatives of the Presidency of the Republic, the Ministry of Health (MOH), NGOs working on the selected diseases, and health institutions affiliated with the Colombian General Social Security System (GSSS). The Colombian Network of Hospital Cooperatives (REDSALUD) is the institution responsible for operational issues. It is composed of 10 cooperatives (non-profit associations) and almost 400 hospitals. Technical orientation is given by a technical committee, composed mainly of specialist physicians.

Funding

Initially the MOH provided US\$160,000 in 1996 for the start-up of the fund. In 1998 the MOH provided US\$332,000, which was matched by the fund from its profits on sales. The fund also benefits from a tax exemption for drug imports.

Objectives

The main objective is to provide, at a very low price, high-cost drugs to persons living with HIV/AIDS, haemophilia, and cancer, and to patients under renal dialysis. The fund aims mainly to benefit patients who are not covered by GSSS arrangements, but also facilitates the acquisition of these drugs at a lower-than-market cost by all health institutions affiliated with the GSSS.

Background

Preliminary planning and design processes started in 1995 after the idea was proposed to the First Lady's Office (at the Presidency of the Republic) by a group of health professionals from the MOH and the Pan American Health Organization (PAHO). The fund started in 1996 in partnership with REDSALUD, an institution with 15 years' experience in acquiring and distributing drugs and hospital equipment (local and imported) at a low cost.

Initially the idea was to create a public fund directed by the MOH's National AIDS Programme, but this required the enforcement of a Senate law, which would have delayed the whole process. Given the urgency of providing drugs to people living with HIV/AIDS, PAHO advisers proposed an alliance with REDSALUD, an alliance that became the cornerstone of the fund development.

The fund is currently one of the biggest buyers of HIV/AIDS drugs in Colombia, and so is able to negotiate discounts of around 40 per cent from suppliers. Its bargaining position is strengthened by the fact that the pharmaceutical companies know these drugs are destined for poor people who would not otherwise buy them.

Main Activities

The fund has three categories of prices, all of which are lower than the regular price of antiretrovirals in the market.

- The highest price is acquisition price plus 12 per cent. It is offered to for-profit organizations, mainly insurance companies and private institutions participating in the GSSS.
- The second price is acquisition price plus 6 per cent, for public hospitals and NGOs.
- The lowest price is subsidized by profits from the first two categories and by an additional contribution from the MOH. It comes to about 40 per cent of the acquisition price, (24 per cent of the normal retail price). The non-subsidized portion is paid by contributions from the hospital, the NGO, and/or the patient.

People eligible for the subsidized drugs have very low incomes. They are usually unemployed, are peasants, or work in informal sectors of the economy. Every subsidized patient is treated with the official protocols for each pathology, and information about each patient's evolution must be sent to the fund. About a third of the Colombian population will eventually be covered within the subsidized programme of the GSSS.

Outcomes/outputs

Fund sales were approximately US\$200,000 in 1997, the fund's first year. In 1998 sales rose to US\$700,000. During 1999 subsidies will be equivalent to approximately US\$600,000, with about half financed by the revolving fund itself. More than 70 per cent of the budget has been assigned to antiretroviral drugs. This is not enough for complete coverage of potential patients, but it has been able to provide significant contributions to institutions and to self-help groups such as the Liga Colombiana de Lucha contra el SIDA.

The fund has become a very important factor in maintaining the financial balance of the new GSSS in the face of the market prices of some drugs. For example, due to contributions from the fund, the highly expensive ZDV (AZT) can be sold at an 80 per cent discount.

Evaluation Findings

It is still too soon to conduct a formal evaluation process. However, a close monitoring process of the cost advantages is being carried out.

Lessons Learned

Although coverage is still relatively limited, coordinated management of drug acquisition and distribution through a central agency seems to have been effective in reducing prices and facilitating access to drugs, particularly to those people in more difficult socio-economic circumstances. Efficient and competitive management, low

administration costs, and transparency in competitive bidding are the main strengths of the fund.

As well, the fund has proved to be an excellent proponent of MOH policies, especially in publicizing and advocating for the application of HIV/AIDS treatment protocols.

An equally important lesson is that this type of government structure works best when it is matched by strong patient advocacy work from non-governmental and community-based organizations that will help people living with HIV/AIDS to gain access to the drugs. In other words, the government initiatives to improve supply must be matched by institutional and community initiatives to identify and give a focused voice to demand.

Further Reading

Fund activities report. Presented in June 1998 to the Executive Committee of the National Fund for High Cost Drugs, MOH, Bogotá.

UNAIDS. NGO perspectives on access to HIV-related drugs in 13 Latin American and Caribbean countries. UNAIDS Key Material, Geneva (UNAIDS 98/25.). This publication is also available on the UNAIDS website.

Antiretroviral therapy

Since the human immunodeficiency virus (HIV) was first identified as the cause of AIDS, enormous research efforts have concentrated on identifying and developing compounds to suppress its replication. In 1987, zidovudine (ZDV, formerly known as AZT) was approved by the US Food and Drug Administration. In the years that followed, four other drugs of the same family were introduced. Large multicentre clinical trials then showed that double therapy with two of these drugs was superior to monotherapy in terms of disease progression and patient survival. Greater and more sustained decreases in plasma levels of HIV-1 RNA were achieved with double combinations.

Monotherapy for the *treatment* of HIV infection is now regarded as obsolete because of serious problems of resistance. However, the use of zidovudine to *prevent* mother-to-child transmission of HIV was shown as long ago as 1994 to be effective (reducing transmission by 50–70 per cent).

Significantly larger reductions in viral load were achieved by adding a new class of agents, the protease inhibitors, which became available in early 1996. Since then, new antiretroviral (ARV) treatments, particularly the triple therapies using combinations of drugs from different classes, have shown impressive short-term results. With regimens of three drugs, over three-quarters of HIV-infected patients had levels of virus in plasma suppressed to below the level at which it could be detected, and this persisted throughout follow up for as long as one year in ARV-naive patients with good adherence.

Clinicians express concerns about ARV's long-term benefit. Only clinical experience over several years will provide evidence that a reliable, long-term treatment has been found. Critical issues still require clarification: when to start and change treatment, and with which combinations, and what drug sequence strategy to adopt. With the rapid progress in drug development, treatment guidelines are likely to require frequent updating.

The major challenges in antiretroviral treatments are:

- ◆ Access – triple therapy is very expensive, and the new treatments are not available to the vast majority of the world's HIV-infected people, most of whom live in developing countries
- ◆ Correct and supervised use – the related services required to ensure ARV's safe and effective use are complex
- ◆ Adherence – therapy requires a strict individual protocol and reliable psychosocial and material support

These three challenges have implications for a fourth key area, development of resistance.

Despite these challenges, ARVs are present in most poor countries of the world, but accessible to a very small and mainly wealthy minority. Efforts to obtain the drugs, often in an irregular and haphazard fashion, may absorb the entire resources of the family. In these situations, problems of incorrect and unsafe use, unreliable supply,

and a black market in both good quality and counterfeit drugs are likely to appear. These problems have serious public health implications because of the almost certain development and spread of ARV-resistant strains of HIV. It is therefore urgent for policy-makers, ministries of health, health professionals, and NGOs to address all aspects of ARV treatments, including access, irrespective of the wealth and circumstances of their country.

Online Conference on ARV Treatment in Developing Countries (International)

Starting Year: 1998

Main Topic Area: Antiretroviral therapy

Other Topic Areas: NGOs and networks • Human rights, ethics, and law • Cost-effectiveness analysis

Contact Person:

Steven Forsythe

Conference Moderator

Phone: +151-708-9393

Fax: +151-707-1766

Email: Forsythe@liverpool.ac.uk

Web Site: <http://www.worldbank.org/aids-econ/arv>

Implementers

The conference was organized by the International AIDS Economics Network (IAEN), a joint initiative of the World Bank and UNAIDS, under the auspices of AIDS Economics, a collaboration between the World Bank Development Research Group; the European Commission; the United States Agency for International Development (USAID) and UNAIDS. A smaller group that meets face-to-face, the AIDS Economics Network (AEN), funded by USAID and originally chaired by Family Health International, is now under the auspices of the Policy Project/The Futures Group International.

Objectives

To initiate a critical discussion on the issue of economics and ARVs.

Background

The electronic conference was held online via the Internet on 4–28 May 1998. The conference focus was formulated as follows:

“Governments in many developing countries are under mounting pressure to pay for anti-retroviral (ARV) therapy for the growing number of people living with HIV/AIDS. Because few developing countries could do this without dramatically restructuring or increasing government expenditures, it has been suggested that an international fund be established to provide the necessary financing. However, even assuming that such a fund could be organized, the question of public priorities remains. Should public funding of ARV therapy be a higher or lower priority than other health interventions (for example, preventing HIV transmission, treating or preventing such diseases as TB and malaria, or treating and preventing childhood diseases)? And what priority should ARV therapy be given relative to the many public concerns that fall outside of the health sector, including poverty reduction, education, infrastructure, and local and global environmental problems?”

Main Activities

The conference was moderated, and “attended” by invitation only. There were 90 postings, and 160 people from over 30 countries visited the conference site. The

online conference was accompanied by a face-to-face meeting of the AIDS-Economics Network (AEN) in Washington, DC, on 12 May 1998.

An overview and key questions, readings, and supporting materials were gathered for discussion in the online conference.

Outcomes/outputs

Online conference outputs included a final summary of the conference by the moderator, a discussion archive (all message posted), and all the materials collected for the conference.

The discussions appeared to produce consensus that there should be additional online discussion groups of this sort. The organizers have agreed that the next session will focus on the issue of the cost-effectiveness of prevention interventions. Other topics that were recommended by participants and may be addressed in future online conferences include: the political economy of setting priorities and choosing approaches to AIDS and other development projects; the role of the private sector in response to AIDS; modelling the effectiveness of HIV/AIDS interventions; modelling the HIV/AIDS epidemic; reducing the price of ARVs; discussion of decision analysis methods; drug pricing and pharmaceutical patents.

Evaluation Findings

While there was no formal evaluation, the positive feedback from participants indicates a continued need for discussions on such specific and timely topics. This online conference was successful in initiating a critical discussion regarding the issue of economics and ARVs.

Lessons Learned

Overall, the online conference offers an efficient and effective means for serious questions to be raised and debated by a large number of geographically dispersed participants.

As regards the specific content of this conference, the moderator summarized the substantive lessons learned as follows.

- There is currently a lack of consideration being given to issues of public economics and its their implications for treatment.
- In many countries, policy-makers remain in the dark in regards to the current and future prevalence of HIV. Numerous contributors noted that figures on people living with HIV and AIDS could be severely over- or under-estimated, which in turn would significantly affect the estimates of costs for providing ARVs.
- The discussion has exposed the lack of data on the potential costs and benefits of ARVs in either developed or developing countries. Economic research is needed on costs and benefits, but it appears that little of this research is currently being initiated, at least in developing countries.
- The discussion has raised the issue of targeting potential recipients of ARVs. When resources are available on only a limited scale, a decision must be made concerning the best ways of selecting those who are eligible for care. In Thailand and Côte d'Ivoire, for example, access to ARVs is based on the assumed compliance of patients (which is likely to be associated with their socio-economic status). In countries where ARVs are available only from the private sector, a decision is implicitly being made to have these drugs available only to the wealthiest members of that society. Other countries offer ARVs only to pregnant women, thereby implying

that saving the child is more cost-effective or of greater political importance than prolonging the life of the mother or the father through longer-term treatment.

- There is no single answer to the question, Are ARVs cost-effective for developing countries?
- Use of a short-course ZDV regimen with pregnant women could be a cost-effective means of limiting transmission of HIV to children. However, in countries with a low HIV prevalence, ZDV would probably not be cost-effective (although targeting ZDV programmes to areas of a country where prevalence is higher might improve the cost-effectiveness of such an option).
- Alternatives to expensive ARV treatments have not been carefully assessed. There is currently no data comparing ARVs and non-ARV alternatives, such as drugs to treat opportunistic diseases.
- Economic research has tended to focus on the current cost-effectiveness of ARVs, but has not developed models that would assist in evaluating the potential cost-effectiveness of ARVs in the future, when prices are likely to be substantially reduced.
- Most economic research has not adequately taken into consideration issues of equity.

In general, it appears that further economic consideration should be given to the rationale for spending public funds on ARVs in developing countries.

There is a need to further define what is meant by "equity" as it applies to access to care that includes ARVs. Where equity and effectiveness are in conflict, it is critical to determine how trade-offs will be addressed.

Further Reading

The outputs of the conference, including the full electronic dialogue, are presented on the web page <http://www.worldbank.org/aids-econ/arv>

Netherlands–Australia–Thailand HIV Research Collaboration (Thailand)

Starting Year: 1996

Main Topic Area: Antiretroviral therapy

Other Topic Areas: Access to drugs • Virology, immunology, and laboratory practices

Contact Person:

Dr Praphan Phanuphak

Phone: +66-2-256-4638

Fax: +66-2-254-7574

Email: ppraphan@chula.ac.th

Address:

HIV-NAT, AIDS Research Center

Thai Red Cross Society

1871 Rama IV Road

Bangkok 10330

Thailand

Implementers

The project was implemented by the AIDS Research Centre of the Thai Red Cross Society (TRCS); the Netherlands National AIDS Therapy Evaluation Centre (NATEC); Australian National Centre in HIV Epidemiology and Clinical Research (NCHECR).

Funding

Starting expenses, core infrastructure (office and laboratory), and salaries of some research staff members were funded by TRCS, NATEC, and NCHECR. Expenses for the studies performed (including the majority of research staff salaries, research drugs, and laboratory assays) and presentation of the results at meeting were funded by the sponsors of the studies, ranging from pharmaceutical companies to the AIDS Division of the Thai Ministry of Public Health (MOPH) and the US National Institutes of Health (NIH).

Additional training of Netherlands–Australia–Thailand HIV Research Collaboration (HIV-NAT) staff was funded by NCHECR, NATEC, and sponsors of the studies. Funding for training of others by HIV-NAT staff was provided by HIV-NAT, the party requesting the training, and/or a sponsor (e.g., the World Health Organization, Thai MOPH, or a pharmaceutical company).

Objectives

The primary objectives are interrelated:

- To establish a multi-centre HIV clinical research organization in Thailand that functions according to internationally accepted Good Clinical and Laboratory guidelines
 - To conduct clinical intervention studies (and potentially vaccine studies) that will yield answers to locally and regionally relevant research questions
 - To convince international pharmaceutical companies and other potential sponsors that scientifically and ethically sound HIV clinical studies can be conducted in Thailand, and that they should invest in such research in Thailand
 - To make drugs available to study participants
 - To strengthen the HIV research infrastructure and regular HIV care infrastructure
-

- To provide health care workers with valuable experience with newly available treatments.

The secondary objective is to serve as a training centre in the practical, ethical, and scientific aspects of HIV care, and in particular of HIV clinical trials, for staff from government and university hospitals and other related organizations in Thailand and the region.

Background

The directors of the three partners agreed on the need for the centre, given the perceived reluctance of pharmaceutical industries to perform HIV-related clinical studies in countries where HIV is most prevalent.

A Dutch HIV clinical trials physician was stationed in Bangkok and worked with a newly recruited Thai clinical nurse to prepare for the first study, which was to involve 75 participants. Upon the successful completion of the first study, funding for further studies enabled recruitment, over the course of two years, of another four nurses, three more physicians (two Thai and one Australian), a secretary, a data manager, and a part-time research pharmacist. Two of the research nurses received additional training from NCHECR in Sydney, whereas the data manager received training from NATEC in Amsterdam.

Laboratory assays are performed by Thai Red Cross Society laboratories' staff, whereas statistical support for protocol design, randomization procedures, and final analysis are provided by NATEC and NCHECR.

Main Activities

So far two clinical studies have been successfully completed and another five are currently ongoing at three sites in Bangkok, providing some 350 HIV-positive individuals with effective treatment. Validated quality-of-life research has been an integrated part of one protocol and will be expanded in future studies.

Results of studies are shared with local HIV-treating physicians and Thai policy-makers and are presented at international meetings.

HIV-NAT staff have taught a total of four courses concerning the conduct of HIV clinical research and principles of Good Clinical and Laboratory Practice, twice at the invitation of the AIDS Division of the MOPH.

HIV-NAT has organized two national and two regional meetings for health care workers who have limited access to international journals, information technology, and international meetings. Sponsorship was found, enabling these health care workers to travel to the meetings, which had well-known international speakers in the field of HIV care and research.

Ongoing and planned studies and the quality of the research are reviewed yearly by an International Advisory Board with 10 expert members. Interim analysis safety and efficacy results of studies are reviewed by an Independent Data and Safety Monitoring Board of three members. All HIV-NAT staff take part in educational activities, often supported by speakers from NATEC or NCHECR with a particular skill.

Outcomes/outputs

Few objective measures are available yet. However, since the first completed study (and the positive feedback received from the United States auditors sent by the sponsor of that study), starting new studies and finding sponsors for proposed studies has been easier; HIV-NAT is now actually actively pursued by potential

sponsors as a clinical trial site. Study-related income enabled HIV-NAT to provide the involved laboratories with some needed infrastructure. Visits from NATEC and NCHECR staff and sponsor audit teams have improved study and laboratory conduct, which have benefited HIV-NAT's educational activities. As well, study results and advice from the International Advisory Board are heard and taken seriously by local policy-makers.

Informal evaluation forms, completed by participants attending the educational meetings, clearly indicate that the educational activities meet an important need felt by health care workers in the country and region. Financially, the organization is nearly self-supporting through its study-generated income, and it needs to rely less and less on overseas skills and intellectual support.

For the first three protocols, HIV-NAT was unable to guarantee follow-up medication to participants upon initiation of the study. However, it was able to enrol all interested participants in follow-up protocols after the sponsors' confidence grew and enthusiasm for the activities increased. For the most recent study, it was able to obtain long-term drug-availability guarantees, either directly from the sponsor or through a reduced pricing scheme.

Lessons Learned

The major lesson learned from the experience of this project is that, properly planned and executed, such international cooperation on HIV/AIDS clinical practices can have valuable benefits for local populations and medical service providers. Among the specific lessons learned:

- Clinical trials can be conducted in Thailand according to Good Clinical and Laboratory Practice (GCLP) guidelines and should be feasible in other settings outside the Western world. However, not all parties involved in clinical research outside the Western world may work according to these standards. The majority of potential sponsor will demand that this standard be implemented. Therefore non-Western research organizations must have the resources (especially time) and the willingness to support and facilitate close collaboration with local institutional ethical committees, hospital laboratories, and local pharmaceutical companies in pursuing GCLP.
- A clinical trial is labour-intensive: adequate personnel, willing to learn new skills, have to be available at a site if a trial is to succeed. It was learned that without dedicated staff and a responsible coordinator at every individual research site, success is impossible. Setting up a single site and expanding the research activities to three sites in the course of two years has been successful. "Long-distance expansion" based on theoretical knowledge, without an initial physical presence by the HIV-NAT team, seemed not to work, given the multidisciplinary nature of clinical trials and the fact that for most staff the trial is only one of many duties.
- Clinical trials do create access to drugs, but only for a limited number of people. Drug access may therefore not be an appropriate primary goal for becoming involved in research.
- Although economic difficulties are the main reason, limited access to anti-HIV drugs in Thailand is also due to a relatively slow registration process of newly available anti-HIV agents and a rather passive attitude on the part of some local pharmaceutical representatives. HIV-NAT's experiences is that if clinical studies are initiated in collaboration with the companies' headquarters, the local subsidiaries are forced into a pro-active import approach. As well, valuable local experience is gained and local data are generated that help the pharmaceutical companies facilitate the registration of the agents.

- Simply establishing a programme, doing the studies, and generating useful data seem to exert pressure on government agencies, local pharmaceutical company representatives, and ethical committees to re-evaluate their tasks and performance in the areas of HIV care, clinical research, and importation and provision of drugs.

Children and young people

Young people are key to the future course of the HIV/AIDS epidemic. The behaviours they adopt now and those they maintain throughout their lives will determine the course of the epidemic for decades to come.

At the end of 1997, over one million children were estimated to be living with HIV and suffering the physical and psychological consequences of infection. Of the estimated 16,000 new infections daily, about 1,600 are in children under the age of 15 years. Young people between the ages of 10 and 24 account for more than 50 per cent of new post-infancy infections worldwide. As well, this age group constitutes more than 30 per cent of all people in the developing world, where the epidemic is concentrated. If HIV prevention in this huge population fails, developing countries will have to face the staggering human and economic costs of vast numbers of adult AIDS cases.

Increasingly, young people are being appreciated as a resource for changing the course of the epidemic. They are responsive to HIV prevention programmes and are effective promoters of HIV prevention action. Investing in HIV prevention among young people is likely to contribute significantly to a more sustainable response to HIV/AIDS. Several lessons have been learned over the past years that can be applied to planning effective actions to focus more on young people in the HIV epidemic.

Priority actions to be considered in the light of situation and response analysis in various countries, and feedback from youth organizations and young people, include:

- ◆ Establishing or reviewing national policies to reduce the vulnerability of young people to HIV/AIDS and ensuring that their rights are respected, protected, and fulfilled
- ◆ Promoting young people's genuine participation in expanding national responses to HIV/AIDS
- ◆ Supporting peer and youth groups in the community to contribute to local and national responses to HIV/AIDS
- ◆ Mobilizing parents, policy-makers, media, and religious organizations to influence public opinions and policies with regard to HIV/AIDS and young people
- ◆ Improving the quality and coverage of school programmes that include HIV/AIDS and related issues
- ◆ Expanding access to youth-friendly health services including HIV and STD prevention, testing and counselling, and care and support services
- ◆ Ensuring care and support of young people living with HIV/AIDS

Two particular groups of children and young people will require a special emphasis: AIDS orphans and young people living with HIV/AIDS. UNAIDS estimates that as of December 1998, the total number of AIDS orphans (defined as children having lost their mother or both parents to AIDS before the age of 15) since the start of the

epidemic totalled at least 8.2 million. In many developing countries, extended family systems have traditionally provided support for orphans. However, AIDS, combined with other pressures such as migration, is pushing the extended family system to the breaking point in the worst-affected communities.

Like older HIV-positive adults, children and young people living with HIV infection require increasing health care as their immune system weakens and their health declines. However, they may face special obstacles in exercising their right to health. Young people may be too poor to buy care, or too afraid of disclosure by health providers who might not respect their confidentiality. The absence of youth-friendly services is an obstacle. In line with the United Nations Convention on the Rights of the Child, all children living with HIV/AIDS must have access to treatment, counselling, education, recreation, and social support, and be protected against any form of discrimination.

Field Experiment: The Better You Know Yourself, the Better You Are Protected (Belgium)

Starting Year: 1997

Main Topic Area: Children and young people

Other Topic Areas: Men who have sex with men • Communications programming

Contact Person:

Thierry Martin

Phone: 32 2 736 28 61

Fax: 32 2 733 96 17

Email: thmartin@skynet.be

Web Site: www.exaequo.be

Address:

Ex Aequo

Rue de Tervaete, 89

1040 Brussels

Belgium

Implementers

The project was designed and implemented by the Belgian NGO Ex Aequo.

Funding

Funders included the Ministry of Health and the Continuing Education service (Service d'Education Permanente de la Communauté française) of the francophone part of Belgium, along with commercial sponsors including a jeans manufacturer, a TV programme, a radio station, a bank, and a youth-oriented magazine.

Objectives

To test and adapt methodologies and information tools which reduce risk of young gay men becoming infected with HIV during their period of sexual self-identification.

Background

The debate concerning young gay men's risk when they decide to "come out" (define their sexual identity as gay) and the stakes involved in the prevention of AIDS have become subjects of current concern for the partner organizations in francophone Belgium.

The Better You Know Yourself, the Better You Are Protected (Mieux te connaître et mieux te protéger) was a field experiment begun in 1997. Its prevention tools were created with the interactive participation of the target group. These tools included a telephone line that provided testimonies from young homosexuals describing their coming out, and an accompanying brochure that was distributed in a variety of places such as family planning and youth centres.

Main Activities

The project developed in five phases:

1. Development of a theoretical framework buttressed by experience
 2. Gathering of semi-directed interviews with young homosexual men discussing the evolution of their concerns and how they arrived at their self-identification
 3. Development of a prevention tool (the telephone "script") through interactive participation, including seeking out individual testimonies for recording as part of the telephone message
-

4. Wide distribution of this information by diverse channels, including the free telephone line and distribution of the brochure in key places where the young men would be able to read them. Time for a radio advertisement was donated by the radio station most listened to by the target age group, and poster ads were carried by public transport.

5. Continuous quantitative and qualitative evaluation of the campaign's procedures and content.

As time went on, the campaign was largely taken over by the young people themselves. Associations of young gays began to ask for the brochures in order to do their own outreach.

Outcomes/outputs

The project's free telephone lines registered 6,100 phone calls asking for the brochure. Approximately 22,000 brochures have been distributed. An important element in this distribution was the cooperation of 80 family planning centres and 53 other distribution points (youth centres, in particular) throughout the francophone part of Belgium.

It should be noted that a significant number of centres declined to distribute the brochure, citing reasons such as:

- Lack of preparedness to respond if questioned on the subject by a young person
- Discomfort with the subject
- Suspicion that the brochure "proselytized" in favour of homosexuality.

The last reason was also cited by the Audiovisual Commission and by the Ethical and Scientific Council for the Prevention of AIDS in the francophone community, the latter of which declined to support the project.

Evaluation Findings

According to written responses on the brochure, young people saw the campaign in general as presenting them with an optimistic and hopeful message. Their ideas about the social risk of coming out were modified in a positive way, which in turn made it easier for them to change their behaviour in ways that would take into account the risk of AIDS.

In evaluation sessions held at the end of the project, the distribution points reported three benefits of collaborating with the project. The first was the unique brochure, the only tool available on the question of sexual identity. Thus the institutions carrying the brochure were the only ones that had something to give people who wanted information or advice on the subject. Second, collaborating meant that the staff at the distribution points had to "take an institutional position" on the subject, which meant both becoming familiar with the subject and debating how to handle it within their institution. Finally, the presence of the brochure signalled to visitors that "you can talk about this here," that the institution was a safe and understanding place.

The evaluation also looked at resistance to the project, especially to the brochure. It was suggested that some resistance might have been avoided if the brochure had not mixed its two elements: the question of identity and a frank treatment of sexual practices. Another suggestion for reducing resistance was that the brochure and the campaign should have addressed sexual identity for girls as well. This might have diminished an appearance that the brochure advocated male-male sex, and would have had the benefit of filling an almost total lack of information for girls uncertain of their sexual identity.

Lessons Learned

This project provides useful lessons in the careful methodology followed to create information tools (see Main Activities) and in the thoughtful analysis that followed (see Outcomes and Evaluation). It is also a valuable example because, in focusing on sexual identity of young people, it addresses a subject area that has received little attention but that is almost certainly of considerable relevance to HIV/AIDS prevention.

On a technical level, the organizers report that the major lesson learned about behaviour change among this population is that the trade-off between various priorities (health risk/self-identity risk, physical risk/social risk, etc.) determines the ways that young men actually adapt to the risk. This trade-off is different for each individual, and it is not clear to what extent the project influenced behaviour.

Further Reading

Project reports are available in French (with English abstract) from Ex Aequo. The brochure may be viewed on the Ex Aequo website.

Women/Life Collective (Brazil)

Starting Year: 1991

Main Topic Area: Children and young people

Other Topic Areas: Sexually transmitted diseases • Reproductive health

Contact Person:

Marcia Dangremon (General coordinator)

Cecilia Marambio (Coordinator of adolescents project)

Phone: +55-81 4324970 / 4311196

Fax: +55-81 4324970 / 4311196

Email: cmvida@cashnet.com.br

Address:

Coletivo Mulher Vida

Av. Ministro Marcos Freire, 3095

Casa Caiada

53130-540 Olinda, PE

Brazil

Implementers

The project was implemented by a NGO, Coletivo Mulher Vida (Women/Life Collective), which worked in the cities of Recife and Olinda, Pernambuco State.

Funding

The NGO currently receives funding from UNICEF, European NGOs, and church-related organizations.

Objectives

The overall aim is to strengthen the self-esteem of adolescent and young girls at risk of violence, abuse and entry into the sex trade, to equip them with skills for conflict resolution, and to provide them through discussion with realistic expectations in their daily lives. Within this context, there are two main objectives:

- Community-level programme for the prevention of violence against adolescent girls aged 12-18
- Prevention of violence against young girls aged 7-12 who live or work in the streets and who are at high risk of being sexually abused, and treatment of the consequences of violence and abuse.

Background

Women/Life Collective aims through educational processes to develop a new relationship between men and women in which solidarity, respect, happiness and growth replace exploitation, violence, and oppression. The initial focus of the group of social workers and psychologists who founded the collective in 1991 was on helping women who were physically or psychologically abused. Subsequently they have focused their attention on the prevention of violence and abuse against adolescent girls and on the treatment of the consequences of this abuse. A particular focus is on young women either involved in, or at risk of joining, the sex trade, where in addition to other dangers the young women are highly vulnerable to HIV infection.

Main Activities

Through specially designed questionnaires administered in public schools to adolescent and young girls at risk of violence and sexual abuse are identified. These girls are invited to join a mutual support group that includes an adult educator and a

teenage monitor. The girls are helped to confront and modify their own familial situations, and if this is not possible or successful, they are offered temporary accommodation until other suitable living arrangements can be made. In addition the girls receive individualized and group psychological assistance as well as skills training.

The organization works with mutual support groups of up to 20 adolescent girls within the community through regular weekly meetings. Each session has a special subject of discussion including family relations, work, school, drugs, and sexuality, including information on HIV/AIDS and STDs. Whenever a girl has a specific problem – for example, the threat of violence within the home, abandoning school, sexual abuse, or drug use – the monitor refers her to specialist organizations where she can receive support from professionals such as psychologists, social workers, physicians, and educators.

After an adolescent has participated in these groups for six months she is offered courses of varying duration in such areas as theatre, handicrafts, and foreign languages. Once they have completed two years in the programme, the girls can follow professional courses, including computer assembly and repair, offered directly by the NGO, or they are referred to other professional courses given by specialized institutions with which the NGO has service contracts. In addition, those girls who complete the programme are encouraged, when necessary possible, to finish secondary school.

In the case of younger children, the organization finds them in the streets of Recife and establishes contact with their families. With the agreement of the family, the children are offered accommodation within the organization. The children attend the programme in the afternoon: they can take a shower, have a meal, and then receive academic coaching in addition to arts and crafts activities. The mothers, who are usually illiterate or semi-literate, are also offered a literacy programme and are encouraged and supported to follow professional training courses given by local institutions.

Outcomes/outputs

Within the programme for adolescent girls, groups were established in 10 poor communities. About 1,100 girls have enrolled in the project, and some have gone on to pass university entrance exams. According to the most recent reports, none of 850 adolescents who have gone through the programme have returned to street gangs or become sex workers.

The long-term approach taken by the institution has provided the older girls with broad personal and professional development. In addition, in most cases the psychological support has been sufficient to meet the long-term needs of the girls. Through the programme adolescents receive an integrated approach toward sex education, probably better in quality than that received by their middle- or upper-income counterparts at school.

Among the young girls the programme has strengthened school performance and reduced absenteeism and repetition of studies. It has provided the girls with after-school activities that have improved both their self-esteem and their academic performance. A special feature of the young girls' component is the inclusion of their mothers in literacy and professional programmes. This has strengthened the desire of the girls to continue in the programme.

Lessons Learned

The main positive features of this programme include:

- The long-term support and care given to the young girls and adolescents
- The multifaceted approach, including psychological attention, social work, and academic and professional training
- Encouraging girls to develop the capacity for taking responsibilities, and then giving them the opportunity to do so
- The inclusion of mothers in the programme, thereby creating mutual support among children and parents
- The incorporation of sexuality education and HIV-prevention activities within the larger approach of life-skills training and community development action
- The low cost of the programme.

In the case of the programmes for both the adolescents and young girls, a formal evaluation is needed. Such an evaluation would identify quantitative achievements as well as areas in which activities or operations could be improved.

Further Reading

<http://www.childhub.ch/webpub/csechome/2276.htm>

Yunnan/Australian Red Cross Youth Peer Education for HIV/AIDS Prevention Project (People's Republic of China)

Starting Year: 1996

Main Topic Area: Children and young people

Other Topic Areas: Sexually transmitted diseases

Contact Person:

Audrey Swift and Li Guozhi

Fax: +86 871 319 6550

Email: hivyrc@elephant.istiy.yn.cn

Address:

6th Floor, 246 Renmin East Road

Kunming 650051

Yunnan

People's Republic of China

Implementers

The project was implemented by the Yunnan Red Cross with the Australian Red Cross.

Funding

AusAID, the Australian Red Cross, and UNICEF provided the funding.

Objectives

The main objective was to prevent the spread of HIV/AIDS among young people in six prefectures of Yunnan Province by increasing knowledge and life skills that lead to safe behaviours. Operational objectives were:

- To develop effective IEC (information, education, and communication) materials
- To implement a training programme
- To implement a peer education programme
- To implement a public awareness programme
- To increase management and implementation skills of the Yunnan Red Cross
- To evaluate project efficacy and efficiency.

Background

The Yunnan/Australian Red Cross Youth Peer Education for HIV/AIDS Prevention Project is modelled on the peer education programme developed by the Asian Red Cross and Red Crescent AIDS Task Force (ART). This work is based on participatory workshops with life-skills development as a framework. Staff monitor and provide feedback to the youth facilitators (peer educators) in order to make workshops complete, consistent, and correct.

Main Activities

Core trainers, usually project staff, provide five days of training for youth facilitators (aged 15 to 30). The training includes HIV/AIDS technical knowledge as well as basic facilitation skills. After the training, the project provides regular in-service training and meetings for youth facilitators in order to increase their confidence and skills.

After attending the five-day training session, youth facilitators work in teams of two to present two-day workshops for other young people on HIV/AIDS and the life skills needed to make healthy life decisions. All workshops use a participatory methodology and life-skills framework to cover the following areas: HIV/AIDS prevention; adolescent health; sexually transmitted diseases; drug use; reproduction; sexual responsibility; care and support for people living with HIV/AIDS; peer pressure; communication skills; and negotiation skills.

Youth facilitators are trained to use a manual called *Protect ourselves from HIV/AIDS: A manual for HIV/AIDS prevention peer education program* which was developed during workshops. In addition, each workshop is supported and monitored by core trainers or project staff to assist facilitators when necessary. Support from staff ensures that the workshop content is complete, consistent, and correct and that young facilitators have the feedback and support necessary to increase their confidence and enhance their facilitation skills.

Outcomes/outputs

Among other outcomes, the project:

- Trained 61 youth facilitators in Kunming, Qujing, and Simao between December 1996 and September 1997
- Held weekly workshops held for 15–20 young people in Kunming City, Qujing, and Simao (672 participants in 33 workshops from 1 March to mid-October 1998)
- Produced a training manual pre-tested with 200 young people
- Produced a range of IEC material (posters, T-shirts, small pamphlet, caps, bags, Chinese-language body charts, diary/booklet with HIV information)
- Held a workshop held for Kunming Prefecture Red Cross staff
- Presented the project model and activities at international and national conferences and workshops, with coverage by local, national, and international media (Reuters and CNN)
- Continues to provide technical assistance in youth peer education strategies to national and provincial Red Cross Societies in China.

Evaluation Findings

Based on individual interviews and a survey, an independent appraisal group noted the following points in its January 1999 report:

“[The project has] trained 78 young project facilitators who are devoted to work and performing their duties in close coordination with the Project Office. The Project has educated 1,300 participants, of whom over 90 per cent have acquired a good understanding about AIDS with intensified awareness of self-protection as well as of the proper attitudes towards AIDS patients. These trained participants in return spread anti-AIDS information to their peers, friends, families, colleagues and other people around them. With tens of thousands of people affected by such an education, the Project has taken a social effect, because it has become the common understanding for masses to contain the HIV spreading and show concern for the HIV-infected. These achievements are exactly what the ‘Project on Youth Education for AIDS Prevention’ is meant for, reflecting the overwhelming success of the Project Office....

“On the part of the local prefectures, the Red Cross societies in Kunming, Qujing and Simao have contributed a great deal, in a concerted effort with the Project Office, to the whole Project in funding, manpower and personnel training. It is evident that the

Project has been successful in the 3 regions, owing to the Project Office's wise selection of local prefectures and its effective guidance on the work."

Lessons Learned

The project demonstrates an effective and sustainable approach to AIDS prevention among young people. Widespread awareness and improved knowledge of HIV/AIDS can indeed be effected by outreach work using young people themselves to disseminate knowledge.

Particular lessons emphasized by the project staff are:

- Realistic expectations and time frames must be set. It is better to implement and monitor the project on a small scale, allowing staff to improve their planning and management skills that facilitate and support the project.
- Exposing project staff to programmes outside of China through study tours and international conferences broadened staff awareness of issues and initiatives, thereby strengthening their commitment and capacities.
- Project success requires the active involvement of the local community in planning and implementation, in collaboration with governmental and non-governmental organizations.
- Planning processes, such as developing and pre-testing the training manual and IEC materials, can serve as valuable opportunities for young people to practise facilitation skills and to gain HIV prevention knowledge.

Further Reading

The Project Appraising Group, *Yunnan–Australian Red Cross Project on Youth Education for AIDS Prevention: Appraisal report*. 27 January 1999.

Peer Educators for Young People (Denmark)

Starting Year: 1989

Main Topic Area: Children and young people

Other Topic Areas: Communications programming • Schools • Sexually transmitted diseases

Contact Person:

John Madsen

Phone: +45 75 82 84 77 or 16 05 96

Fax: +45 75 82 07 30 or 16 03 97

Email: johnmad@post2.tele.dk

Address:

Landsforeningen Ungdomsringen

Fredericiavej 100

7100 Vejle

Denmark

Implementers

The Peer Educators for Young People (Sexualisterne) project was implemented by approximately 75 young people at the 15 different peer groups spread throughout Denmark.

Funding

Ungdomsringen, an umbrella organization for all leisure-time youth programmes in Denmark, provided the funding.

Objectives

The main objective was to develop an programme of peer educators to increase young people's knowledge about sex and thereby enable them to make their own decisions about sexual activity and its consequences.

Background

"Sexualists" are youth club members between 14 and 18 years of age who have an interest in the subject of sexual health and have participated in a compulsory training programme. On a voluntary basis, they share information on the topic with young people of their own age group. The programme has its roots in the Danish national campaign against HIV/AIDS, but since 1999 it has expanded its focus to include other sexually transmitted diseases.

Main Activities

To become a sexualist the young person has to attend a training programme. These feature:

- An adult member of the youth club as a backup person
 - A minimum of four to five persons from the same youth club, aged 14 to 16, of both sexes
 - Compulsory weekend course taken together with the adult
 - Yearly weekend courses with follow-up information meetings
 - Self-recruitment – when a sexualist leaves, he or she must find another to fill the vacant place.
-

Once or twice a week, the sexualist group holds discussions to inform other young people about subjects related to sexual behaviours, including HIV prevention and safer sex.

A booklet called *Sexguide*, with sex-related information and advice on where to find more information, is used at these meetings. The booklet contains a section dedicated to HIV/AIDS. Its original edition was published in English, Arabic, and Turkish as well as Danish.

Outcomes/outputs

The information developed by the Sexualisterne project is now part of the general sex health curriculum for young people and has received status both at the state level and in local communities. About 10,000 young people all over Denmark are involved in the project each year.

Lessons Learned

In addition to the accomplishments noted in Outcomes/inputs, this project shows the capacity of teenagers to take on the role of peer educators, and to spread accurate and useful information about STDs and HIV/AIDS.

The project staff have learned a number of important lessons in the course of the project. First, young people's enthusiasm for the project is linked to several factors. Involvement in the project not only gives opportunities for participation, involvement, and communication with other young people, but also empowers the participants to become expressive and self-determined on issues of importance to them as young people.

A key lesson learned was the importance of involving the "right adults" in the project. These are adults who accept young people on their own terms, like to interact with them, and have the necessary skills and resources to contribute to the development of the group at different levels. At the same time, young people as peer educators are better than adults at conveying certain elements of sexuality, because they are in the same situation as their peers.

A final lesson learned is an administrative one: it is essential to have a central person who is in charge, to inform the groups of new things, and prepare activities such as prepare courses, study visits, and so on.

Further Reading

The booklet *Sexguide* has been published in English, Arabic, and Turkish, though the latest version is currently only in Danish. See also *Modern youth and peer education* by Svend Laursen and Sven Mørch for an evaluation of the project (in Danish).

Save Your Generation Association (Ethiopia)

Starting Year: 1995

Main Topic Area: Children and young people

Other Topic Areas: Communications programming

Contact Person:

Mr Fasil Nabeycleul

Phone: +251 1 123 882 or 126 244

Email: syg@telecom.net.et

Address:

Save Your Generation Association

P.O. Box 14685, Addis Ababa

Ethiopia

Implementers

The Save Your Generation Association (SYGA) was implemented by youth members of the Save Your Generation Association, a local NGO.

Funding

The German Foundation for World Population (DSW), German Technical Cooperation (GTZ), and AIDS Control and Prevention Project (AIDSCAP) provided the funding.

Objectives

The main objective was to change the health behaviours, including the sexual behaviour, of out-of-school young people in Ethiopia through peer education.

Background

The association was created by a group of young men who wanted to do something about the rising impact of AIDS on young Ethiopians.

Through participatory and entertaining means, like puppet shows, dramas, and songs, the Save Your Generation Association targets IEC activities to out-of-school young people in Ethiopia. The project takes into account young people's need for income by including income-generating activities along with its health message.

Main Activities

The project's various activities include:

- Puppet drama performances
- Educational materials production and distribution
- Training of peer counsellors and educators
- Youth economic projects
- Condom promotion
- Advocacy.

Outcomes/outputs

Between February and May 1998, the project reached 492 people through advocacy meetings, and trained 50 peer counsellors and educators. As well, it reached 6,800 people through drama, songs, and puppet shows, and another 20,000 people

through other campaign activities. Cumulatively since the beginning of the project, about 430 peer educators have been trained, and 230,000 condoms either sold or distributed free by the project.

Lessons Learned

In addition to the accomplishments noted in Outcomes/inputs, the most important lesson learned in this project is that in order to achieve behaviour change among young people, the support of the wider community is crucial. To this end, meetings have been started with established community groups (Edir members) to discuss the conditions and risks facing young people and what can be done about them. Other important lessons:

- The most pressing need of out-of-school young people is a source of income. Without addressing this need, the possibility of successfully reaching them is extremely narrow.
- Youth are easily bored by health messages disseminated through meetings and formal occasions. Their attendance at these events is extremely limited. SYGA has learned that if the messages are disseminated in a participatory manner using puppet drama, and in an entertaining environment through music and songs, youth attendance at educational events is greatly improved.

Further Reading

See photos and description at:

(in English) <http://www.unicef.org/cyaids/purple/docs/purptxt3.html>

or <http://www.dsw-online.de/projects.html#syga>

(in German) <http://www.dsw-online.de/SYGA.html>

Umbrella Project (Germany)

Starting Year: 1991

Main Topic Area: Children and young people

Other Topic Areas: Sex workers and clients • Counselling and voluntary counselling and testing

Contact Person:

Frank Jankowski, Manager

Norbert Langer, Social Worker

Phone: +49 345 517 0367

or +49 177 538 6017

Fax: +49 345 517 0367

Email: norbert.halle@t-online.de

Web Site: www.netcomplett.de/schirm

Address:

SCHIRM Projekt

Rudolf Ernst Weise Str. 8

06112 Halle/Saale

Germany

Implementers

The Umbrella Project – in German, SCHIRM Projekt – was implemented by the City of Halle. "Schirm" means "umbrella" in German, but is also an acronym for "Streetkids in a Communication House with Integration Help and Rehabilitation Possibilities."

Funding

Forty-four per cent of the funding comes from the Youth Department of Halle, 44 per cent from the Youth Department of Sachsen-Anhalt, and 12 per cent from other sources such as donations.

Objectives

The project seeks to help disadvantaged young people in a holistic way, including helping them to prevent infection with and transmission of HIV.

Background

SCHIRM is both a centre and an outreach project. It is aimed at young people who have problems either with their parents or with children's homes or other institutions, and also at young people who do not know where else to turn because of drug abuse, prostitution, homelessness, or other problems. They are encouraged to use SCHIRM as a starting point for a better life.

Main Activities

Outreach work is done by social workers, who meet with young people at the places the latter frequent. As a part of the holistic approach, HIV prevention information is given out, free condoms are distributed, syringes and needles are exchanged, and talks on HIV prevention are given to young male sex workers.

SCHIRM has a house that offers young people a place where it is warm, where there is something to eat and drink (1 DM for a hot meal), and where they can wash themselves and their clothes. They are offered confidential counselling and help from the social workers to encourage them to think about further steps in their lives. The house also offers young people opportunities to relax, do creative work, talk, and exercise. It provides information on sexual health and HIV prevention, and advice

and help regarding drugs, law, debts, institutions, educational options, and so on. Young people have the opportunity to help out with the operation of the house by doing volunteer jobs such as cleaning and cooking.

The project is a first step for many of its clients to access other social services through referrals by staff.

Outcomes/outputs

The house's services are used by between 15 and 30 young people daily. Beyond this, it is difficult to identify further outcomes. SCHIRM is an entry point to other social services, which do more formal monitoring of a variety of indicators.

Lessons Learned

This project shows the importance of non-judgemental and highly open service centres operating outside (but in cooperation with) more formal institutions, to work with vulnerable young people who otherwise do not or will not seek help.

Working closely with cooperating partners such as social workers, SCHIRM gives the young people a "safety net" of supportive possibilities, which can provide a feeling of security. This feeling of security is reinforced by the principle of voluntarism, which has concrete benefits. The young people become active in the project themselves, and build up their own identity and sense of self-worth. In time, many of the young people feel connected with the project.

An important lesson learned by the project is that little successes – like washing every day, keeping an appointment, accepting help – are signs that the young person wants to come out of the situation she or he is in. These little successes are often necessary before the young person feels ready to take advantage of other opportunities offered by SCHIRM, such as receiving and discussing HIV prevention information. In other words, any attempt to promote behaviour change and HIV prevention among this population must be done at the speed and in the way desired by the individual young person.

Asian Red Cross/Red Crescent Youth Peer Education Programme (International)

Starting Year: 1994

Main Topic Area: Children and young people

Other Topic Areas: Reproductive health • Sexually transmitted diseases • NGOs and networks

Phone:

+632 527 8384

Fax: +632 527 0857

Email: pncrnhq@pdx.rpnet.com

Address:

ART Secretariat

Philippines National Red Cross

Bonifacio Drive

Port Area

Manila 2803

Philippines

Implementers

The programme was implemented by the Asian Red Cross/Red Crescent AIDS Task Force (ART).

Funding

The range of funders included the Asian Red Cross and Red Crescent, with a variety of national Red Cross and Red Crescent organizations, plus a number of other funders including AusAID, UNICEF, the Government of the Netherlands, and local donors.

Objectives

The goal is to combine clear and accurate information on reproductive health, STDs, and HIV/AIDS with participatory activities to equip and empower young people with skills, motivation, and support to sustain existing safe behaviour and change unsafe behaviour.

Background

The Youth Peer Education Programme on Reproductive Health, STDs, and HIV/AIDS was initiated as a single collaborative effort by the Asian Red Cross/Red Crescent AIDS Task Force in 1995. The programme was taken up by the 12 participating ART countries (Cambodia, China, India, Indonesia, Laos, Malaysia, Myanmar, Nepal, The Philippines, Thailand, the Republic of Korea, and Vietnam).

Main Activities

The key training tool for the youth peer education programme is a common core manual developed with the participation of young people, and from which manuals reflecting each country's language, culture, and socio-economic circumstances have been developed and pre-tested. The manuals cover the following topics: sexual health and reproduction; personal capacity building; support from friends; societal norms; STDs and HIV/AIDS; other health issues; and factors affecting risk behaviour. In each participating country, young people have been selected and trained as core trainers, facilitators, and peer educators. Young people themselves

are implementing the training programme among their peers with an emphasis on equal participation of men and women.

For descriptions of the programme at country level in China and Myanmar, see Yunnan/Australian Red Cross Youth Peer Education for HIV/AIDS Prevention Project (China) and Asian Red Cross and Red Crescent AIDS Task Force (Myanmar).

Outcomes/outputs

As of mid-1998, ART in-country organizations report having trained a total of 300 core trainers, 1,206 facilitators, and 9,002 peer educators. A total of 42,031 young people have been educated about reproductive health, STDs, and HIV/AIDS. Training manuals have been pre-tested and produced in nine countries. More generally, outcomes have included:

- Increased collaboration and exchange of experiences among Red Cross/Red Crescent organizations in the region: common and unique issues have been identified; skills and knowledge have been extended by more experienced ART member to their peers; collaboration on training of youth peer educators has occurred; awareness and sharing of available resource materials has increased; collaboration with other agencies has been strengthened.
- Increased skills-building on prevention and care/support components in programmes, along with greater commitment to encouraging participation of project beneficiaries
- Development of regional/local capacity and increased self-reliance, along with growing sense of ownership of the national programmes.

Lessons Learned

The project has shown the value of large-scale peer education training for young people using a common but adaptable approach.

An important lesson learned during the course of the project has been that pre-testing manuals with different youth groups in various setting is essential. The pre-testing suggested the training approaches and methodologies that are appropriate to each group. As well, the words used to describe sensitive issues must be chosen in a culturally and socially acceptable manner.

Effective ways to recruit youth volunteers include:

- One-day AIDS awareness workshops that give an opportunity to assess participants and select those with potential to be core trainers/facilitators
- Advertising and posters, which can provide valuable publicity for the AIDS programme if they are attractively designed
- Core trainers, who can encourage their friends to become facilitators. Peer motivating can be a useful means of recruiting.

Constant evaluation and review of care trainers following their own training are important, along with follow-up workshops and practice sessions. Ongoing monitoring of the needs of youth core trainers and facilitators permits provision of appropriate incentives and rewards.

Finally, flexible timing for training sessions is essential while working with volunteers, since they may have a difficult time scheduling the rest of their activities around the training.

Mathare Youth Sports Association (Kenya)

Starting Year: 1994

Main Topic Area: Children and young people

Other Topic Areas: Sexually transmitted diseases • Community mobilization

Contact Person:

Salim Mohamed

Phone: +254-2-763614

Fax: +254-2-583055

Email: munro@form-net.com

Address:

Mathare Youth Sports Association

P.O. Box 69038

Nairobi, Kenya

Phone: +254-2-717664

Fax: +254-2-714837

Email: kenaida@iconnect.co.ke

The Kenya AIDS NGOs Consortium
(KANCO)

P.O. Box 69866

Nairobi, Kenya

Implementers

The leagues of the Mathare Youth Sports Association (MYSA) are run by local committees of team coaches and captains, who constitute a Sports Council. MYSA also has a Community Service Council, consisting of local community and youth leaders, and an Executive Council. The chair of MYSA's AIDS Committee reports to the Community Service Council.

Funding

MYSA has a number of private-sector sponsors, including OrbitSports (supplies sporting equipment), Norsk Hydro (sponsors MYSA's professional football team), Coopers & Lybrand (audits the club's annual accounts gratis), Norwegian Agency for Development (NORAD), the Ford Foundation, and the Population Council. In addition, the Stromme Foundation supports the MYSA AIDS Programme, which was earlier supported by Norwegian Church Aid.

External funding is channelled through a local committee called Friends of Mathare Youth. It is hoped that the earnings of the professional football team associated with MYSA will eventually provide sufficient funding for most activities, including the AIDS programme.

Objectives

To fight the HIV epidemic by promoting healthy living, teamwork, and involvement in community-improvement activities.

Background

Mathare is the largest slum area in the Kenyan capital, Nairobi. MYSA began in 1987, when a football league was formed with the dual purpose of carrying out environmental clean-ups and organizing sporting activities. By 1988 MYSA had established 120 football teams of boys 12 to 18 years old. A decade later, it was Africa's largest football club (410 boys' teams and 170 girls' teams). The aim is to promote social responsibility and leadership both on and off the field.

Main Activities

MYSA has been training its footballers to be peer educators about HIV since 1994. Members of the senior squad, who were well-known and respected, and therefore had influence with their peers, were the first to be trained. The adolescents stress abstinence from sex; but for those who are sexually active, they emphasize the importance of using condoms and staying faithful to one partner.

MYSA peer educators talk about the problems of boy–girl relations, particularly the problems that arise when boys base their self-esteem on sexual conquests, and girls base theirs on having boyfriends. Peer educators aim to provide information and improve communication skills, with the goal of changing values and attitudes.

Outcomes/outputs

The MYSA AIDS Programme is estimated to have reached some 20,000 young people between 1994 and 1997. In the first year, 25 peer educators were trained. In 1996, an additional 26 boys aged 12-18 were trained. In 1997, 25 girls and 26 boys completed advanced courses, and 25 boys and 25 girls completed the basic course. A small AIDS reference library had been started for materials to be used in training and programme planning.

Evaluation Findings

No evaluation has been undertaken to date. Anecdotal evidence suggests some behaviour change among both boys and girls in Mathare.

Lessons Learned

The project demonstrates that adolescents and other young people can be effective peer educators for HIV prevention, and that their mobilization is a useful strategy for prevention and attitudinal change.

However, adequate training and materials are essential to support the work of peer educators and to help maintain their motivation. These materials need not be of high cost, but the support must be ongoing and secure.

Another lesson underlined by the project is that the focus of peer education must go beyond prevention messages (i.e., the physical “mechanics” of prevention). Instead, it must deal with the questions and anxieties that most young people have about their social lives and sexual identities.

Further Reading

Williams G, Ng'anga L, and Ngugi J. *Youth to youth: HIV prevention and young people in Kenya* (Strategies for Hope). London: ACTIONAID, Kenya AIDS NGOs Consortium, UNAIDS, 1997.

Red Cross Youth Peer Education Programme (Myanmar)

Starting Year: 1994

Main Topic Area: Children and young people

Other Topic Areas: Sexually transmitted diseases

Contact Person:

Dr Kyaw Win,
President,
Myanmar Red Cross Society

Address:

Myanmar Red Cross Society Red Cross
Building
42 Strand Road
Yangon, Myanmar

D. Juan Aguilar, Representative
Thazin Oo, Project Officer (HIV/AIDS)

Phone: +95-1-212086/212087

Fax: +95-1-212063

Email: unicef.yangon@unicef.org

UNICEF Yangon
Yangon International Hotel,
6th & 7th floor
330 Ahlone Road
Dagon Township, Yangon, Myanmar

Implementers

Implemented by the Myanmar Red Cross Society (MRCS) and UNICEF. The programme is part of major programme by the Asian Red Cross/Red Crescent AIDS Task Force (ART) which is being implemented similarly in at total of 11 countries; see also Youth Peer Education Programme on Reproductive Health, STDs, and HIV/AIDS (International) and Yunnan/Australian Red Cross Youth Peer Education for HIV/AIDS Prevention Project (China).

Funding

UNICEF provided the funding.

Objectives

The main objective is to use wide-scale youth peer education:

- To equip and empower young people with skills, motivation, and support to sustain existing safe behaviour and change unsafe behaviour
- To promote reproductive health.

Background

The Myanmar Red Cross has been implementing its programme with the support of UNICEF since October 1994. The programme has trained ten youth facilitators (five male, five female) and one coordinator in each township. As the project progressed, young people took the lead in developing manuals and other documentation, designing activities, conducting the training, and visiting sites to be monitored.

Main Activities

The local coordinator is selected by the local Red Cross chapter as the focal person to coordinate the programme and ensure implementation. The township coordinator invites the participation of young people, aged 15–25, from different socio-economic backgrounds, and organizes their training. Youth training is held on Saturdays and Sundays to enable the in-school youth to participate. These trained young people in

turn reach out to educate their friends. (See also Youth Peer Education Programme on Reproductive Health, STDs, and HIV/AIDS (International) for a wider discussion of ART's activities.)

The training on reproductive health includes life skills, non-formal counselling, friend-to-friend education, information on physical and mental changes during adolescence, and diseases, especially HIV/AIDS. To encourage discussion during the training, the number of trainees in each session is limited to 40. The training methodology includes discussions, games, role playing, and identification and discussion of behaviours that the young people perceive as risky.

Outcomes/outputs

The programme is the largest in the ART network. It has trained 937 facilitators and peer educators, all between the ages of 14 – 24, in the participating townships across the country. A total of 18,266 males and 17,480 female young people have received education on life skills, reproductive health, TB, STDs, and HIV/AIDS from the programme. As well, 5,400 manuals and 1,100 sets of flipcharts have been printed.

Experience from the programme has been shared in ART annual meetings. The Myanmar manual served as a core manual for adaptation by other manuals.

Evaluation Findings

Given the lack of any baseline data, it was not possible to conduct a formal pre-test/post-test evaluation of the broader impact of the life-skills training programme. However, a participatory evaluation of the training activities was carried out by MRCS and UNICEF in 1998. The training in participatory evaluation methods was provided by staff from the Bangkok office of the Population Council. The primary purpose of this evaluation was to encourage self-reflection among the local implementing agencies.

Eight of the townships covered by the project were identified as evaluation project areas, and one township not receiving training was selected as a comparison township. Data collection was qualitative in nature and involved the use of in-depth interviews and focus group discussions.

The evaluation found that the training has had a beneficial effect in terms of improving the knowledge base of the young people who were directly exposed to the training. It also appears to have had a positive effect on their reported attitudes toward persons living with HIV/AIDS. Knowledge of HIV, STDs, and other reproductive health topics was consistently better among urban than rural participants, regardless of whether the participant had received life-skills training. The findings also suggested that participants in project townships had better pre-intervention knowledge than those in the comparison township, where no life-skills training had taken place. However, one must exercise caution in drawing this conclusion, given the courtesy bias inherent in such a participatory approach and the fact that only one township was used for comparison.

Lessons Learned

First, the programme proves that it is possible in a resource-poor setting to implement community-based peer education among young people on a very large scale. Second, active and voluntary participation by young people is the key to this programme's success.

Sexplain: Peer Education on Sexual Health for Young People (Netherlands)

Starting Year: 1996

Main Topic Area: Children and young people

Other Topic Areas: Communications programming • Male condoms

Contact Person:

Mr Onno de Zwart

Phone: +31 10 433 9262

Fax: +31 10 433 9237

Email: dezwarto@ggd.rotterdam.nl

Address:

HIV/AIDS Policy Co-ordinator

Municipal Health Service Rotterdam

P.O. Box 70032

3000 LP Rotterdam

Netherlands

Implementers

Implemented by Municipal Health Service Rotterdam, using trained peer educators.

Funding

Municipal Health Service Rotterdam and the Dutch AIDS Fund provided funding for the project.

Objectives

The goals of the project are:

- To inform young people aged 15-20 about HIV, STDs, and birth control
- To promote a positive attitude toward safer sex among young people
- To teach young people the skills to use condoms properly and to negotiate their use.

Background

The project trained and employed 12 peer educators with a variety of backgrounds and characteristics (age, gender, ethnicity, education, religion, and sexual preference) to run workshops on sexual health at community centres, youth group meetings, and at other projects for young people.

Main Activities

Each workshop was led by two peer educators, who, at the start of the project, had attended a three-day training session that concentrated on knowledge, communication skills, and attitude toward sexuality. Workshops included group discussion, games, and practical exercises emphasizing three themes: improved knowledge, attitude, and skills.

Knowledge: The workshop participants discussed eight questions concerning knowledge about HIV, STDs, and contraceptives. Apart from informing the participants, the discussion also worked as an indicator of the level of knowledge. Another technique was the "Ken and Barbie game." Participants were divided into three groups. Each group had to list as many sexual techniques as possible. The techniques were written on "post-its" and attached to a large drawing of two nude figures (male and female), on that part of the body appropriate to the particular

technique. The peer educator then discussed the techniques in terms of safety for HIV and STDs. The techniques were divided into three categories: "safe," "unsafe," and "safe when...."

Attitude: The participants focused on attitudes toward safer sex and condom use by discussing excuses and reasons to engage in unsafe sex. The participants were divided into two groups. Each group received a set of cards with excuses for not engaging in safer sex. One group had to defend the excuses, while the other group had to oppose them. The peer educators facilitated the discussion and pointed to the fallacies in the excuses.

Skills: Peer educators gave information about and demonstrated the use of condoms, dental dams, lubricants, and the pill. Condom use was practised in a dildo-condom "race." The participants were divided into two groups. Each participant received a condom and each group a dildo. The first participant in each group took the dildo, opened the condom, and put it on the dildo. He or she then handed the dildo over to the next person. The team that succeeded in putting the condoms on the dildo in the correct way won the race. All participants received a key chain that held a condom. The peer educators gave instruction and judged whether the condom was put on in the correct way.

At the end of the workshop, brochures were handed out, and participants could ask peer educators individual questions.

As well, peer educators participated in monthly meetings for supervision, feedback, and continuous education.

Outcomes/outputs

In 1996 and 1997, 60 workshops were carried out with 450 participants. Outcomes included a significant increase in the knowledge of the participants and significant changes in their attitudes toward AIDS and homosexuality. The participants also said that they would behave more safely, offering concrete examples such as condom use with a new partner and in a relationship, and visiting a doctor when they suspect they may have an STD. (See Evaluation Findings for more details.)

Evaluation Findings

Two evaluations have been carried out. In the first, all participants received a written questionnaire before and after the workshop. The survey included questions on background, knowledge, sexual experience, attitude, behavioural intentions and expectations, and evaluation of the workshop. In total 311 participants (a response rate of 69 per cent) filled in one of the questionnaires; 262 (58 per cent) filled in both the pre- and post-intervention survey. Only the latter have been included in the analysis.

The general characteristics of the respondents were as follows:

- Mean age was 17.8; 78 per cent were under 20
- 53 per cent had lower education only, 34 per cent middle, and 13 per cent higher education
- 62 per cent were boys; 38 per cent girls
- 54 per cent of the respondents were of non-Dutch origin; 46 per cent of Dutch origin
- 8 per cent of boys and 7 per cent of girls felt attracted to people of their own gender.

The sexual experience of the respondents included: deep kissing, 96 per cent; masturbation, 83 per cent; vaginal intercourse, 72 per cent; oral sex, 52 per cent; anal sex, 12 per cent.

Fully 96 per cent of respondents said that they had enjoyed the workshop, and 95 per cent felt that they had learned something useful. Eighty-four per cent of the respondents felt that the peer educators had done a good job in facilitating the workshop; and 65 per cent would recommend the workshop to their friends.

The second evaluation occurred after the last workshop was carried out. Semi-structured interviews were conducted with the peer educators by an external researcher. Interviews focused on the experience of the peer educators with the workshops and its impact on their lives. The main conclusions were:

- Adequate training and constant support for peer educators is necessary to ensure the quality of the intervention and to support the peer educators in their work and role (especially in unexpected situations)
- Peer educators experience their work as challenging but manageable and find it personally rewarding
- Young people are able to function as peer educators and acknowledge both the advantages and limits of such a role.

Lessons Learned

The experience shows that young people appreciate and are influenced in positive ways by a peer-led intervention if it is well-designed and properly supervised. In particular, adequate training and constant support for peer educators is necessary to ensure the quality of the intervention and to support the peer educators in their work, especially in unexpected situations.

A welcome lesson is that bringing together peer educators with different backgrounds is feasible. The peer educators themselves appreciate the variety of backgrounds that the recruiting strategy exposed them to.

Sema Life Development Project (Thailand)

Starting Year: 1992

Main Topic Area: Children and young people

Other Topic Areas: Sex workers and clients • Schools

Contact Person:

Dr Sangob Laksana

Phone: +662 281-6013, 628-6512,
281-3490

Fax: +662 628-5610

Address:

Dr Sangob Laksana

Deputy Permanent Secretary

Ministry of Education

Rajdamnern Avenue

Bangkok 10200, Thailand

Implementers

The Ministry of Education is the implementer of the Sema Life Development Project, with a special budget allocated by the Ministry of Finance. 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 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.

Funding

The funding is provided by the Ministry of Education, the Ministry of Finance, and UNICEF.

Objectives

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.

Background

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 – those from poor families and with little opportunity to continue their education – 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, Lampang, Phayao, Chiang Mai, Prae, Mae Hong Song, Lamphun, and Nan) were identified as the target area. 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 per cent) who did not continue in school after completing Grade 6.

Main Activities

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.

Teachers who have selected girls for this project note that some girls had already been sold to an agent for prostitution. Prior to offering these girls their scholarships, the teachers had to convince the girls' parents or guardians to change their minds.

Outcomes/outputs

Over 500 girls are provided scholarships for boarding school each year. Over 4,000 scholarships are provided for day students to further their education in schools located in their communities.

Evaluation Findings

An evaluation is being commissioned by the Ministry of Education.

Lessons Learned

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. As well, 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.

Further Reading

UNAIDS. *Reducing girls' vulnerability to HIV/AIDS: The Thai approach* (Best Practice Case Study). Geneva: UNAIDS (in press).

Youth Career Development Programme (Thailand)

Starting Year: 1995

Main Topic Area: Children and young people

Other Topic Areas: Workplace

Contact Person:

M.R. Usnisa Sukhsvasti, Rattan
Promrak, or Kitiya Phornsadja

Phone: +662 280-5931

Fax: +662 281-6032-3

Email: unicef_bao.unescap@un.org

Address:

UNICEF Office for Thailand

P.O. Box 2-154

Bangkok 10200

Thailand

Implementers

The Pan Pacific Hotel Bangkok and UNICEF were the original implementers. Additional hotels now involved included the Regent Bangkok, Shangri-la Bangkok, Fortune Hotel, Grand Hyatt Erawan, Royal Orchid Sheraton Hotel and Towers, Sheraton Grand Sukhumvit, and Westin Banyan Tree.

Funding

The hotels provide training, uniforms, meals, and pocket money for trainees. UNICEF supported the cost of the participants' accommodation during their five-month stay in Bangkok, their round-trip transportation, and the cost of education for those attending non-formal education including workshops on child rights. There is also some support from corporations such as AIA, which provides health insurance coverage, and Colgate-Palmolive.

Objectives

The dual objectives of the Youth Career Development Programme (YCDP) are:

- To assist rural young people who have little access to educational and vocational training
- To ensure long-term social and economic security for the participants.

Background

The Youth Career Development Programme was initiated in 1995. It offers young people in rural areas the education and training to help them avoid becoming sex workers or child labourers.

From 10 participants and 1 hotel in 1995, the programme has expanded over the years. In 1998, 47 young people and 8 leading Bangkok hotels took part in the training programme. The young people, aged 17-19, came from various provinces in the North and Northeast such as Nan, Yasothon, Srisakes, Mae Hong Son, Phayao, Lamphun, Chiang Mai, and Chiang Rai.

The programme was endorsed at the fiftieth anniversary Congress of the International Hotel and Restaurant Association, a global network of independent and chain operators, national associations, hospitality suppliers, and educational centres in the hotel and restaurant industry. As a result, the programme will be implemented on a worldwide basis by members.

Main Activities

In addition to receiving training in vocational skills including food and beverage work, housekeeping, flower arrangement, and kitchen and laundry work, the girls are provided with supplementary training and orientation on relevant issues, particularly children's rights and protection, HIV/AIDS, and community development.

Outcomes/outputs

To date, 135 young people have completed the training programme. Most are now employed in leading hotels (or, less frequently, in restaurants) both in Bangkok and their home provinces.

Evaluation Findings

Evaluation and project documentation has been conducted with support from the Swiss Fund through the Gender and Development Section, UNICEF, New York.

Lessons Learned

Partnerships and alliance-building among the various sectors of a country are critical and necessary resources for the promotion of child development and protection.

With the resources and contacts facilitated by this networking, YCDP provides an opportunity for young people at risk to explore their options through career development, professional experience, income-earning, and the enhancement of self-esteem and self-confidence.

Further Reading

UNICEF Information Note, 12 May 1998. "Eight Bangkok Hotels Join UNICEF Youth Career Development Programme 1998."

Chaturvedi S. *Youth Career Development Programme, making a difference to children and youth in Thailand at risk of exploitation*. Bangkok: UNICEF Office for Thailand, 1998.

National Strategies to Reduce Vulnerability of Thai Girls (Thailand)

Starting Year: 1992

Main Topic Area: Children and young people

Other Topic Areas: Sex workers and clients • Schools • National strategic planning

Contact Person:

Dr Kitiya Phornsadja, Project Officer
(Children in Especially Difficult
Circumstances), UNICEF

Phone: +66-2-2805931 (ext. 910)

Fax: +66-2-281 6032 or 6033

Email: kphornsadja@unicef.org

Address:

UNICEF Office for Thailand

P.O. Box 2-154

Bangkok 10200

Thailand

Dr Sangob Laksana

Deputy Permanent Secretary,

Phone: +662 281-6013, 628-6512,
281-3490

Fax: +662 628-5610

Office of Special Affairs,

Ministry of Education

Rajdamnern Avenue

Bangkok 10200,

Thailand

Implementers

The various implementers include the Ministry of Education, the Ministry of Finance, the Ministry of Public Health, educational institutions including Chiang Mai University and Mahidol University, hospitals, and private businesses.

Funding

The bulk of the funding comes from the Ministry of Education, with funding from UNICEF on some project components.

Objectives

National Strategies to Reduce Vulnerability of Thai Girls seeks to assist children at risk of entering the sex industry, and thereby to reduce their vulnerability to exploitation or to contracting HIV or other STDs.

Background

In 1992, a national effort was launched to eradicate child prostitution and to assist those at risk of entering the sex industry. The Ministry of Education (MOE) conducted a survey of Thai sex workers both in Thailand and abroad to uncover information about their hometown, age, education, reasons for becoming a sex worker, the channels used to find work abroad, and so forth. This information, along with data on villages with high HIV/AIDS rates as well as on the number of students who finished Grade 6 but did not continue their education, was used as the basis for planning the intervention. Several strategies were implemented, including prevention, assistance, rehabilitation, and legal measures to eliminate entry into the sex industry by children under 18. Preventive measures were viewed as the most important approach.

Main Activities

The following broad guidelines for intervention were identified for implementation in programmes:

- All children should receive nine years of quality basic education. Impoverished children with no opportunity for further education need access to education and vocational training. At the same time, the educational curriculum and vocational training must be relevant to the local environment and conditions, as well as to the demands of the labour market.
- The quality of education must be improved to enable a child to think about and uphold moral principles and be able to choose a way of life with human dignity.
- Girls and boys must have equal access to both formal and non-formal education.
- Counselling and guidance services, in particular for solving family and youth problems and for job selection, must be provided in every school and to out-of-school children.
- Recreational and social services should be provided so that children and young people can spend their leisure time appropriately.
- Campaigns to raise awareness about child prostitution should be conducted to foster correct attitudes among parents, guardians, teachers, and the general public.
- Neighbouring countries should be encouraged to cooperate on campaigns and publications about prevention and feasible solutions to problems related to the sex industry.
- An inspection and surveillance system should be set up to prevent coercion or deception of children into prostitution.

Outcomes/outputs

In response to the national strategy, several projects have been implemented. Three of these projects are described elsewhere in this summary: Sema Life Development, Thai Women of Tomorrow Project, and Education Loan Fund Project.

Lessons Learned

Education and vocational training appear to be among the best strategies to prevent young girls from entering the sex industry. However, these strategies have to be part of an integrated prevention programme that includes counselling services for members of high-risk groups, therapy sessions for girls who have been abused, and good coordination between schools and other institutions such as police, social welfare service, NGOs, and sub-district administrative organizations.

As well, alternatives to scholarships need to be explored and provided for girls who cannot be at school.

The practical application of these lessons can be seen in the components of the three projects listed under Outcomes above.

Further Reading

UNAIDS. *Reducing girls' vulnerability to HIV/AIDS: The Thai approach* (Best Practice Case Study). Geneva: UNAIDS (in press).

The assessment of child prostitution intervention programmes in Thailand: Five case studies. Social Research Institute, Chulalongkorn University, 1997.

Thai Youth AIDS Prevention Project (Thailand)

Starting Year: 1995

Main Topic Area: Children and young people

Other Topic Areas: Schools • Community mobilization

Contact Person:

Amporn Boontan

Phone: +6653 274157

Fax: +6653 808493

Email: tyap@loxinfo.co.th

Address:

Thai Youth AIDS Prevention Project

P.O. Box 287

Chiang Mai University

Chiang Mai

Thailand

Implementers

Originally founded by three young foreigners who had recently graduated from an American university, the Thai Youth AIDS Prevention Project (TYAP) is now run entirely by Thai nationals.

Funding

Funding has been obtained from a variety of sources including international NGOs, a television company, UNICEF, and many individual donors.

Objectives

The project has several objectives:

- To promote AIDS prevention and care among young people in northern Thailand
- To encourage behaviours that will protect young people from HIV infection
- To reduce discrimination toward people living with HIV/AIDS
- To build peer support networks among young people.

Background

The Thai Youth AIDS Prevention Project was established in Chiang Mai as a non-government organization in September 1995 to target youth AIDS prevention and care in northern Thailand. TYAP's philosophy includes promoting long-term interactive life-skills education, providing the tools and skills necessary for young people to protect themselves in modern times, training young people to teach their peers and to work with people affected by HIV/AIDS, and challenging young people to be involved in effecting policy change.

Main Activities

TYAP engages in a wide range of activities:

- Training AIDS educators: Each semester, 25 youth volunteers aged 17–23 receive a month of intensive training followed by weekly training and planning sessions throughout the semester.
 - Outreach: AIDS educators teach a series of workshops that run for eight weeks and take up two and a half hours a week; these workshops are aimed at young people (aged 10–18) in middle schools, vocational schools, orphanages, and the streets of Chiang Mai
-

- Camp Sanook! Sanook!: TYAP runs a week-long camp for 30 children aged 4–11 from families in which some members are HIV-positive. The camp provides the children with a chance to build support networks, and aims to reduce community discrimination against children affected by HIV.
- Train the Trainer Programme: TYAP trains staff for 18 NGOs in northern Thailand and provides continued support while they initiate HIV-related activities with youth groups in communities and schools.
- The TYAP centre also functions as a youth centre where people can relax, study issues related to HIV/AIDS and young people, and communicate with like-minded people. The youth centre supports much of TYAP's other work such as the peer leader and outreach activities.

Outcomes/outputs

In the first two years, over 1,000 young people participated in TYAP activities. Five peer educators eventually joined TYAP as staff after demonstrating their strong commitment to the work and the issues TYAP deals with.

As result of TYAP projects, two street youth went on to develop their own outreach programmes, and students in four different schools set up peer educator programme.

Lessons Learned

The project has learned a great deal about what works effectively in training and organizing young people as peer educators. TYAP reports:

“Continuous weekly training sessions proved to be critical for the peer educators. One long intensive training is not enough. It takes people a long time to process all the information, skills, and teaching techniques. Weekly trainings provide a good opportunity for the educators to come together and problem-solve and also provides the educators with a support group that they can count on for their work.

“It was found useful to ask the educators to take time to invent their own games, based on the knowledge and skills they had acquired from trainings. This was VERY useful because they were then not just participants in workshops, but had to learn in order to either produce an HIV prevention material or to teach others in their communities. As well, some excellent new ideas were created from such exercises.

“It is important to hear what the educators are saying, both through formal and informal evaluation. It is equally important for them to be listening to what their groups in schools are saying.

“Although it was a difficult decision to take, TYAP decided to pay the educators because it wanted street youth to be educators and such young people need sources of income. It also gave a financial value to their work, so that it would be perceived as professional training, not just volunteerism. This became a source of pride for them and made the time spent legitimate in the eyes of parents (when they were living with parents).

Further Reading

TYAP News, the project's newsletter, is available from the TYAP office.

Thai Women of Tomorrow Project (Thailand)

Starting Year: 1992

Main Topic Area: Children and young people

Other Topic Areas: Sex workers and clients • Schools

Contact Person:

Dr Kitiya Phornsadja
Project Officer (Children in Especially
Difficult Circumstances)

Phone: +66-2-2805931 (ext. 910)

Fax: +66-2-2816032,-6033

Email: kphornsadja@unicef.org

Address:

UNICEF Office for Thailand
P.O. Box 2-154
Bangkok 10200
Thailand

Implementers

The project was initiated by researchers at the Faculty of Social Sciences, Chiang Mai University (CMU) in northern Thailand.

Funding

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 given support to parts of the programme.

Objectives

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.

Background

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 has the same objective as the Sema Life Development Project and focuses on the same group of children, namely, girls who have finished Grade 6 and do not go further in their education. There is, however, greater emphasis than in the Sema project on changing attitudes of girls and their parents against prostitution and towards vocational training as an alternative to school.

Main Activities

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. The project's objectives were to change the attitudes of both girls and their parents against sex work and in favour of higher education and alternative occupations.

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).

Outcomes/outputs

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:

- 140 girls attended the Assistant Health Worker six-month training programme 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.
- 75 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.
- 150 girls were trained for three months 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.

- 60 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 contains 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 toward prostitution changes. Focus-group sessions and home visits were also 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 on, and try to affect decisions about the girls' futures. As a result, a great number of girls and their parents changed their minds and decided to either continue schooling or join vocational training programmes.

Lessons Learned

In addition to the accomplishments noted in Outcomes/inputs, a variety of very useful lessons were learned about designing this type of project.

One was that the short-course training provided for girls in rural areas had to be designed in accordance with the girls' abilities and prospects. A computer-training programme may not be appropriate because it requires skills in English, one major weakness of students in rural areas. It is difficult for them to learn the material and, even after they finish training, their skills often are still not competitive with those of well-trained persons.

The training programmes that are best-suited to the girls in this area are gem cutting and the garment industry. They can learn fast and get a well-paying job after finishing their training. Matching the right training programme with the target population should be a priority.

Another important lesson learned is that great care must be exercised in choosing the companies to participate in this kind of project. If the girls who finish training are placed in companies that exploit them with low pay or excessive work hours, it will discourage girls from such work and encourage them to become sex workers, who earn much higher incomes. As a result, prostitution may again be seen as the most viable form of work for rural poor women. Selecting the right business partners and involving them in every step of the project, especially in the planning and implementation stages, can increase their awareness and understanding of the objectives of the project and may reduce the likelihood of exploitation.

Further Reading

UNAIDS. *Reducing girls' vulnerability to HIV/AIDS: The Thai approach* (Best Practice Case Study). Geneva: UNAIDS (in press).

Education Loan Fund Project (Thailand)

Starting Year: 1996

Main Topic Area: Children and young people

Other Topic Areas: Schools • Sex workers and clients

Contact Person:

Dr Sangob Laksana

Deputy Permanent Secretary

Phone: +662 281-6013, 628-6512,
281-3490

Fax: +662 628-5610

Address:

Ministry of Education

Rajdamnern Avenue

Bangkok 10200,
Thailand

Implementers

The Education Loan Fund Project was implemented by the Ministry of Education and Krung Thai Bank, with supervision from the Ministry of Finance.

Funding

Funding is provided by the Ministry of Education and the Ministry of University Affairs.

Objectives

The goal is to assist children to continue their education, and thereby reduce their vulnerability to being recruited for the sex trade.

Background

Like the Sema Life Development and Thai Women of Tomorrow programmes, the Education Loan Fund Project aims to help girls from disadvantaged families, but it focuses on a higher education level. Children (both girls and boys) who finish Grade 9 and cannot afford to enter upper-level secondary school, or secondary school graduates who wish to enter vocational school or university, are eligible for a loan from the education fund. The project aims to help poor families regardless of the risk children may have of entering the sex industry. However, if they apply for education loans, Sema Life Development Project students receive priority. Thus, although this project does not address the AIDS problem directly, it is viewed as a supporting project to the objectives of the Sema Life Development and Thai Women of Tomorrow projects (see both of these projects in this Summary Booklet), both of which help to reduce vulnerability to HIV risk situations.

The Education Loan Project was approved in 1996 to provide educational opportunities to students who are economically unable to continue their education after completing Grade 9. Human resource development and equal access to education are the project's major objectives. In Thailand, only six years of education are compulsory; education to a higher level is thought to be up to individuals and their families. But families with limited incomes may decide to put their children into the labour market rather than sending them to school. As a result, they will be trapped in unskilled and low-paying jobs, unable to improve their quality of life.

Main Activities

This project offers low-interest loans to students to continue their education as far as the university level. Students can request a loan to cover tuition fees, education-related expenditures, and living expenses. The yearly expenditure ranges from 53,640 baht (US\$1,372 in early 1997) for high school or equivalent to 76,500 baht (US\$1,956) for a bachelor's degree. Contracts are made on a yearly basis. After the first-year loan is approved, students are guaranteed subsequent loans until graduation, unless they have educational problems and are unable to complete their studies.

Students must begin to pay back their loans two years after finishing their education. The loan reimbursement includes both interest and principal on the loan, and is paid back on a progressive schedule. The loan should be completely paid off within 15 years (that is, 17 years after students complete their education). The interest rate is set at 1 per cent per year. The loan is terminated when all the money is returned or the borrower dies.

Outcomes/outputs

In 1996 more than 131,000 students took advantage of this programme to study in schools under the Ministry of Education, and just over 21,500 in those under the Ministry of University Affairs. The number of students receiving loans under the MOE increased to over 373,000 (up 185 per cent) in 1997 and over 65,000 (up 205 per cent) for students under the Ministry of University Affairs.

Evaluation Findings

Despite the impressive successes mentioned above, the Educational Loan Project has not been fully successful in providing loans to the girls participating in the Sema Life Development Project. During focus-group discussions with these girls about why they did not apply for loans, most said they did not receive information about the project. Loan project announcements are made at the high school level. Students at lower educational levels receive such information only through indirect channels, such as television or radio spots. Moreover, students who are eligible to apply for loans must already be enrolled in a high school or higher-level educational institution, which means that those who finish Grade 9 are unable to apply until they are already enrolled in a higher-level educational institution. This process is different from that of the Sema Life Development Project, in which students who receive a scholarship know the results before they finish Grade 6; in this way, they are certain that they will have adequate funds to continue their education. The Educational Loan Project's process thus reduces the chances for poor students, such as those in the Sema Life Development Project, who want to continue their education but do not have adequate information or are uncertain about getting approval.

Lessons Learned

This project has been able to benefit many young Thai women, giving them an opportunity they would not otherwise have had and thus helping many avoid the sex trade and its manifold risks of HIV/AIDS and STDs.

As well, the programme has provided a wealth of practical lessons about the complexity of implementing such a programme, which will be of strong interest to other countries or organizations attempting to implement similar activities. During the first year of implementation, students did not understand the objective of the loan project and feared being in debt. The total loan amounts requested by students were less than the amount of money allocated. Thus, the need to inform the target population of the availability of funds and the terms of the loans is the first lesson learned. Moreover, each school should receive detailed information in order to

answer any questions that students may have. The implementation process is rather complicated, and details of contracts need to be accurate. Many schools did not understand the project's process, which led to delays.

The students who received loans during the first year of implementation had to wait about a semester before their loan was approved. During the second year, when the students learned from others who had already received loans, the number of students who applied doubled, and accessing the money was faster. Information dissemination and detailed implementation guidelines are crucial. NGOs can act as information disseminators to particular populations, especially to the groups in greatest need. This might involve identifying target groups and providing necessary information such as the availability of funds, the application process, the contract and repayment processes, and so forth.

It was found to be important to avoid words that some population groups might find obstacles to applying for loans. For example, the word "interest" is not accepted by Muslims, thus reducing the chances for students from that group to apply for loans. The project therefore changed the word to "fee," which was acceptable to the target population.

Students who received loans reported that they could concentrate more on their studies because they did not have to worry about earning money to pay for their education. They also said that they feel more responsible about finishing their studies in order to get a job and pay back their loans.

HIV Prevention in First Year of Secondary School (USA)

Starting Year:

Main Topic Area: Children and young people

Other Topic Areas: Male condoms • Communications programming

Contact Person:

Dr Jeffrey D. Fisher

Phone: +1 860 486 5917

Fax: +1 860 486 4876

Email: CHIP@psych.psy.uconn.edu

Address:

Center for HIV Intervention and
Prevention

Department of Psychology, Box U-20

University of Connecticut

Storrs, CT 06269-1020

USA

Implementers

The project was implemented by high school teachers and high school student peers trained by the Center for HIV Intervention and Prevention, Department of Psychology, University of Connecticut.

Funding

The funding is provided by the National Institutes of Mental Health (NIMH).

Objectives

The two goals are to increase condom use among sexually active high school students, and to encourage abstinence among those students not already sexually active.

Background

The programme provides school-based HIV prevention intervention for inner-city, minority students in their first year of high school in New Haven and Hartford, Connecticut, USA. The intervention is based on Fisher and Fisher's (1992) Information, Motivation, Behavioural (IMB) skills model of HIV prevention. The IMB model posits that in order for individuals to engage in prevention, they must:

- Possess behaviourally relevant information about HIV transmission and prevention
- Be motivated to practise HIV prevention (they must believe that HIV could happen to them, have positive attitudes toward prevention, and perceive positive social norms for prevention)
- Have the necessary behavioural skills for HIV prevention (discussing abstinence and safer sex with partners, purchasing and using condoms)
- Be confident in their ability to execute these skills.

Main Activities

The centre uses two delivery systems to increase information, motivation, and behavioural skills. The first is a classroom-based, teacher-delivered intervention. This four-day programme involves the use of videos that are age-appropriate and culturally relevant to this population. The teachers conduct discussions about the videos, and engage the students in activities designed to increase both their

perceived social normative support for prevention and their behavioural skills for prevention.

The second delivery system uses natural opinion-leaders to encourage pro-prevention norms, attitudes, and skills, and to disseminate HIV prevention information. First, students nominate a group of popular and respected peers from the first-year class of the high school. This cadre attends the four-day programme described above, and is given additional training regarding how to initiate discussions of HIV prevention with peers. The peer leaders then talk to their friends and people in their social groups about HIV prevention and how they can engage in safer behaviours.

Outcomes/outputs

The classroom-based intervention, the peer leader-based intervention, and a combination of the two approaches were compared to a control condition. Overall, each of the interventions resulted in increases in HIV prevention information, motivation, and behavioural skills. In addition, participants in the interventions were more likely than controls to have bought condoms, carried condoms, discussed condoms with a partner, and actually used condoms at both an immediate post-test and a three-month follow-up. The combined condition (both a classroom-based and peer leader-component) showed the greatest gains in information, motivation, behavioural skills, and behaviour.

Lessons Learned

In addition to research results noted in Outcomes/inputs, Both school-based and peer-based HIV prevention programmes using the IMB model can be successful at increasing HIV prevention information, motivation, behavioural skills, and behaviour among high risk, inner-city, minority high school students. A mixture of the two is more effective than one or the other in isolation.

Further Reading

The Center for HIV Intervention and Prevention is currently preparing a manuscript for publication detailing the findings. The actual curriculum for the intervention and the training sessions will be provided upon request from the centre.

Wan Smolbag Theatre: Popular Theatre for Health Education (Vanuatu)

Starting Year: 1989

Main Topic Area: Children and young people

Other Topic Areas: Communications programming

Contact Person:

Ms Jo Dorras

Phone: +678 24 397 or +678 27 119

Fax: +678 25 308

Email: jopet@vanuatu.com.vu

Address:

Wan Smolbag Theatre

P.O. Box 1024

Port Vila

Vanuatu

Implementers

The project is implemented by Wan Smolbag Theatre (WSB).

Funding

The core funds to run Wan Smolbag Theatre, and its tours and videos, come from the British aid programme the UK's Department for International Development (DFID). The funds to run the drop-in centre come from the Secretariat of the South Pacific, UNICEF, and the United Nations Population Fund (UNFPA). Contributions to the building of the centre came from DFID, New Zealand (NZODA), and Australia (AusAID). Present core funding from DFID ends in March 2000, and the theatre group is looking for continued funding to carry on its work.

Objectives

The goal of the group is to improve understanding of reproductive health issues through development theatre techniques. The group also runs a youth drop-in centre whose goal is to facilitate the treatment of STDs and the access to family planning for young people.

Background

Wan Smolbag Theatre has been working in the field of health education since 1989. Since that time the theatre has covered many different health topics. The main focus of its health work has been in the area of reproductive health, looking at the problems of teenage pregnancy, maternal health, STDs, and HIV/AIDS. Plays are often aimed at a specific age group, and there are plays specifically for urban and rural audiences.

The need for discussion and explanation of family planning issues was seen when the group first began in this field in 1989, with a play called *Storian Blong Angela*. The play told the story of a girl who has a baby when she is very young. She then tries to go on the pill, but is stopped from doing so by the chief. When she gets pregnant again, the chief realizes his mistake and says he needs to understand about family planning. At the end of the play, the health worker character asks if the audience wants to know about family planning. Invariably the answer is yes. The group then divides the village or settlement into two groups – men and women – and every family planning method available is explained and discussed.

Main Activities

Wan Smolbag Theatre has developed a model of popular theatre that explains to people (especially young people) at the grassroots level about family planning, and provides basic knowledge about how the body works. The group has developed a series of sketches, showing how diseases like gonorrhoea are transmitted through sex. There is a representation of a penis and a vagina on stage, with members of the group playing a sexually transmitted disease germ, a sperm, and the liquid that carries the sperm. The sketches are in very short sections, lasting no more than about 30 seconds. After each sketch the audience is invited to explain what they have just seen and to answer questions. This new format has been used extensively in secondary schools and in workshops in Vanuatu and overseas.

In its play for primary schools, performed by Wan Smolbag Kids – a group of primary school dropouts who perform plays for their peer group – WSB has further developed the idea of using drama to explain how the body works. Their play on how a baby is born was the first with the theme of sex allowed into the primary school system in Vanuatu.

In 1998, WSB developed an interactive play on population growth, which was performed for the upper years of secondary school and for groups of urban, unemployed people over 15. It looks at the effects of population growth on the running of the government. This play was developed with groups from the islands of Ambae and Pentecost, including many young people, looking at how life has changed for them over the years and at the effects of the growing population and life in large families.

The actors play government ministers and sit on platforms in a circle around the audience. They are discussing the current year's budget, which is unchanged from the previous year. Two of the ministers point out that the budgets for health and education are constantly going down, as the population is expanding but the amount of money to be spent remains the same. They talk about the need for good family planning services. When they start explaining to the audience how to use condoms, a chief comes in and stops them. They want to carry on, but the prime minister and other ministers are worried they will be unpopular. The story then moves 25 years into the future: there has been a huge influx of people into the capital, and draconian laws have been passed to keep the rapidly growing population under control. The audience is involved in trying to find solutions to the growing problems the government faces and is taken on a journey into a grim future.

Outcomes/outputs

WSB creates at least two new plays and tours at least six times each year. It has developed and taped four new videos and is currently developing a feature-length film on good governance. WSB has also adapted and taught 15 plays to associated theatre groups in Vanuatu and has assisted Solomon Island theatre groups and a Fiji group with developing and directing new plays. It retains 21 plays in its active repertoire.

Evaluation Findings

Wan Smolbag has a research department, which constantly undertakes evaluation into the effectiveness of the plays and into people's attitudes and needs regarding reproductive health education. Various studies from the research department are available (see address above). WSB has documented not only improved rates of family planning after its tours to the islands but also greater understanding about AIDS and STDs after people have watched the plays.

An example of the detailed information collected can be seen in a report describing a visit made by the theatre to a school (ages 7–13) in Port Vila: “One of the main points that Wan Smolbag is trying to emphasise in the STD sketches, is about the curing of STDs by ‘klevas’ or traditional doctors. That is that ‘klevas,’ who treat STD patients with leaf medicines, can only remove symptoms of STDs and not the bacteria that cause it (sic). There has been a big difference in the answers to the questions concerning this particular point. In the baseline survey, 22% of the students stated that ‘klevas’ can cure STDs. In comparison to this figure, only 13.8% of the students came up with the same answer in the follow-up survey. The percentage of students stating that ‘klevas’ cannot cure STDs rose dramatically from 23.6% to 68.2%.”

There is growing evidence that WSB’s work in Vanuatu is leading to beneficial change in the areas of health, family planning, and sanitation, and to greater public awareness of issues such as voting rights and population growth. Although the full extent of these achievements is not readily measurable without a large and expensive survey, a review by the UK’s Department for International Development concluded that the project has or is meeting its planned objectives and outputs.

Lessons Learned

In addition to the accomplishments noted in Outcomes/inputs, the group considers that the greatest lesson they have learned regarding effective educational theatre is to keep repeating the same messages in different forms.

They also consider research essential, particularly an ongoing effort to find out what people – especially young people – think and understand about AIDS and STDs.

Finally, the group emphasizes the importance of backing up awareness-raising with services where possible. This is the reason the theatre group has recently built its own drop-in centre, where services such as STD treatment and condom distribution can be carried out.

Further Reading

Wan Smolbag has published an number of videos and papers. The most recent is the video *Kasis Road*, which looks at teenage pregnancy. It comes with a teacher's guide.

Communications programming

In the early days of communications for development programmes, including those focusing on health issues, information was often simply conveyed from sender to receiver. No feedback was sought, and there was therefore little information on how a particular message was understood by the receiver. Today, this has largely changed: development programmes often now use formative research and feedback for a better understanding of their audience and of how delivered messages are perceived. Feedback has become an essential part of communications programming, and is used as a tool to monitor programmes.

While communications in the field of HIV/AIDS is usually thought of in terms of prevention – of establishing or changing behaviour in a way that prevents or minimizes the risk of HIV transmission – communications programmes are becoming increasingly relevant to care and support. This is true of information, educational and communications (IEC) activities aimed at those providing care and support – in the home, in the community, and elsewhere. It applies equally to communications between care providers and people with HIV and AIDS – for instance, on adherence to treatment regimes, either to treat or prevent particular conditions.

Communications programmes are also being challenged by the need to reflect correctly to the wider public the strengths, limitations, and potentials of antiretroviral treatments.

There are a number of best practice lessons learned in communications programming:

- ◆ A broad contextual approach is necessary for all communications strategies. The five most important contextual areas are culture, socio-economic situation, gender relations, spirituality, and government policy. Those setting up communications programmes should make themselves aware – by new research, if necessary – of these contextual factors as they apply to a target group or groups.
- ◆ The language used in messages should be straightforward, direct, and simple. It should reflect carefully measured levels of understanding by the audience and any particular sensitivities on topics that are addressed.
- ◆ Communications should go through the appropriate channels in communities. Generally, multimedia communications are encouraged and are more effective than use of one medium.
- ◆ A wide range of media can be used. Choice of a particular medium should be directly relevant to the groups being targeted. Innovative media that have been used include: drama and dance (puppet theatre, street theatre, modern ballet, television soap opera); music (live or broadcast concerts, song writing competitions, and recordings on audio cassettes, CDs, and videos); humour (comedians, comic books, and cartoons) and the visual arts (films, videos, paintings, photography, and sculpture).
- ◆ Outreach programmes including interpersonal communications for advocacy should precede communications programming. For the purpose of

communicating information on HIV/AIDS, reaching families, groups, and communities should be considered equally important to communicating with individuals.

- ◆ Many people can be effective communicators, but there are two particular groups that should be mentioned in communications strategies for any given society. First, where possible, opinion leaders should be mobilized and involved in communications strategies. Second, members of the target group are often the most appropriate and effective communicators when they have been trained for the work. (They are usually called “peer educators” when employed in this way.)
- ◆ Similar to other programmes, monitoring and evaluation are crucial to successful communications. Through effective monitoring, changes can be made during implementation of programmes, and communications can be adjusted to support modifications in behavior by audiences. Communications programming relies on inputs from several other disciplines, especially anthropology, social sciences and psychology. They provide a thorough understanding of the audiences and the context of behavior; hence, they enhance potential for comprehensive, well-focused communications programmes.

The Red Ribbon of Solidarity (Japan)

Starting Year: 1998

Main Topic Area: Communications programming

Other Topic Areas: Human rights, ethics, and law • Health system personnel and training

Contact Person:

Dr Noriyuki Kawasaki
Director,
National Sanatorium Fukui Hospital

Fax: +81 770 45 2420

Address:

National Sanatorium Fukui Hospital
315-1, Kiyama, Mikata-cho, Mikata-gun
Fukui, Japan

Implementers

The project was implemented by staff of National Sanatorium Fukui Hospital, under the leadership of the hospital director.

Funding

Funding came mostly from the hospital budget, with some support from special funds of the Ministry of Health and Welfare.

Objectives

The purpose of the project was to demonstrate to the public the hospital's solidarity with people living with HIV/AIDS. In particular, the project conveys that hospital staff do not discriminate against PLWHAs. Finally, it hopes to make a contribution toward fighting prejudice against PLWHAs.

Background

A large permanent red ribbon has been placed on the exterior of the building, and a special ceremony was held in July 1998.

Main Activities

The red ribbon was put on the façade of the outpatients ward of the hospital so that it would attract the attention of visitors. Staff also wear red ribbons.

Outcomes/outputs

The ribbon and ceremony attracted the attention of the general public and the mass media. They have helped the general public, patients, and visitors understand the meaning of the red ribbon in relation to human rights issues. There has been no decrease in admission of patients since the ribbon was installed.

Evaluation Findings

No formal evaluation has been done, but anecdotal evidence of reactions by the public and the media is overwhelmingly favourable.

Lessons Learned

The activity proved that both hospital staff and the greater community were capable of accepting the presence of the red ribbon as a symbol of solidarity between service providers and persons living with HIV/AIDS. This is an important lesson, because

cultural norms in Japan tend to favour being undemonstrative and emphasize conformity rather than difference. The installation of the red ribbon is a positive example of stepping outside the usual cultural norms. Moreover, it teaches that this is possible within the context of the apparently sensitive issue of HIV/AIDS.

Safe Sex, My Choice (Russian Federation)

Starting Year: 1997

Main Topic Area: Communications programming

Other Topic Areas: Children and young people • Sexually transmitted diseases

Contact Person:

Ilona van de Braak

Campaign Coordinator

Phone: +7 503 956 19 58

or +7 095 161 56 87

Fax: +7 503 956 19 58

Email: msfhol@online.ru

or msfhids@glasnet.ru

Web Site: <http://www.msfholru.org>

Address:

Médecins sans Frontières

Bolshaya Cherkisovskaya Street 20B

4th & 5th floor

107553 Moscow, Russia

(or Médecins sans Frontières

Project: AIDS project Moscow

P.O. Box 10014

1001 EA Amsterdam, Netherlands)

Implementers

The campaign was implemented by Médecins sans Frontières (Holland).

Funding

Design, development, production, and research costs were all covered by project funds from Médecins sans Frontières (MSF). Free placement of the campaign materials in outdoor advertisements, in magazines and newspapers, and on TV and radio was provided courtesy of Russian media companies.

Objectives

The objective was to create and implement an awareness campaign about HIV/AIDS prevention for young people, which would influence them to practise safe sex.

Background

Research conducted by Médecins sans Frontières among young Muscovites in the 15–25 age bracket showed that many thought condom use necessary only if their partner had a sexually transmitted disease, and that they were able to judge which persons were “safe.” However, levels of STDs are high enough in Russia that precautions need to be taken as a rule rather than an exception. The respondents knew condoms can prevent disease, but most rarely used one or limited use to specific situations. Many felt that using condoms was tantamount to distrusting their partner.

MSF identified the need for interventions that would convince young Muscovites to practise safe sex. It decided to focus on a mass media campaign designed to appeal specifically to young Russians.

Main Activities

The campaign was launched in July 1997 in Moscow. Development and implementation was done in close cooperation with the Ministry of Health of the Russian Federation and local NGOs and media companies. The goal was to achieve maximum exposure at minimum cost, while increasing Russian experience in using mass media in public health interventions.

By establishing personal contacts with all kinds of media organizations, and explaining the necessity of media contribution to the campaign, MSF was able to get ad time and space donated to the project. The Ministry of Health sent the media letters that explained the importance of cooperation with MSF and the need for media support for this campaign. As, the project was able to maintain a high standard of design and production quality, even though advertising was donated.

Outcomes/outputs

The campaign distributed 800,000 leaflets, broadcast a TV commercial, and placed ads in magazines and newspapers, using the equivalent of \$9 million in free advertising. However, complaints by anonymous groups led Moscow officials to ban the outdoor advertising on public transportation.

Evaluation Findings

An impact evaluation was carried out using a random telephone sample of 1,228 persons aged 15–25. The survey found that :

- 80 per cent of the respondents had seen the campaign
- 83 per cent thought this type of information was important for a person their age
- 84 per cent thought this type of information should continue to be given
- 93 per cent supported the introduction of sex education in schools.

Lessons Learned

The experience provided a number of lessons, perhaps the most important being the high potential value of partnerships with the private sector. In this particular case, it was demonstrated that the Russian mass media can be an efficient tool for reaching young people with a well-designed and specifically targeted public health message. Other strategy-level lessons were apparent.

- There is a large gap between what young persons need and want regarding HIV/AIDS/STDs information and what the rest of society and government are prepared to allow. Many social groups are uncomfortable with the open discussion of sex and sexual health. In this case it led to strong opposition and resistance by a vocal minority. The resistance included the destruction of posters, demands that city council ban outdoor advertisement, and the appearance of flyers in the metro saying condoms are ineffective.
- Lobbying on the political level is very important to guarantee successful implementation.

On a technical level, it was learned that:

- Rather than being promoted on its own, HIV/AIDS prevention for all young people should be embedded in an overall message for sexual health, since pregnancy and STDs are more immediate concerns for the target group.
- As in most places, in Russia a positive message with regard to safer sex and condom use works better than a threatening or intimidating message.

Further Reading

More information can be found at the following websites:

- <http://www.msf.org> (general information on MSF)
- <http://www.msfholru.org> (information on MSF in Russia)
- <http://www.postman.ru/~safelove> (campaign leaflet)

Community mobilization

Community-level action – much of it initiated by persons infected or affected by HIV – has always played a major role in the global response to AIDS. In many countries, community response preceded the official national response. It has proved essential to many components of a successful national response, most notably awareness, prevention, policy and legal changes, impact alleviation, advocacy, and family or community care and support.

UNAIDS defines “community” in its widest and most inclusive sense: a community is a group of people who have something in common and will act together in their common interest. Many people belong to a number of different communities – the place they live, the people they work with, and their religious group, for example.

A community becomes mobilized when a particular group of people becomes aware of a shared concern or common need, and decides together to take action in order to create shared benefits. A community's ability to act together may have existed for centuries, or it may be triggered in a very short time by some urgent problem. In the past, community mobilization has usually meant initiatives at a neighbourhood, village, or local district level.

Today, however, the AIDS pandemic and modern communications technology have challenged traditional ideas of community. National and even global communities have emerged with shared concerns to prevent the spread of the virus, to care for those affected by HIV and AIDS, and to advocate for health and human rights. While the concept of community has been widened, the need to design culturally and epidemiologically specific responses to help particular groups of people has created a corresponding need to define individual communities more closely.

In terms of HIV/AIDS, a “mobilized community” exhibits most or all of the following characteristics:

- ◆ Members are aware – in a detailed and realistic way –of their individual and collective vulnerability to HIV/AIDS
- ◆ Members are motivated to do something about this vulnerability
- ◆ Members have practical knowledge of the different options they can take to reduce their vulnerability
- ◆ Members take action within their capability, applying their own strengths and investing their own resources, including money, labour, materials, or whatever else they have to contribute
- ◆ Members participate in decision-making on what actions to take, evaluate the results, and take responsibility for both success and failure
- ◆ The community seeks outside assistance and cooperation when needed.

Starting a community effort is generally much easier than sustaining it. Many community organizations and programmes have been at work for years, and continue today with the same enthusiasm. Others have withered and lost their former

energy; some have disappeared. For national responses to be effective, existing community initiatives must be reinforced, and new ones must be nurtured as they establish themselves. This will require flexible partnership arrangements with governments and other forces in the campaign against HIV/AIDS, particularly in developing countries.

A huge range of activities has been found effective in the field of community mobilization projects for HIV/AIDS. However, experience indicates that best practice in this field is distinguished by the following basic principles:

- ◆ Uphold the rights and dignity of people infected with and affected by HIV/AIDS
- ◆ Ensure active participation by as broad and representative a group of community members as possible
- ◆ Provide for equal partnership and mutual respect between the community and external facilitators
- ◆ Build capacity and ensure sustainability
- ◆ Build on the realities of living with HIV and AIDS while maintaining hope based on community collective action
- ◆ Maximize use of community resources while identifying and using additional external resources as needed.

Project Hope (Brazil)

Starting Year: 1988

Main Topic Area: Community mobilization

Other Topic Areas: Persons living with HIV/AIDS • Resource mobilization • Communications programming

Contact Person:

Americo Nuñez Neto

Vice President

Phone: +5511 207 776

Fax: +5511 968 6670

Address:

Projeto Esperança

Rua Comandante Carlos Ruhi 75

08410-130 São Paulo - SP

Brazil

Implementers

Instituted by a Catholic nun with the support of her local bishop, Project Hope (Projeto Esperança de São Miguel Paulista) has a small staff. However, Project Hope could not do its job without the work of a variety of volunteers. They include 74 volunteers who work daily or weekly in the health programmes; 97 “godmothers” and “godfathers” who help with orphaned children; and 40–50 people who help from time to time with particular events such as fundraising bingos, raffles, or bazaars.

Funding

The British agency CAFOD has supported some of the activities at the San Miguel centre for many years, while CARITAS-Holland provides funding for the centres in Guaianases and Vila Esperança. As well, the Austrian agency DKA funds part of Project Hope’s education and prevention activities. In recent years, Project Hope has worked closely with the Brazilian Ministry of Health’s National Programme for STDs and HIV/AIDS through an agreement that is subject to review on a yearly basis. The opening of the two new centres in Guaianases and Vila Esperança was strongly supported by this programme, which has maintained its financing for the centres’ operations from their inception. As well, Project Hope benefits from a great deal of community support, which is often expressed in contributions of materials or services.

Objectives

From the beginning, the goal of Project Hope has been to improve the quality of life of people living with HIV/AIDS by changing the behaviours and attitudes of people living with HIV/AIDS (particularly toward a positive, hopeful attitude), and involving the community in care and prevention work.

In addition, the project bases its home care work on the following principles:

- The ideal environment and best therapy for a person infected with the virus is to be with his or her family
 - Families should be helped to accept and face up to the reality of living with HIV/AIDS
 - Infected individuals and their families should be helped to demand and fight for their rights as citizens.
-

Background

In 1988, Sister Gabriela O'Connor began to work on the problem of AIDS in Eastern Zone II of Brazil's largest city, Sao Paulo. The local bishop, Dom Angelico Sandalo Bernadino, gave his support to her work and provided a small building in the working-class neighbourhood of Sao Miguel, which still functions as one of the project's centres. Following a period of information-gathering on the HIV/AIDS situation, Sister Gabriela made a large number of personal contacts in the area and brought together a group of volunteers. These volunteers were already well organized and making house visits to people living with HIV/AIDS and their families by the time the project was legally constituted in 1991. Three years later, two new centres were formed in Guaianases and Vila Esperança with the support of Brazil's National Programme on STD/AIDS.

Main Activities

Project Hope is structured around four programme areas:

1. Health programmes including support and training for people living with HIV/AIDS and their families, nursing care, occupational therapy, and mutual help groups for emotional and psychological support. Two professional nurses on staff provide care both at the project's centres or in patients' homes.
2. Social programmes including a Campaign for Orphans
3. Educational programmes including training of volunteers, production of educational material, and public talks aimed at specific groups such as students, young people who are not in school, and housewives
4. Mobilizing financial support, including fundraising from local donors and from national and international agencies.

Within these programmes, several activities can be further detailed as major elements of the project.

The first is home visits. An average of 183 new cases are taken on by the project every year. Initial contact with the person living with HIV/AIDS is made in several ways, most frequently through the initiative of the person or his or her family. Some introductions are arranged by the social services unit of the local hospital. The first home visit is generally aimed at collecting information. It is carried out by a nurse accompanied by a volunteer. The visit begins with learning about the background of the person with HIV/AIDS, and is followed by evaluating his or her clinical condition. Finally, the social and economic situation of the person is discussed in order to make an assessment of needs. In approximately 90 per cent of the cases attended by Project Hope, the families undertake to look after the person living with HIV/AIDS.

Second, an important job is carried out by paid staff who are known as "multiplying agents" (because their job is to "multiply" the knowledge they have among many more people). These are young people (average age is 15 to 20) whose job is to promote awareness of HIV/AIDS among their peers, and knowledge of the ways that individuals can prevent infection by or transmission of the virus. Examples of the methods used include role-playing how a couple can negotiate condom use.

Outcomes/outputs

Project Hope was the first NGO in Sao Paulo to provide home care. Its initiative has been acknowledged as an important factor in sensitizing government health authorities to the feasibility of home care and in changing the authorities' original scepticism of this approach to AIDS care.

Currently, Project Hope provides services to hundreds of people who are living with HIV/AIDS. Of these, approximately 10 per cent are seriously ill, 30 per cent are asymptomatic, and the rest show some symptoms of the virus. A recent count of people being served totalled 212 men, 189 women, and 68 children. In addition, through its “godparenting” programme the project was helping 94 children who had lost parents to AIDS.

Evaluation Findings

The single most important strength of Project Hope has been its ability to improve the quality of life of people living with HIV/AIDS. This is measured in terms of numbers of people visited, medical attention given, and so forth. However, there are other indicators that suggest success of a different kind. One important indicator has been the project’s ability to attract volunteers who do not have a direct stake in HIV/AIDS. For example, in addition to people living with the virus and their relatives, the project has attracted the participation of a number of volunteers who are not seropositive and have no family members living with the virus. Such solidarity indicates success in the project’s participatory, community-based approach.

Project Hope’s internal evaluations recognize several weaknesses. An important weakness is the lack of professional management training within the organization. Project Hope has also had difficulty in managing the relationship between paid and volunteer work, which has occasionally led to misunderstandings or conflict. On a broader level, the project shares the sense of many NGOs that encouraging true behaviour and attitudinal change among people living with HIV/AIDS is a highly difficult goal to achieve.

Lessons Learned

A highly important lesson demonstrated by this project is the importance of looking after not only patients and people living with HIV/AIDS but also the people who contribute their time and labour to community projects.

Project Hope has placed a great deal of thought and energy in sustaining its volunteers, who are such an important part of its activities. For example, social activities such as dances and outings are used specifically to build morale and to recognize contributions by the volunteers in a non-monetary way. The limits of people’s energy are recognized by the provision of massage and other relaxation techniques and the use of “holidays” to prevent volunteer burnout. Regular meetings aid in communication among volunteers and between staff and volunteers by explicitly discussing volunteers’ needs and perceptions. Finally, the project coordinators are highly aware that their responsibilities include looking after the volunteers as people rather than as tools to provide services.

Sustainability has been pursued through contacts with the local religious authorities and with businesses and community members.

Further Reading

UNAIDS. *Comfort and hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS*. Geneva: UNAIDS, (in press).

Diocese of Kitui HIV/AIDS Programme (Kenya)

Starting Year: 1992

Main Topic Area: Community mobilization

Other Topic Areas: Communications programming • Persons living with HIV/AIDS
• Counselling and voluntary counselling and testing

Contact Person:

Elizabeth Kyalo

Fax: 0141 - 22899

Address:

Office of the AIDS Coordinator

Diocese of Kitui

P.O. Box 123

Kitui, Kenya

Implementers

The programme was implemented by mission hospitals at Mutumo and Muthale, and government hospitals at Kitui and Mwingi.

Funding

The programme collaborates on an ongoing basis with Ministry of Health personnel. This collaboration began in 1993 with the secondment of two diocesan nurse/counsellors to the government hospitals at Kitui and Mwingi. The ministry has financed some of the programme's World AIDS Day activities, and the National AIDS Programme has provided it with educational materials. Recently, all four hospitals have been accepted by the ministry as Sexually Transmitted Infections centres, which will greatly assist the programme in its work against HIV infection. The government hospitals supply the programme with some nursing materials such as gloves and disinfectants, while other supplies are bought by the programme. As well, some free drugs are distributed to persons living with HIV/AIDS (PLWHAs) in the government hospitals and the Mutumo Mission Hospital.

Objectives

The goals of the programme are:

- To reduce the incidence of HIV infection
- To enable people infected and affected by AIDS to live positively.

These goals are pursued by two means. The first is to provide counselling and holistic care to people infected and affected by HIV/AIDS. The second is to encourage behavioural change by increasing public awareness of both the impact of the epidemic and methods to prevent its spread.

The programme provides an important service to the local health system, as it helps reduce the bed occupancy rate in the area's 4 hospitals. With home care offered as an effective alternative in a familiar environment, PLWHAs can be discharged as soon as they learn their serostatus and have been given counselling

Background

Kitui and Mwingi are two districts in eastern Kenya that make up the diocese of Kitui. Together they cover an area of 29,389 miles and have a total population of over 812,000 people. There are no industries in this arid and semi-arid area, and most of the people depend on small-scale farming and livestock. Unfortunately, intermittent

droughts result in frequent food scarcity and famine. Poverty is widespread, and there has been a marked migration of men between the ages of 16 and 50 to the larger Kenyan cities in search of employment.

The diocesan HIV/AIDS programme evolved from the initiative of Dr. Frank Engelhard, from the Dutch organization Memisa, who came to Mutomo Hospital in 1989 following work in Uganda. Observing that some PLWHAs were presenting with symptoms of AIDS, he arranged for a visit to Kikova Hospital in Uganda by six diocesan representatives including Mutomo Hospital's chief medical officer, Dr Marian Dolan. Soon thereafter, nurses were selected from the two mission hospitals of Mutomo and Muthale to be trained in basic counselling by the Kenyan Red Cross.

In 1992 a pilot project was started. After the project was in progress, the need for further training in counselling was identified, and it was decided to include the staff of the two government hospitals of Kitui and Mwingi in the training programme. This led to collaboration with the Ministry of Health, and the evolution of the HIV/AIDS programme with outreach, home care, and group counselling.

Main Activities

The programme's main activities include:

- Pre- and post-test counselling – while some features of the counselling are general, some types of clients are handled in specific ways according to their particular needs. These include TB patients, children who may be infected with HIV, and elderly caregivers who are taking care of orphans
- Home visits to families affected by HIV/AIDS
- Group counselling sessions for PLWHAs
- Community education – HIV education visits are frequently made by counsellors (including persons living with HIV/AIDS) to schools, hospitals, workplaces, churches, and public gatherings
- Services for people with STDs
- Preparing people for death – services provided to people who are dying include helping them identify guardians for their children, and helping them write wills to ensure that their land and belongings are passed on to their children. Efforts are made to help people with AIDS spend their remaining days in familiar surroundings, and to die with dignity.
- Other services include encouraging economic activity for PLWHAs, and providing simple curative medicines and basic supports for needy clients.

Evaluation Findings

Monitoring of the programme's activities in home care clinics and hospitals is carried out on a monthly basis by supervisors. Every three months, programme personnel meet with Ministry of Health personnel. Evaluation and planning sessions for programme staff are held every six months. The following items are among the information these various evaluation activities provide.

- Self-assessment by the programme indicates that staff are well trained and motivated, with the concrete benefit that minimal supervision of staff is needed. Provision of group counselling for staff is an additional source of strength for these people.
- Communication among the various groups in all four hospitals is good, as is collaboration with the Ministry of Health.

- Two important elements in the programme itself need reinforcing. First, more effort is needed in education aimed at changing attitudes and increasing acceptance of sick people by families and the community. Second, there is not enough coordination between the programme and other NGOs, government departments, and the community. Regular meetings, even on a semi-annual basis, might help to ensure that all necessary activities are being covered and to avoid overlapping of efforts.

Lessons Learned

This programme provides an important lesson in the practical and organizational side of creating community- and family-care services.

In particular, the programme has clearly taken into account the diverse needs of specific groups of PLWHAs and has devised effective strategies for each. Different groups include PLWHAs with HIV-relevant medical conditions such as TB and STDs, seropositive or potentially seropositive infants, elderly caregivers, and people who are in the terminal stages of AIDS.

Programme staff express concern that success in changing attitudes and behaviour in the greater community has so far been limited, particularly with regard to increasing acceptance of people living with HIV/AIDS. It seems likely that effectiveness in these areas of endeavour will remain limited unless greater resources become available for community education.

The main weaknesses appear to be directly related to the increasing gravity of the epidemic and the lack of resources available to deal with it. For instance, with 200 new orphans being identified each month, the programme is unable to serve all orphans being left without caretakers. Similarly, there are not enough counsellors or material resources to meet rising demand for counselling services, which are very time-consuming activities. This has the effect of increasing physical and emotional stress on counsellors. It has also caused a problem of confidentiality: it has proved impossible for only one counsellor to follow each PLWHA, so information must be shared between counsellors. It has also made it difficult for counsellors to keep abreast of new practices in the field of HIV/AIDS.

Further Reading

UNAIDS. *Comfort and hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS*. Geneva: UNAIDS, (in press).

Drug User Project, Ikhlas Community Centre, Pink Triangle (Malaysia)

Starting Year: 1991

Main Topic Area: Community mobilization

Other Topic Areas: Injecting drug use • Persons living with HIV/AIDS • Men who have sex with men

Contact Person:

Julian Jayaseelan
Executive Director, Pink Triangle

Phone: +60-3-441 4699

Fax: +60-3-441 5699

Email: isham@pc.jaring.my

Address:

Pink Triangle
c/o P.O. Box 11859
50760 Kuala Lumpur
Malaysia

Implementers

Pink Triangle, which created the Ikhlas centre, was the first NGO in Malaysia to work at the community level on HIV and sexuality issues. It had begun to work on behalf of a marginalized community – the gay community of Kuala Lumpur – in 1987, shortly after the first cases of AIDS were diagnosed in Malaysia. By the early 1990s it was well established, with its own HIV education and support programmes. One of the best-known is Positive Living, a support and care project specifically for people living with HIV/AIDS. Today, Pink Triangle has 18 staff and about 100 volunteers involved in its HIV prevention and support programmes.

Funding

Ikhlas receives donations in kind and cash from a variety of sources, including the European Commission (EC) and the Dutch agency HIVOS. Currently the Malaysian AIDS Council (MAC) is the main funder. In addition, pharmaceutical and health-care companies have contributed medicines and nursing materials (treatment drugs, gauze, bandages); and hotels and food manufacturing companies have donated food to the nutrition service. Fund raising for the drug user project has been carried out by students and other volunteer groups.

Objectives

The project serves the injecting drug user (IDU) population of Chow Kit, a poor community in Kuala Lumpur, by:

- Providing information on health, harm reduction, and HIV itself
- Providing care and support including medication, nutrition, shelter, employment, and psycho-social support
- Advocating for IDUs' needs and concerns.

Background

The drug user project is based at the Ikhlas (Malay for "sincerity") community centre in Chow Kit was created by Pink Triangle in 1991. Operating through a drop-in service at the community centre and through outreach workers, the project works with the IDU population of Chow Kit, a bustling, traffic-congested area of the Malaysian capital. Chow Kit's ethnically mixed population is composed mainly of

working-class Malays, Chinese, Indians, and a significant migrant population of Indonesians. Several of its side streets are lined with seedy brothels, and are home to drug users. According to one estimate, there are about 8,000 IDUs, sex workers, and transsexuals living and working in the area (Pink Triangle also has projects for these other groups at the Ikhlas centre).

The IDU community is not an easy one to get to know. IDUs in Chow Kit form close-knit peer groups or “comradeships.” One group that has stopped injecting drugs may exclude people who are still shooting drugs. Fortunately, prior to the start of the Ikhlas programme, certain volunteers of Pink Triangle Malaysia had already established contact and developed a good relationship with several members of the IDU community in Chow Kit. These contacts had been formed through the volunteers’ work with the gay community in the area. Through the initial contacts, informants in the area were consulted about the needs and concerns of the community. These informants were visited on their terms, in places where they felt most comfortable, including “shooting galleries” and on the street. The key informants were chosen during the outreach activities, based on their knowledge of the IDU community and on their contacts in Chow Kit.

The original needs assessment gave the Pink Triangle volunteers a clear sense of what IDUs in Chow Kit saw as priorities for improving their lives. These priorities were extremely basic, emphasizing the extreme marginalization and vulnerability of the IDUs: basic medical care; shelter; food; jobs; children’s welfare; and obtaining identification papers.

Main Activities

After first carrying out a needs assessment, Pink Triangle moved to set up the major elements of the drug use project. They include the drop-in services at the Ikhlas centre, outreach services, and the ongoing motivation and participation of the IDU community.

- The Ikhlas centre is a “safe space” located on a side street not far from the brothels and the areas where the IDUs spend much of their time. Medical care and treatment is provided by a full-time nurse and volunteer doctors, with referrals to hospitals/drug treatment centres given as needed. Counselling and psychological support are also available. As well as care and treatment, the drop-in centre has a strong education and prevention role to play. Information and education on HIV and other STDs (including prevention) are available to all. The centre also provides condoms and lubricant. Finally, the drop-in centre offers its clients a variety of services not specifically related to HIV or STDs, but which respond to their stated needs and priorities: bathroom/toilet facilities so that clients can maintain basic hygiene (bathe, wash clothes, and so on); food; referrals to job placements.
- Outreach workers, both staff and volunteers, meet clients at home or on the streets, wherever the clients are most comfortable. The outreach workers also make visits to hospitals and to drug rehabilitation centres. Among the services provided by these workers are transporting clients to hospitals, assisting with getting identification papers.
- Client involvement is an important part of community mobilization. IDUs are recruited as community health outreach workers and trained in HIV education, harm reduction approaches, and facilitation skills. There are many ways for clients to participate on a more basic level, and to take “ownership” of the project. For instance, clients are encouraged to take responsibility for the nutrition programme and maintaining the cleanliness of the Ikhlas drop-in centre. Under supervision from the staff, they handle the food shopping, do the cooking, and clean the bathroom/toilet facilities. This not only helps the project itself by making it more cost-

effective, but is part of the process of “re-socialization” and the building of self-esteem among the clients.

Outcomes/outputs

Each month, an average of 1,040 contacts with clients are made by staff and volunteers. Contacts include such activities as providing basic medical care and food, handing out and discussing information on HIV and harm reduction, and making referrals to other care and support services.

Evaluation Findings

The mechanisms employed by Pink Triangle for monitoring and evaluating the work are fourfold: seeking programme beneficiaries’ feedback (stories); regular meetings for peer review and evaluation among clients, volunteers, and staff; monitoring referrals to and from other agencies; and obtaining feedback from affected families.

There are no quantitative measures for the impact the project has had on IDUs in Chow Kit. However, the available evidence suggests that the Drug User Project has been highly effective in gaining the trust of its target community (which is likely a function of its effectiveness in providing services this community wants or needs) and in attracting resources (food, medicines, services, funds) from the wider community. The project has also been effective in its advocacy activities through the favourable media profile it has been able to generate and the institutional links it has created with government and NGOs.

Lessons Learned

An overall lesson learned is that the principles of community mobilization for HIV/AIDS prevention and care can be applied successfully to a traditionally hard-to-reach group of people, even when their behaviour (in this case, injecting drug use) leaves them outside the protection of the law. Another important lesson is that members of one marginalized community – if they have already gone through their own mobilization process – may be extremely effective at reaching out to another, even more marginalized community.

Pink Triangle has grouped the lessons learned into seven categories.

1. The need for programmes to be client-centred: In the project’s six years of operation, it has been able to keep the focus on what the clients want and need. There are probably many reasons for this, but one especially important factor is that the project is structured so that the ongoing involvement and feedback of clients obliges staff and volunteers to keep this focus. Structurally, the project is community-based; located within the area where its clients live, work, and congregate; and largely run by IDUs/persons with HIV/AIDS for IDUs/persons with HIV/AIDS.

- The ability to show real care and concern for clients: This is related to the previous point, but probably has more to do with recruiting. In particular, the concentration on immediate needs and the outreach component that meets clients in their own preferred places (homes, shooting galleries, the street) provide clients with concrete evidence of concern.

- A peer support system: No one can relate to an IDU living with HIV/AIDS in the same way as someone who shares the same challenges and the same lifestyle. Providing a space and a structure in which people can talk, share experiences and problems, and receive both good information and positive advice, is key to effective work at the individual level.

- External relations: The development of good working relationships with governmental agencies and NGOs has paid off in a variety of ways.

- Stress experienced by staff and volunteers: The work can be emotionally very intense. The project's main way of dealing with such stress is to hold regular sessions among staff and volunteers for discussion of problems, "ventilating," and counselling.
- Volunteer recruitment: As in any difficult activity that is heavily dependent on volunteers, the Drug User Project has trouble getting interested and committed volunteers on an on-going basis. One of its most effective techniques for recruiting has been to recruit drug users and ex-drug users from within the community.
- Dialogue with police decision-makers: Despite efforts to maintain good relations with the police, IKHLAS' drop-in centre services are sometimes affected by police raids in the area. The project tries to deal with this problem through dialogue with the police at the decision-making level (that is, not by trying to confront the police officers carrying out the raid but by speaking with their superiors).

Further Reading

UNAIDS. Comfort and hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS. Geneva: UNAIDS, (in press).

National Meetings for People Living with HIV/AIDS (Poland)

Starting Year: 1996

Main Topic Area: Community mobilization

Other Topic Areas: Persons living with HIV/AIDS • NGOs and networks

Contact Person:

Matthew Kahane, UNDP

Phone: +4822 628 32 85

Fax: +4822 628 32 85

Email: registry@undp.org.pl

Address:

Be with Us Association

Al. Jerozolimskie 31 m. 2

Warsaw

Poland

Implementers

The meetings are based on an idea originally proposed by individuals from NGOs working with people living with HIV/AIDS. From the beginning of the project, the Be with Us (Badz z Nami) Association was the leading organization in the meetings' preparation.

Funding

Funding was originally provided by the United Nations Development Programme (UNDP). At the second meeting the organizers attracted the attention of private-sector donors and substantively decreased the budget to be provided by UNDP. The third meeting took place in late 1998 thanks to the contribution of the National Office for AIDS Prevention, donors (pharmaceutical companies and other institutions), and UNDP.

Objectives

The objectives of these national meetings are:

- To bring together the community of people living with HIV/AIDS in Poland
- To build networks throughout the country among individuals living with HIV/AIDS
- To provide PLWHAs with the most current information on treatment, prevention of infection in sexual behaviour, rights and responsibilities of the HIV/AIDS-positive individual, and networks and institutions helping people affected by the epidemic
- To provide a forum for an open discussion of intimate problems, which are otherwise never shared.

Background

The first meeting was held in September 1996, the second in October 1997, and the third in October 1998.

Participants in the project are people living with HIV/AIDS, some of whom are ex-drug users, alcoholics, MSM, mothers with infected children, and homeless people. Particular attention is given to women living with HIV/AIDS and their children. For example, special activities for children were arranged during the official sessions and meetings.

Main Activities

The Be with Us Association advertised the first meeting using the channels of collaborating NGOs and HIV/AIDS treatment centres. Information about the meeting was published in the HIV Network newsletter issued by UNDP. Specific information about the event was available through the national HIV/AIDS Hotline administered by Be With Us.

The organizers invited several specialists from different fields (doctors, sexologists, drug specialists, psychologists, and counsellors) to facilitate parts of the meeting. Interested individuals (at the first meeting there was no upper limit to the number of participants) could register with Be with Us in order to participate.

The meeting was organized near Warsaw in an attractive but modest training centre. The agenda of the meeting was flexible and allowed plenty of time for spontaneous experience-sharing and informal discussion, support, and networking.

Outcomes/outputs

There were over 100 participants at the first meeting, and 130 at the second. One of the most visible results of the national meetings of PLWHAs was the establishment of two NGOs (in Gdansk and Chorzów) run by people living with HIV/AIDS. Another important result was the organization of a separate meeting for women living with HIV/AIDS and their children. In this meeting, specific issues of coping with infection and being responsible for the well-being of the child were discussed in a presence of psychologists and counsellors. The October 1998 meeting led to the organization of the National Network of Persons Living with HIV/AIDS.

For many of the participants, this was the first time they received information about available treatment methods. All participants left the meeting with printed materials, to which they can always refer when searching for guidance on some practical aspects of living with HIV/AIDS. Immediately after the first meeting, UNDP began receiving numerous letters of appreciation from participants, who had had their first chance to publicly disclose their HIV/AIDS status and not be excluded from the group. Since the meetings, an increase in individual contacts and networking across Poland has been reported by NGOs working with PLWHAs.

As the community evinced a strong interest in continuing these meetings on a regular basis, it was decided that Be with Us will continue efforts to ensure funding of meetings in the coming few years.

Lessons Learned

The national meetings of people living with HIV/AIDS improve this population's quality of life in a direct way because the consequent networking has helped to increase access to health care and to volunteer-based services.

Such meetings can have a number of unplanned but highly desirable benefits. For instance, the networking initiated at such meetings brings immediate effects in terms of information and experience exchange. Many individuals left the meeting with specific instructions for their doctors on available treatment programmes and contact information on other specialists. Some participants gain new knowledge about the implications of their status and are able to better protect themselves from life-threatening infections and lifestyles.

The meetings are also an opportunity to present positive examples of living with HIV/AIDS. Many group moderators are HIV-positive and are excellent examples of active, positive living with HIV/AIDS. They shared their experiences of coping with infections and their successes as HIV/AIDS educators.

There were some problems, however, which have also provided lessons. Chief among these was that the first meeting did not have a rule that participants must be drug-free. As a result, four participants were clearly under the influence of drugs. This situation is dangerous not only for those who use drugs, but especially for those who have just quit the habit and are still undergoing rehabilitation.

Tateni Home Care Services (South Africa)

Starting Year: 1995

Main Topic Area: Community mobilization

Other Topic Areas: Palliative care

Contact Person:

Veronica Khoza

Coordinator

Phone: 27 12 805 7638

Fax: 27 12 805 7638

Address:

Tateni Home Care Services

P.O. Box 77980

Mamelodi 0101

South Africa

Fax: 27 35 550 1674

Email: jfrohlic@mrc.ac.za

Janet Frohlich

CERSA Medical Research Council

Private Bag X385

Pretoria 0001, South Africa

Implementers

The project was implemented by local retired nurses and trained community care workers.

Funding

Financial support for Tateni Home Care Services comes entirely from local donors and the provincial government. There are currently no national or international sources of funding. The medicines and nursing materials dispensed by Tateni are possible only because of donors. In some cases, medicines may be supplied by a local clinic if the patient or a family member is able to collect them.

Objectives

Tateni Home Care Services is a non-discriminatory, non-judgemental organization that aims to ensure that home-based care is provided in the former black township of Mamelodi – a community of 1.5 million lying west of South Africa's administrative capital of Pretoria. Its goals are:

- To provide counselling and support services to infected and affected persons
 - To implement home-based care that is affordable, accessible, equitable, and efficient
 - To enhance the collective capacity of the community to provide care and support, and to collaborate with health care professionals working in the formal health sector
 - To enable and empower ancillary health care workers to care for and cope with the chronically ill persons in their community
 - To teach, advise, and provide guidance to the seropositive person and family members (or other significant persons in the patient's life) about relevant aspects of health care, infection, and health promotion.
-

Background

Mamelodi contains an estimated 250,00 dwellings, with an average of six people per dwelling. A large proportion of the population is impoverished, and the incidence of HIV/AIDS is high.

Tateni Home Care Services began with a group of retired nurses living in Mamelodi, who in 1995 identified a need for home-based care. The group visited some 2,000 dwellings during the first year and identified about 1,000 chronically ill persons, of whom 427 would benefit from home-based care. A consultant to the provincial Department of Health's Directorate for AIDS and Communicable Diseases acted as an adviser to the group in developing home-based care policy and training materials. During that same year, the group began providing home-based care services.

Tateni's approach recognizes that copying models of home-based care from industrialized countries, with their high levels of funding and extensive formal health systems, would lead to failure. First, doing so would set unattainable goals in an area with a large population and limited resources. Second, it would be inappropriate to the social and cultural context of the people of Mamelodi, whose African traditions emphasize complex family and community relationships of support, obligation, and consensus rather than formal, state-directed services.

However, collaboration with the formal health system is an important part of the approach. When necessary, patients are referred to hospitals and other institutions such as clinics for services including short-term admissions to control difficult symptoms, respite for primary care-givers (that is, when the family needs a short break from looking after their seropositive member), or admission for more extensive treatment.

Main Activities

Tateni's home-based activities aim mainly at providing and enabling palliative care. However, HIV/AIDS prevention, education, and surveillance are also important parts of the work.

People with HIV/AIDS and their families come to Tateni in a number of ways. Many arrive in search of services, having heard about Tateni through word of mouth. Formal referrals are received from local clinics, general practitioners, and the Pretoria Academic Hospital. Finally, Tateni receives clients through contacts with other local NGOs and CBOs (community-based organizations), notably those in the Mamelodi coalition of organizations working with Tateni. These include Women Against Abuse, Children's Day Care Centre, and several youth groups.

Tateni's training activities are carried on at two levels. The first is training of community care workers. These are local people who typically live nearby the clients they will be assigned to work with once training is finished. The training is given by a professional nurse with help from a social worker. Currently, the training is very basic and takes six months, but this will be upgraded to 12 months in order to meet the standards of the National Policy for Health Workers.

The second level of training is carried out by the community care workers, with coordination and supervision by the professional staff. This training is directed to two areas. The first is teaching persons living with HIV/AIDS and their families how to provide effective home care. This includes discussing various aspects of HIV/AIDS itself, presenting a holistic approach to wellness, and accessing the formal system as needed. The second area is teaching volunteers to provide services such as counselling and health promotion.

Outcomes/outputs

The total number of home visits made since the beginning of the project is 224,000. Of these, support and counselling accounted for almost 207,000, and the rest are divided between care (bandaging, etc.) and bereavement. About 9,100 people have received counselling by telephone.

The project has distributed 600,000 condoms and 245,000 information pamphlets.

The total number of community care workers trained is 260, of whom 78 per cent currently have some form of employment, 11 per cent are continuing with tertiary education, and 7 per cent are unemployed (the status of the remainder is unknown).

The number of professional health care workers to whom the project has provided orientation in home-based care and community participation is approximately 980 professional nurses, 176 teachers, and 66 social workers.

Between 1995 and 1998 about 2,100 family members and volunteers have been taught capacity-building skills to enable them to care for and support someone in the home. As well, the project's community workshops, information sessions, and seminars have reached over 10,000 people, including 6,000 young people.

Networking has also provided important outcomes. A total of 21 heads of government departments have visited the project. The national departments of Social Welfare and Health have visited the project as a model not only for care but community mobilization. The National Council for the Aged and the Directorate for Chronic and Special Diseases have also visited and have utilized the project as a model. More concretely, the project lobbied hard for a part-time medical officer and full-time professional nurse to visit home-bound patients, and recently these two persons were seconded and funded by the provincial government. (The project emphasizes that this is a considerable accomplishment, given current cutbacks in the health system.)

Finally, numerous international visitors have shown interest in the project and visited Mamelodi. This has had the extra benefit of increasing awareness of the project within the community.

Evaluation Findings

In 1996, at the end of its first year of operation, Tateni Home Care Services carried out a qualitative assessment of its work. The retired nurses in the group distributed a questionnaire to 500 participants, of whom 369 responded. As well as showing overwhelming appreciation of the services provided, the results indicated that most respondents preferred Tateni's home care and training to continue to take a general approach to health care activities rather than to focus exclusively on HIV/AIDS. This has been borne out in the rapidly growing demand for services in the past two years.

In self-evaluation, the organization notes two significant weaknesses. First, resource mobilization is difficult, and the service is dependent on donors. Additional partnerships and fundraising will be necessary if further progress is to be made. Second, although commitment from volunteers is high, hours that can be volunteered are extremely limited. This is likely a problem in any impoverished community. Ultimately, the organization would like to add incentives such as travel costs and meals to its budget.

Lessons Learned

Coordinator Veronica Khoza comments: "The community has accepted the services rendered by Tateni to a point where we no longer have people isolated because of

HIV and AIDS. The project has been a model and many organizations are now following us in providing home care and support.”

"Among the important lessons we have learned in past two years are the following:

- Proper planning is crucial. Tateni was built on an emotional response without planning, and this lack of planning inhibited growth in the early days.
- Perseverance and hard work are the mother of success.
- Record-keeping and documentation are crucial.
- The importance of communication can never be measured.
- Be prepared to learn from your community and patients.
- Never be a dictator.
- Respect other people's values and culture.
- Learn to improvise. Never leave a person because there is nothing available. There is always something that can be done.
- Never undermine the family's or community's ability to do things for themselves."

More specifically, staff feel that the primary strengths of Tateni are twofold: its success at encouraging community participation and its achievement of widespread feelings of community ownership. They believe these are the reasons that Tateni has been able to reach and provide services to so many people in a relatively short time. These two strengths have given it enough credibility that government services were willing to enter into a partnership with it. Another significant strength is the project's successful integration of government and community activities.

Further Reading

UNAIDS. *Comfort and hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS*. Geneva: UNAIDS, (in print).

Sanpatong Family Care Project (Thailand)

Starting Year: 1992

Main Topic Area: Community mobilization

Other Topic Areas: Persons living with HIV/AIDS • Impact on children and families
• Counselling and voluntary counselling and testing

Contact Person:

Samboon Suprasert

Phone: 6653 801 232

Fax: 6653 321 969

Address:

Research Institute for Health Science

Chiang Mai University

P.O. Box 80 CMU

Chiang Mai 50202

Thailand

Dr Praphan Phanuphak

Phone: +66-2-256-4638

Fax: +66-2-254-7574

Email: ppraphan@chula.ac.th

AIDS Research Center

Thai Red Cross Society

1871 Rama IV Road

Bangkok 10330

Thailand

Implementers

The project is a joint activity of the Thai Red Cross Society health centre in Sanpatong and the district hospital.

Funding

The major donors are:

- The Thai Red Cross Society AIDS Programme, which provides medications and nursing staff
- Pharmaceutical companies, which have donated medications (some prominent members of the industry have made donations of cash)
- Rotary Clubs
- Milk companies, whose donations of soya bean milk make possible the distribution of milk to families of those living with HIV/AIDS.

Objectives

It is traditional in the Buddhist culture of Thailand for several generations of a family to live together, and to look after one another when one member is sick. The goal of this project is to reinforce traditional values through training and other supports that will, in a holistic way:

- Enable primary health-care for PLWHAs in the home
 - Change negative attitudes of family members, friends, and the community toward HIV/AIDS
 - Promote self-care and self-reliance of families and individuals infected or affected by HIV/AIDS.
-

As a secondary goal, it is hoped that this strategy will reduce costs both to individual families and to government health services.

Background

In 1992, a group made up of staff nurses from Sanpatong's Red Cross health centre, volunteers from the Faculty of Medicine at Chiang Mai University, and Chiang Mai public health staff saw an opportunity to create a new kind of care project. Their goal was to help PLWHAs be cared for at home by family members, a strategy that would reinforce all three parts of the holistic approach. Such a project, they knew, would require education and skills training for many people: family members, volunteers from the community, and even village leaders. It would also require funding and resources in order to get started and sustain itself.

At the same time, the group recognized the importance of providing support for people who are HIV-positive but have not developed full-blown AIDS. In addition to meeting these people's needs for emotional support, the group's strategy included providing training on practical matters of self-care and self-reliance before individuals get sick. Again, it was intended that this preparation would eventually reinforce all three parts of the holistic approach.

The Sanpatong Family Care Project is located in the Sanpatong area some 25 kilometres south of Chiang Mai City. A joint project of the Thai Red Cross Society health centre in Sanpatong and the district hospital, it currently works with about 600 PLWHAs.

The project aims to make it possible for families to support and care for persons with HIV/AIDS (PLWHAs) at home. The concept of home care is different in Southeast Asia than in Western countries, where it generally refers to home visits by doctors and nurses for purposes of treatment or monitoring. In contrast, people served by this project are taken in to a hospital or clinic by their families when they need medical attention. Visits by doctors and nurses are not a key element in the services provided.

Main Activities

Services include training for family members; health care visits and referrals; provision of some basic necessities; meditation and spiritual instruction in the Buddhist tradition; and support activities, including a weekly club with visiting speakers and doctors. Specific activities include:

- Thursday Club: Modelled on the well-known Wednesday Friends Club in Bangkok, the Thursday Club is a monthly lunch gathering and support group for men and women with HIV/AIDS. It regularly attracts 40–50 people to its lunches, which include meditation, exercise, and talks featuring a wide variety of speakers. Medical attention is available at each meeting. Food and herbal medicines (including royal jelly tablets) are also offered. These gatherings are also used as an opportunity for the home-care team to monitor the health of club members.
- Support Groups: The project helps bring together small support groups of about 30 persons living near each other in sub-districts. These support groups enable PLWHAs to share their experiences and concerns with each other. In order to create a family feeling, sightseeing trips and overnight camping are also organized.
- Meditation and spiritual care: Spirituality has always been important in Thai life. Therefore spiritual care is a well-accepted and necessary part of the project's work. In particular, meditation is taught by local Buddhist monks as a means of helping those hardest-hit discover tranquillity and mobilize enough mental strength to continue.

- Community care: This activity was begun in 1995. Its goal is to encourage whole villages to accept and participate in the care of PLWHAs and their families. In particular, the sessions aim to involve village leaders in ensuring care for relatives of the deceased, and to encourage neighbours to support each other.

- Supporting the special care role of grandmothers: Thai grandmothers have always had important roles in the care and upbringing of children, and the running of households. Yet these women in their later years can face a heavy and unexpected task in caring for a relative affected by HIV/AIDS. This is particularly true if they have no previous knowledge of HIV/AIDS or of basic techniques such as universal precautions that are applicable at home. The project has begun a new activity aimed at improving the care skills of grandparents as well as providing support to them.

Outcomes/outputs

At present, there are approximately 600 PLWHAs served by the project, about 60 per cent female and 40 per cent male. The age range is from 25 to 45. About 60 per cent of these PLWHAs are asymptomatic, with 20 per cent presenting some symptoms and another 20 per cent having full-blown AIDS.

Each month the project conducts one- and two-day training sessions, mostly in Chiang Mai City, focusing on home-care skills. Thirty group sessions, each training 30 participants, have been held each year since 1994. Thus, these sessions have reached about 900 persons annually since the project's inception.

While there is no evidence yet available on the effectiveness of spiritual resources (talks from Buddhist monks, retreats, meditation techniques) to achieve psychological and physiological benefits for PLWHAs, documentation provided by other fields of medicine suggests that this strategy is a beneficial one.

The project does not increase visibility (and therefore the potential for stigmatization) of PLWHAs, since their care is provided by family members rather than visiting doctors or nurses.

Evaluation Findings

No formal evaluation has yet been made of the project. Some indication of project success (as well as of demand for the kinds of services provided) has been the speed with which community care activities have spread from zero to 20 houses in each village.

Lessons Learned

The most important lesson learned is that the Thai tradition of care of the sick by families can be adapted to the challenges posed by the AIDS epidemic. Primary health-care can indeed be provided at home by family members and through self-care. Self-reliance is enhanced at the same time as health care costs to the family and state are reduced, since the project does not involve paying doctors or covering the costs of staying in hospices or hospitals. Other lessons learned include:

- Quality of service is safeguarded by the participation of departments of the formal health system (the Thai Red Cross, Chiang Mai public health staff, and the Faculty of Medicine at Chiang Mai University).

- The project's efficiency appears to be relatively high, in that it permits large numbers of individuals to partake of valuable services at a low monetary and administrative cost. This is achieved by training unpaid volunteers (mostly, though not entirely, family members of the persons with HIV/AIDS) to assume care

responsibilities that would otherwise be carried out – if at all – by salaried medical staff in overburdened hospitals and clinics.

- Efficiency is also increased by providing training to seropositive individuals and their families before symptoms of AIDS appear. The use of the lunch club, a strategy pioneered in Thailand, has already proven valuable as a non-threatening, low-cost access point through which infected people can receive services and information.

- Viewed from the outside, there may be an ethical concern relating to the component that supports grandmothers as care providers. This misgiving arises from the limited energy and increasing frailty of these older women and the assumption that they, rather than grandfathers, will assume this role. However, this concern is mitigated by understanding that the project aims to give grandmothers better skills to carry out a role they willingly assume (both through tradition and links of personal affection) and some measure of assistance through home visits and support groups. It also relieves grandmothers of the sole responsibility for care by training other family members.

Further Reading

UNAIDS. *Comfort and hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS*. Geneva: UNAIDS, (in press).

Chirumhanzu Home-Based Care Project (Zimbabwe)

Starting Year: 1994

Main Topic Area: Community mobilization

Other Topic Areas: Persons living with HIV/AIDS • Communications programming
• Palliative care

Contact Person:

Etta Dendere

Address:

St Theresa's Hospital
Private Bag 7015
Mvuma
Zimbabwe

Implementers

The Chirumhanzu Home-Based Care Project grew out of an initiative by hospital health workers including senior nurses, Dominican sisters, and expatriate doctors.

Funding

In the 1994–95 period, the project received financing from UNICEF through the Zimbabwean government. Since 1996, overseas donations have come from the Swiss NGO SolidarMed, and from German parishes and private donors with the help of the Dominican Sisters. The project is organizationally separate from St Theresa's Hospital, but collaborates fully with it in referrals and has space in the hospital wing built by the Dominican Sisters. A full-time nurse paid by the hospital works with the project, while the group's full-time coordinator is paid a small honorarium from project funds provided by SolidarMed. A smaller honorarium is provided to a volunteer who helps the nurse and coordinator. Nursing materials and drugs used in the home-care service are provided mostly by the Ministry of Health.

Objectives

The project is founded on two primary goals:

- To meet HIV-affected people's needs as close to their homes and relatives as possible
- To provide the necessary information, skills, care, materials, and support to everybody involved or interested.

From the beginning, the project has taken a comprehensive approach that includes meeting not only medical demands but also social and emotional needs. It promotes HIV/AIDS awareness and prevention, both among the general public and among target groups such as sex workers, students, and STD patients.

The project strongly believes in, and builds on, African traditions of family support and mutual obligation – including consensus regarding the designation of a direct caregiver within each family.

A final principle is the encouragement of persons infected or affected by the virus to participate in all aspects of the project. This principle is important not only in itself, but also because it increases the profile of persons living with HIV/AIDS within the community and thus serves to reduce stigmatization.

Background

Chirumhanzu District is a farming area in the central Midlands province of Zimbabwe. The HIV/AIDS epidemic has hit the area hard. At St Theresa's Hospital, which is the first-level referral centre in the district, just over half of the 253 in-patient deaths occurring in 1997 were due to AIDS, and the numbers are increasing.

Concerned by overcrowded hospital wards, the initiators of the project were also well aware of the wish of local HIV/AIDS patients to stay at home under the care of their families up to, and including, the time of their death. They also realized that home care would be essential to look after growing numbers of AIDS patients. Project initiators canvassed churches and communities searching for people willing to be trained in this task.

The home-based care part of the project is provided primarily by family members supervised by home-care volunteers. These volunteers are themselves supervised by the project coordinator and the professional nursing staff at the hospital.

Main Activities

The project's comprehensive approach includes three main elements:

- Home-based care for HIV/AIDS patients
- Support groups for HIV-positive people
- Awareness and prevention for the general public and target groups.

The first two are aimed at meeting the medical, social, and emotional needs of persons with HIV/AIDS. The third focuses on encouraging the local society to take greater responsibility in accepting and caring for its HIV-positive members.

Home-based care begins with the identification of potential clients in hospital through the admissions process or as a result of HIV/AIDS testing. If diagnosed as HIV-positive, the individual receives counselling sessions that include assessment of individual needs and wishes. This assessment helps identify appropriate follow-up procedures once the patient has been discharged from hospital.

When the patient is ready to go home, a letter is provided from the hospital to the patient's nearest local clinic and to the caregiver and relatives. This letter confirms that the patient has been discharged for home care. A volunteer, who has been trained as a community-based caregiver, undertakes follow-up at home. Each client is visited once a week. The reports written by the volunteer following the visit are used by the project coordinator at the hospital to decide whether a home visit by a qualified nurse is needed.

Many patients diagnosed with HIV/AIDS are mobile and able to take care of themselves. These people receive self-care training in nutrition, hygiene, and techniques such as caring for HIV/AIDS-related skin problems. The patient also receives training in "positive living" – taking on a forward looking, optimistic attitude. When the individual requires a greater degree of care and has come to St Theresa's for in-patient treatment, the patient's family is asked to send a member over the age of 12 to take home-care training while the patient is still in hospital. Like self-care patients, family caregivers receive training in nutrition, hygiene, oral rehydration, and control of simple infections.

Most of the project's volunteer home caregivers are recruited through the district's church parish councils and other base-level religious organizations. Criteria that guide the councils in their recruitment of these volunteers include compassion and willingness to provide spiritual support and care where needed. Most of the

volunteers are HIV-positive themselves, though an increasing number are relatives of infected persons. There are currently about 30 volunteers in Chirumhanzu.

The project has also created a number of support groups for PLWHAs in the district. There are currently six groups with between 12 and 22 persons in each group, which come together each Thursday.

The project's principal tool for awareness and prevention has been its drama group. The group performs skits to entertain the public while at the same time providing information on HIV/AIDS. The group usually accompanies the nurse and coordinator when they attend village meetings, and performs at these meetings. Recently, the project has begun to organize public netball and football clubs for the community's young people. Games between clubs are used as an occasion to give talks and to show a video about HIV/AIDS.

Currently, eight women who volunteer with the project have taken on responsibility for prevention work. These women visit popular meeting places, where they inform the public about HIV/AIDS in addition to other sexually transmitted diseases, hand out pamphlets on these subjects, and distribute condoms.

Outcomes/outputs

The project currently provides home care for over 200 persons living with HIV/AIDS. There are also six support groups.

Lessons Learned

The connection with St Theresa's Hospital has been a particular source of strength and continuity, particularly due to the availability of trained health professionals able to participate in the project when needed.

An important feature of the project is its management by local people. The majority of project members are either HIV-positive or are directly affected in some way by the virus – for example, having had a family member who died of AIDS. Dependence on overseas donors and foreign medical staff is far from ideal. Yet the area is a poor one, and there are few options for greater resource mobilization locally or nationally.

As yet, the project has not been successful in enlisting the active support of local chiefs or village health workers (passive support or tacit acceptance, however, is essential to the project's work). Some of the local chiefs feel they should receive payment for supporting the project, as do the health care workers, whose regular salary is very low. The project does not have the financial resources to provide any such payment, and this lack of involvement has resulted in less community participation than might otherwise be possible. A promising sign is that, while the chiefs are not inclined to talk publicly about HIV/AIDS, many of their children attend public meetings arranged by the project.

Faced with the problem of providing information in an area of low literacy, the project has chosen three forms of communication that are most cost-effective: public meetings, drama, and – where electricity and a VCR are available, such as at clinics or in the hospital – videos. As well, the creation of sports leagues for young people appears to be a highly effective way of getting public attention in a place where over half the population is under the age of 25.

Further Reading

UNAIDS. *Comfort and hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS*. Geneva: UNAIDS, (in press).

Counselling and voluntary counselling and testing

HIV counselling has both prevention and care as its objectives. It concentrates on emotional, behavioural, and social issues related to possible or actual infection with HIV. In essence, counselling is a confidential dialogue between a client (in counselling, the word “client” is preferred to “patient”) and a counsellor, aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. With the consent of the client, counselling can be extended to spouses, sex partners, and other persons considered important by the client. While a counsellor might be a doctor, nurse, or social worker, she or he can also be a member of the community such as a teacher, village leader, or religious leader (e.g., imam, minister, or priest.)

Voluntary counselling and testing (VCT) is a combination of two activities – counselling and testing – into a service that amplifies the benefits of both. It is an approach that is useful in all settings – resource-rich and resource-poor, urban and rural. Because VCT is adaptable to clients’ needs, it can be done for individuals and couples, for people of all ages and of all backgrounds. And, with proper training, members of the clients’ local community, regardless of their educational level, can do the counselling component.

Counselling can be done in any location that offers peace of mind and confidentiality for the client. While typically delivered in a hospital, clinic, or health centre, it can also be offered in temporary or community-outreach settings such as mobile vans or spare rooms in a non-care building – so long as they provide the level of privacy needed for confidential counselling. This flexibility reflects one of the most useful aspects of counselling: it is “client-centred,” which means it is focused on the client’s specific needs and situation. Counselling is often very effective when offered along with HIV testing services. Even without testing, however, HIV counselling offers a safe environment for discussing sensitive matters and personal worries. This augments AIDS education by making HIV-related information personally relevant.

Examples of best practices in the provision of counselling and VCT services include the following:

- ◆ The location and opening hours of the service should reflect the needs of the particular community. Voluntary counselling and testing is usually carried out in STD clinics, hospital outpatient departments, and hospital wards, but can also occur in centres dedicated to this specific purpose (such as the Anonymous Clinics of the Thai Red Cross). VCT services as well as condom supplies for sex workers are sometimes offered in the vicinity of night clubs, and operate at night.
- ◆ VCT needs to be well planned so that informed consent is always sought and counselling offered before a client takes an HIV test.
- ◆ Counselling should be integrated into other services, including STD, antenatal, and family-planning clinics. In particular, community-based counselling services can be initiated and expanded quickly, and at little expense.
- ◆ A referral system for provision of comprehensive HIV/AIDS prevention, care, and support should be developed in consultation with NGOs, community-based

organizations, hospital directors, and other service managers, as well as with networks of people living with HIV and AIDS. Regular meetings should be held among service providers to review and improve the referral system.

Counselling services, with or without testing, can and should be tailored to the needs of particular client groups, some of which have very different needs. These groups include:

- ◆ Women (regardless of their HIV status) who are or who want to become pregnant
- ◆ Couples who agree to attend sessions together before and after testing
- ◆ Children, including those living with HIV/AIDS, or who are part of a family in which one or both of the parents are either infected with the virus or have died of AIDS
- ◆ Young people, both in and out of school
- ◆ Injecting drug users (including those who are young people)
- ◆ Sex workers (including those who are young people)
- ◆ Other socially marginalized or vulnerable groups such as gay, lesbian, or transgendered individuals, and migrants and refugees.

Effects of HIV Counselling on Sexual Behaviour of Men Attending STD Clinics (India)

Starting Year: 1993

Main Topic Area: Counselling and voluntary counselling and testing

Other Topic Areas: Male condoms • Sexually transmitted diseases • Sex workers and clients

Contact Person:

Dr Sanjay Mehendale
Deputy Director

Phone: 91-20-791342, 791343,
791280, 791072

Fax: 91-20-791071

Email: hivnet@giaspn01.vsnl.net.in

Address:

National AIDS Research Institute
G-73, MIDC, Bhosari
Pune 411 026
India

Implementers

The project was implemented by researchers from the National AIDS Research Institute in Pune, India, and the Johns Hopkins School of Public Health, Baltimore, United States of America.

Funding

The study was sponsored by Family Health International with funding from the US National Institute of Allergy and Infectious Diseases.

Objectives

The study sought to describe changes in sexual behaviour and condom use among male heterosexual clients at two public STD clinics after exposure to HIV testing, counselling, and condom promotion.

Background

The project ran from May 1993 to April 1997, during which time 6,819 heterosexual men were tested for HIV infection as part of the HIV Network for Prevention Trials study. A total of 1,628 HIV-negative men agreed to return every three months for HIV counselling and testing.

At their first visit to a clinic, only 10 per cent of the men reported consistently using condoms with sex workers, 78 per cent had one or more STD, and 20 per cent were already HIV-positive.

Main Activities

Counselling at each visit focused on reinforcing messages of monogamy and condom use with sexual partners. Participants received as many free lubricated condoms as they wished to take. Each counselling session included a demonstration, on an anatomical model, of how to use a condom; participants repeated the activity following the counsellor's demonstration. Counselling was provided by a clinical social worker.

Data were collected at the beginning of the study and at three-month intervals regarding demographics, previous STD diagnoses, medical history, sexual

behaviour, knowledge of HIV/AIDS, and practices related to prevention. STDs were assessed through physical examination and specimen collection, and blood was drawn for HIV-1 and HIV-2 antibody testing.

Outcomes/outputs

The researchers followed the men for three years and noted that the number of men visiting prostitutes decreased from 63 per cent at baseline to 23 per cent after two years of counselling. Men who continued to see prostitutes were 4.7 times more likely to use a condom after two years of counselling.

Counselling did not have as much success at increasing condom use with other partners (such as wives or other partners in long-term relationships): by the end of the study only 13 per cent of men reported always using condoms with other partners, up from 5 per cent at baseline. However, knowledge of HIV/AIDS prevention increased, with 96 per cent of men after 24 months reporting that they were aware that condoms could prevent the transmission of HIV/AIDS. Only 45 per cent of the men knew this at the beginning of the study. Participants who were single or were not living with a spouse and who had less education, less accurate information about HIV/AIDS, and a history of STDs were the most likely to continue to see sex workers and the least likely to change or maintain behaviour, especially as follow-up time increased.

The risk of HIV seroconversion was lowest (4 per cent) for those who reported “always” using condoms, and highest (14 per cent) for those who reported “never” using them.

Lessons Learned

HIV testing and counselling on an ongoing basis can reduce risk behaviours. Such one-on-one intervention is relatively expensive in physical, human, and financial terms. For this reason, it is feasible for focused use in specific groups, but less so as a prevention measure for large populations.

The researchers commented: “Individual counselling and testing approaches to STD/HIV prevention and condom use can bring about behaviour change. We found that ongoing counselling that reinforced desired behaviours and aimed at sustaining those changes over time did have a positive outcome with a large proportion of the men recruited for this study. However, counselling and testing, which provides information about HIV transmission and serostatus, is not sufficient for changing behaviour for the majority of the individuals seen in these clinics in India.... Social and cultural factors, such as poverty, lack of access to condoms, low self-efficacy of most Indian women to negotiate condom use, and belonging to marginalized or stigmatized communities (such as prostitutes) make it difficult for individuals to fulfil the intention to change behaviour. The ultimate goal of HIV prevention efforts must also focus on efforts to change the behaviours and norms of entire communities.”

Further Reading

Bentley ME. HIV testing and counselling among men attending sexually transmitted disease clinics in Pune, India: Changes in condom use and sexual behaviour over time. *AIDS*, 1998, 12:1869–77.

Demetra Social Diseases Consultation Centre (Lithuania)

Starting Year: 1998

Main Topic Area: Counselling and voluntary counselling and testing

Other Topic Areas: Injecting drug use • Sexually transmitted diseases • Sex workers and clients

Contact Person:

Mr Saulius Chaplinskas, Director

Phone: +370 2 72 04 65

Fax: +370 2 72 02 25

Email: saulius@lac.ktl.mii.lt

Address:

Lithuanian AIDS Centre

Kairiukscio 2,

2021 Vilnius

Lithuania

Implementers

The project was implemented by the Lithuanian AIDS Centre.

Funding

Activities of the Demetra Centre are funded by the Lithuanian AIDS Centre. The AIDS Centre supplies counsellor staff salaries; testing equipment and materials; medicines; condoms, syringes, and needles; and IEC materials (the latter sponsored by UNAIDS) for distribution. The AIDS Centre also provides part-time physicians to treat prostitutes and drug users at the Demetra Centre, and pays for its utilities.

Objectives

The Demetra Centre seeks:

- To provide HIV/AIDS/STDs testing, treatment, and counselling to both sex workers and injecting drug users
- To promote behavioural changes in vulnerable groups by increasing awareness of the consequences of drug use, HIV/AIDS, and STDs as well as of methods to prevent their spread.

Background

The centre was established in April 1998 in Vilnius, the capital of Lithuania. It is located in the railway station district, which is en route to the city's main drug-dealing area. The centre services both the drug-using community and the street prostitutes - many of whom are migrants - working at and around the railway station,. In addition to the 1,000 registered drug-users in Vilnius, estimates of the number of unregistered IDUs in the city range from 12,000 to 50,000.

Prostitution is illegal, and sex workers can be arrested by police on the grounds of public order infringement. Registered drug-users do not have any precise legal status, but are registered with the medical authorities and police.

Main Activities

Contacts with prostitutes and pimps started at the Lithuanian AIDS Centre's anonymous STDs testing site. It became clear that HIV/AIDS/STDs prevention among this high-risk group could be improved significantly by opening a separate centre. To this end, the Demetra Centre opened, hiring a nurse and selecting two peer counsellors from among the pimps who were most active in STD-prevention

work among their sex workers. Soon after the new centre opened, it conducted a sociological survey of the existing knowledge, approaches, practices, and behaviour among the city's IDUs and sex workers.

The main daily activities of the Demetra Centre include:

- Pre- and post-test counselling
- HIV/AIDS/STDs testing of sex workers and injecting drug users
- Individual counselling sessions
- Treatment and services for people with STDs
- Needle and syringe exchange; condom distribution
- Showers and other hygiene facilities for street prostitutes (many of whom are migrants or homeless)
- Drug users' community education as well as support for those giving up drugs
- Referral of those IDUs willing to end drug use to the Narcology Centre for social rehabilitation and/or methadone programmes.

Outcomes/outputs

The centre provides services to between 40–80 sex workers and injecting drug users daily.

Approximately 800 people in the community visit the centre on a regular basis. Although there has been no formal evaluation of the project, the level of condom distribution indicates that those who visit the centre are increasingly aware of the importance of condom use for the prevention of HIV/AIDS and STDs. In addition, the growing attendance at the centre indicates that this message is reaching an increasing number of people.

Lessons Learned

The centre's experience indicates that in order to better provide counselling and holistic care for people at high risk of HIV/AIDS in Vilnius, the specific needs of two different groups (sex workers and injecting drug users) have to be understood and planned separately. Counselling, support, and care activities for these people need to be implemented separately also, due to ongoing tension between the two groups. Experience has also shown that the target groups are better motivated to attend if they each have their own counselling centre.

Location is one of the most important factors in the success and high attendance of the centre. A location further away from where the high-risk activities take place would not likely have attracted as many visitors.

It appears that the peer counselling/education approach is effective because the counsellors' backgrounds are similar to those of their target audience. Peer counselling contributes to higher level of trust and perhaps better communication than if the sessions were provided by "outsiders."

Finally, the level of demand for services provided by the centre has shown that there is a need for expansion of the network of social rehabilitation institutions. In particular, the increasing number of young drug users visiting the centre appears to indicate that primary drug prevention education in schools is of low quality or is ineffectively presented.

Wandzin: A Village for People Living with HIV/AIDS (Poland)

Starting Year: 1992

Main Topic Area: Counselling and voluntary counselling and testing

Other Topic Areas: Persons living with HIV/AIDS • Community mobilization

Phone:

+48 597 369 13

Address:

ECO "Szkoła Życia"
w Wandzinie
gm. Przechlewo p-ta 77-323
Poland

Implementers

A local NGO, the ECO School of Life, implemented the project.

Funding

Funding was originally provided by the Polish government, at a time when available moneys were decreasing in relation to local needs. In 1996 and 1997 UNDP's HIV/AIDS and Development Programme assisted the project with the costs of therapists so that the centre could invest its resources in agricultural production. Currently, the project receives limited funding from the Ministry of Labour.

Objectives

The project has several major objectives:

- To provide shelter and therapy for people from socially disadvantaged groups, the majority of whom are People living with HIV/AIDS
- To assist individuals in re-establishing their skills of living in a community and working in a household
- To rebuild ability to accept, cooperate with and take responsibility for other community members
- To improve the practical skills of inhabitants
- To ensure the self-sustainability of the village through diverse agricultural investments and innovative activities such as the adaptation of ecological heating systems
- To establish and maintain good contacts with local government based on the rule of reciprocal benefits.

Background

Many people living with HIV/AIDS in Poland find it very difficult to continue normal lives in their family environment after disclosure of their HIV/AIDS status, particularly as the majority have had drug-related problems or have a current drug habit. All of these people need support, but they especially need an opportunity to take on responsibilities, to be trusted and accepted.

Based on this understanding of the problem, the ECO School of Life (ESL) in Wandzin was established in 1992 with the fundamental aim of assisting former drug users living with HIV/AIDS. With the help of external financing, two consultants

prepared a development strategy for agro- and eco-development of the village, which was implemented and remains in place today.

However, in working with the original small group of 20 ex-drug users living with HIV/AIDS, leaders of the ESL found that simply focusing on old drug-use habits did not help community members rebuild their lives. ESL leaders therefore decided to accept other groups of people into their community: alcoholics with criminal records, mentally disadvantaged individuals, single mothers with children. The majority of these people had the same problem – HIV infection.

Features of the Wandzin's development have included:

- Renovation of a nineteenth-century building, which was later adapted to house mothers and their children
- A kindergarten for 30 HIV/AIDS-infected children (the teacher was provided by the local job-centre) to free women for participation in community life
- The adaptation of 40 hectares of land for cultivation, along with stock-farming and cattle-breeding to provision the entire village.
- The installation of an ecologically sound heating system. In keeping with the project's ecological orientation, the ESL sought and obtained a grant for installation of a biomass-fired furnace (using waste wood from a nearby sawmill) as well as a central heating system compatible with this source of energy.

Main Activities

Activities in Wandzin are designed to offer a mix of opportunities, responsibilities, and necessary care. All adult inhabitants work for the village, with different responsibilities based on the ability to contribute. Some participants work outside the village for personal income to repay the debts they had accumulated before coming to Wandzin. In order to ensure upgrading of professional skills, skilled individuals work as instructors and teach others the basics of mechanics, electronics, carpentry, and so forth. They also renovate housing and community facilities as well as arranging special workshops targeting each profession.

The ESL provides medical services and assistance to HIV/AIDS patients with the help of a doctor and a nurse trained at the HIV/AIDS Clinic in Szczecin. Therapists working in the centre are responsible for ongoing monitoring of individual rehabilitation plans.

An important activity is participation in the national response to HIV/AIDS. Many of the inhabitants of Wandzin are active members of the national network of People living with HIV/AIDS, and maintain regular contact with that community.

Outcomes/outputs

As of mid-1998, the ESL had assisted over 200 individuals to re-establish positive relations with wider society, to build skills, and to improve both self-esteem and self-discipline. About 30 persons have left the centre and rebuilt their own lives within a family or in other addiction-free environments. Currently, about 80 permanent inhabitants maintain a home and decent living conditions in the village.

Lessons Learned

Because of its apparent separateness from the rest of society, a village of People living with HIV/AIDS may at first seem to contradict best practice in other parts of the world. Yet it offers an alternative for many individuals who, without this opportunity (and its various built-in supports), would continue using drugs, engaging in criminal

behaviours, or abusing alcohol. Many of them would be homeless or deprived of the right to take care of their children.

Organizers stress that the Wandzin model is not the only route for people affected by the HIV/AIDS epidemic. However, in a situation characterized by homelessness and hopelessness, this model can provide comfortable housing, high-quality health care, and a safe workplace for many. The project shows that a warm, accepting atmosphere, coupled with hard work, provides a sound basis for psychological and social therapy.

Finally, the project confirms the organizer's initial analysis that ecologically sound agricultural production is the easiest way to ensure self-sustainability in Poland's economic context of high unemployment and few industrial job opportunities.

Health system personnel and training

The knowledge of health care workers (HCWs) about HIV/AIDS varies from place to place, and in many cases is incomplete. Because the epidemic is relatively recent, many HCWs received little training on HIV/AIDS. Unless in-service training is offered, there is no opportunity to develop knowledge or skills in this area of work.

Nevertheless, most HCWs – nurses, midwives, doctors, dentists, and paramedical personnel – will at some point encounter people living with HIV/AIDS, and may be involved in their care. To do so, they will need new skills and increased knowledge. As well, support staff need to learn about HIV/AIDS if they are to be effective in their work, become educators for health, and protect themselves from harm.

A planned programme of education in HIV/AIDS can be a cost-effective investment in recruitment and retention of the health care workforce for several important reasons. First, enhanced knowledge and skills lead to improved patient care, in both prevention and treatment. Second, greater knowledge will help HCWs to protect themselves from infection, both professionally and personally. Third, there is growing evidence that improved knowledge of HIV/AIDS positively affects attitudes to caring for people living with HIV/AIDS and reduces levels of discrimination towards them.

Educational methods, as well as content, can significantly influence the outcomes of programmes. For example, guided learning based on experience is more effective in both imparting knowledge and changing attitudes than a didactic, information-giving approach. It is also important to note that training has the potential for capacity-building, as more HCWs become knowledgeable enough to become teachers themselves, provided that they are taught to have and use those skills during their training.

Recent experience in various parts of the world suggests the following among the many lessons learned about HIV-related training and awareness for health care personnel:

- ◆ While health managers and workers often feel in danger of being overwhelmed by the HIV/AIDS epidemic and have neither time nor resources for training, this view is short-sighted. Training can actually strengthen capacity in the health sector, if it is planned as an integral part of health system development.
- ◆ Training programmes in many countries have not only enhanced the knowledge and skills of HCWs, but have also changed their attitudes towards working with people with HIV/AIDS. In some cases, increased knowledge corrects misconceptions, and in that way can change attitudes.
- ◆ HCWs who are HIV-positive can continue to be valuable members of staff, provided they are offered support, and do not fear discrimination from their co-workers. Training can correct misconceptions about risk of infection, and can help to change attitudes too. (At the same time, HIV-positive HCWs need to be protected from opportunistic infections, especially from TB, and both managers and colleagues must be empowered to do this.)

- ◆ HCWs at all levels should be taught counselling skills with HIV/AIDS patients, especially in relation to testing.

Preparing new students in all health sciences to care for people with HIV/AIDS is of course essential and will, in the longer term, build the capacity of the health services. As well, there is a continuing need for research into the effects of education on all aspects of caring for people living with HIV/AIDS, and on health workers themselves, and therefore evaluation is a vital component of any training programme.

Integrated Pilot Project for Prevention of STDs and HIV/AIDS among Rio's Low-Income Population (Brazil)

Main Topic Area: Health system personnel and training

Other Topic Areas: Health reform and HIV • Male condoms

Contact Person:

Dr Regina Guedes
Programme Director

Phone: +55-21-533 4152

Fax: +55-21-240 2588

Address:

State AIDS Programme
Rua México 68, 4th Floor
Rio de Janeiro
Brazil

Implementers

The Rio de Janeiro State Health Department's STD/AIDS Division acted as general coordinator. Partners included the Municipal Health Department, the State Department of Labour and Social Services' Solidarity Community Programme, the Municipal Department for Social Development, Médecins sans Frontières, and the State University of Rio de Janeiro.

Objectives

The main objectives are to:

- Develop a multisectoral and integrated strategy for HIV and STD prevention within a developmental perspective
- Reduce vulnerability and risk factors conducive to STD and HIV transmission
- Promote preventive and safer sexual behaviour for youth already participating in existing social programmes
- Increase access to STD diagnosis and treatment, and to HIV counselling and testing
- Promote access to condoms.

Background

The State of Rio de Janeiro, which has a population of 15 million people, has the second largest number of AIDS cases in the country. The capital city, Rio de Janeiro, is home to 6 million people, and its metropolitan area (which includes another eight municipalities) features dramatic differences in social and economic strata. Extensive slum areas called "favelas" are located mostly in hill areas, with populations ranging from 20,000 to 500,000 people in each favela. They are made up of working-class families, with an average of four children raised by a single parent (generally the mother) with only grade school education. Rio is also a city that receives a great number of national and international tourists throughout the year.

The metropolitan area accounts for 90.4 per cent of all AIDS cases reported to the State AIDS division – 15,000 cases by July 1998. Sexual transmission, much of it between men who have sex with men, is the principal form of transmission in the region.

Since the epidemic in Brazil is presently characterized by increasing impact on people with low incomes and increasing levels of transmission among heterosexuals, new strategies for reaching populations with low incomes and low educational levels

have become necessary. These concerns served as the impetus for the implementing agencies, supported by the National AIDS Programme, to create an integrated AIDS prevention pilot project directed toward the general population of the favelas, with special emphasis on young people and women.

Main Activities

The strategy adopted by the pilot project was to integrate the activities of condom distribution and dissemination of preventive information on STDs and HIV/AIDS within existing government programs directed to lower-income segments of the population, rather than to create new programmes or agencies. Thus, an important step was creation of a “management group” composed of representatives of the eight participating institutions, with the task of monitoring and evaluating project activities.

Another important step was to provide all participating institutions with a common base of information and approach. This was accomplished through training provided for health professionals, educators, social workers, and community leaders at the University of Rio de Janeiro (UERJ) training centre. Using a participatory methodology, they learned to be disseminators of STD and HIV/AIDS prevention information.

The participating institutions were as follows:

- Family programmes: 20,000 registered families participate in educational meetings linked to monthly basic food distribution. Ninety per cent of the participants are female heads of families. Trained educators now regularly address themes of sexuality and of AIDS and STD transmission and prevention during these meetings, before the distribution of food supplies begins. Condoms are distributed along with the food.
- Rio Youth Programme: Directed to young people aged 14 to 24 years, this programme includes sports and cultural activities, and professional training with the purpose of giving youth a sense of citizenship. The pilot project trained programme monitors to discuss prevention skills and distribute condoms to participants.
- Return Home Project: This project is directed toward young people who live on the streets but have families that they might return to. It provides temporary shelter and social adaptation for young people’s reintegration into their families and communities. Educators were trained to counsel youth on HIV prevention issues and life skills and to promote condom use.
- Doctors without Borders: This NGO expanded its work to 12 favelas, where it helped the community to organize condom distribution “banks.” Most important, it set up a referral and counter-referral arrangement with municipal health units to guarantee proper assistance and care for community members with STDs or HIV.
- State Labour and Social Service: This programme provided a link with a network of agencies and organizations that assist low-income people in 15 locations throughout the state through the “centres for the defense of citizenship” and “solidarity communities” for the rural areas. Community leaders were trained on prevention issues and promotion of safer behaviour in the four municipalities with the highest incidence of AIDS cases in Rio (Campos, Itaboraí, Caxias, and Nova Iguaçu).

In addition, drug store attendants were trained to make proper referrals to the health units for those people who come to them to buy medicine for STD complaints.

Outcomes/outputs

Specific results included:

- Implementation of condom distribution points within 12 poor communities
- Training of 218 monitors and 102 educators for AIDS prevention activities
- Training of 35 pharmacy counter attendants, and distribution of informational materials with the names and address of available health centres for diagnosis and treatment of STDs
- Production of a documentary video on project experiences and outreach work in both urban and rural areas
- Production of an educational video suitable for persons with lower educational levels
- Development of software for control of condom distribution
- Production of informative material (posters and leaflets) appropriate to the literacy level of the population and within the particular cultural perspective.

Evaluation Findings

Qualitative evaluation with focus groups of professionals and community members showed high acceptance of integrated activities. There was also found to be a high level of involvement by community members with health promotion activities.

It has become evident that financial and logistical resources from implementing agencies are being optimized with the networking process: that is, they reach a greater number of people with the same amount of effort, and in a more integrated and sensible form.

Lessons Learned

An important lesson is that rationalization (in the sense of greater efficiency) and greater impact from existing human and financial resources within implementing agencies is possible, even when dealing with very different agencies and diverse programme areas. However, for such a multisectoral approach to be successful, it is essential to monitor activities with a coordinating or management unit that meets on a regular basis to make any necessary adjustments of planned activities. Constant communication between members of this group is very important to plan for technical supervision.

Different types of partnerships can be developed to enhance efforts for prevention of HIV/AIDS and diminish vulnerability factors for lower-income populations. However, these partnerships work only when there is a common approach to AIDS as a broad development problem rather than as a single public health problem unrelated to other issues. Health professionals and social workers have to be oriented to this approach, and must be trained (and supervised) to conduct educational talks and meetings on sexuality, HIV/AIDS, STDs, and drug use.

Another important element in the project's success is providing management training to community leaders from local neighbourhood associations. This is desirable for sustainable and efficient implementation of service.

The project members judge that there is potential for the overall approach of the pilot project to be replicated in other metropolitan areas, so long as the project builds into it the elements mentioned above, along with a participatory methodology for involving community members in the development of materials and activities.

Health Promotion in Action (Canada)

Starting Year: 1993

Main Topic Area: Health system personnel and training

Other Topic Areas: Community mobilization • Communications programming

Contact Person:

Keith Walls,
National Prevention Programs
Coordinator

Phone: +613 954 5155

Fax: +613 941 2399

Email: Keith_Walls@hc-sc.gc.ca

Web Site: www.hc-sc.gc.ca

Address:

Prevention and Community Action
Programs/Care, Treatment and Support
Program

Health Canada

Jeanne Mance Building

Address Locator 1918B1

Ottawa, ON K1A 1B4

Canada

Implementers

This project was funded by the HIV/AIDS Prevention and Community Action Program and the HIV/AIDS Care, Treatment, and Support Program, Health Canada (federal Ministry of Health) as an initiative of the National AIDS Strategy. Health Promotion in Action was a national cooperative venture between a group of NGOs including AIDS Vancouver, British Columbia Persons with AIDS Society, Positive Women's Network (partners in the Pacific AIDS Resource Centre, Vancouver [PARC]), and the Canadian AIDS Society, Ottawa, and its member community AIDS organizations.

Funding

Health Canada, through Prevention and Community Actions Programs and the Care, Treatment, and Support Program provided AIDS Vancouver with the support to pursue this initiative.

Objectives

The initiative had two major objectives:

- To advance the practice of health promotion in community-based AIDS work
- To help people meet their own, self-determined, positive health goals, pursued through personal, group, and community development in a context of supportive policies, resources, and environments.

Background

The project started in 1993 when Health Canada provided AIDS Vancouver with the support to pursue this initiative at PARC and with the Canadian AIDS Society and its members across the country.

Main Activities

This project undertook a nation-wide consultation with community-based HIV/AIDS organizations in a broad effort to develop the health-promotion capacities of their personnel. The project sought to discover the inherent principles of success behind community initiatives that had broken new ground or crossed significant barriers to achieve positive outcomes. Participating agencies were kept abreast of

developments by a newsletter, a series of oral reports, and several national meetings. The newsletter regularly featured an interview with agency personnel who had achieved outstanding results with their work as well as a “think-piece” on leading concepts of health promotion applied to the HIV/AIDS context.

As community breakthrough stories accumulated, shared patterns of success began to emerge. One of the key findings was that all successful project leaders had engaged in systematic research activities with the intended audience or client group.

Outcomes/outputs

The products of the consultation (including a meta-analysis of breakthrough stories using the health-promotion concepts of leading authors in the field) were used to create a manual, *Taking care of each other. Field guide: Community HIV health promotion, theory method and practice*. This has been followed by other publications. A portable workshop, entitled Study Plan Do and featuring research skills building, was created for agency personnel.

Evaluation Findings

The project used process evaluation and qualitative research methods in its procedures. The Study Plan Do workshop was closely monitored for participant satisfaction. That evaluation indicated a high degree of acceptance by agency personnel. (The workshop received so many applicants that they had to go on a waiting list.) While it is still too early to judge the overall impact of the project, community-based research has become a policy priority in Canada's HIV/AIDS Strategy due largely to interest expressed by community personnel and the scientific community alike.

Lessons Learned

Perhaps the most important lesson learned is that increasing the capacity of community agencies to conduct research also increases their overall capacity to manage local HIV conditions. It should therefore be encouraged as a way of making community efforts as complete and effective as possible.

Two other lessons were also significant.

- Research skills learned during such a programme provide personnel with the ability to create practices that can be systematically applied in difficult situations where programme solutions are not easily forthcoming.
- While community-based research is not a solution to HIV/AIDS issues, it can provide important information and data to guided programme implementation.

Further Reading

Two documents by Drs Terry Trussler and Rick Marchand are available from the Canadian HIV/AIDS Clearinghouse at telephone +613 725-3769. They are: *Taking care of each other. Field guide community HIV health promotion theory method practice* and *Knowledge from action: Community-based research in Canada's HIV Strategy*.

Support to Antenatal Clinics (Uganda)

Starting Year: 1994

Main Topic Area: Health system personnel and training

Other Topic Areas: Refugees • Counselling and voluntary counselling and testing

Contact Person:

Dr Silvia Declich

Phone: +39 06 49387217 or 49902820

Fax: +39 06 49903111

Email: silvia@iss.it

Web Site: www.iss.it

Address:

Reparto Malattie Infettive

Laboratorio Epidemiologia e Biostatistica

Istituto Superiore di Sanità (ISS)

Viale Regina Elena, 299

00161 Rome

Italy

Implementers

Implementers included Lacor Hospital personnel in charge of the antenatal clinic (ANC) activities, laboratory, health education, and counselling; community representatives of local organizations; and rural leaders of women's groups.

The AIDS Service Organization (TASO), a local NGO, trained personnel in HIV counselling, while a medical doctor with expertise in public health trained personnel in health education.

Funding

The Istituto Superiore di Sanità (ISS) in Rome provided supplies and equipment, while the Italian Ministry of Foreign Affairs provided laboratory equipment, data management services and expert personnel.

Italian NGOs International College for Health Cooperation in Developing Countries (CUAMM) and Associazione Volontari per il Servizio Internazionale (AVSI) operating in Uganda provided resource persons and access to data for future analysis concerning other districts of Northern Uganda. Lacor Hospital contributed its data from 1992 to 1998 and the involvement of its personnel.

Objectives

The overall objective is to improve those health services provided by the ANCs that are specifically aimed at preventing the spread of HIV/AIDS, syphilis, and other STDs.

Other objectives include:

- Improving the knowledge of HIV/AIDS and STDs among pregnant women attending the ANC, and among young women identified as highly vulnerable to these diseases
 - Increasing the number of women seeking HIV testing and counselling
 - Strengthening the sentinel surveillance system for HIV/AIDS and STDs at antenatal centres
 - Utilizing the collected data for trend evaluation, planning of new activities, and coordination of activities with other antenatal clinics in other districts of Northern Uganda.
-

Background

This project is part of a collaborative effort of the Italian Istituto Superiore di Sanità (ISS), the Italian Ministry of Foreign Affairs, and the Ugandan Ministry of Health (see also Data Collection and Analysis in Northern Uganda.)

The project started in 1994 at the Antenatal Clinic of St Mary's Lacor Hospital (Gulu, Northern Uganda), working with women's groups at community level and in the nearby refugee camps. In the future the programme will be extended to include the antenatal clinic at the Governmental Hospital of Gulu District.

Regular sentinel surveillance and diagnosis of HIV/AIDS and syphilis among pregnant women attending the ANC of Lacor Hospital have been taking place since 1994. In 1997 the clinic created a database of information on approximately 9,500 pregnant women tested for HIV/AIDS from 1993 to 1997. This database is regularly updated. Analysis of the data collected until 1997 was completed in June 1998, with the results being published in October of that year.

One hospital staff member has been designated and trained to organize and coordinate health education activities and counselling. Other hospital personnel and community representatives of local organizations have been trained in health education and counselling.

Health education sessions for pregnant women at the ANC began in 1994; health education activities targeting young women in the community began in 1998, following the results of data analysis.

Main Activities

Ongoing activities of the project include:

- Anonymous HIV/AIDS screening (utilizing the serum tested for syphilis)
- Weekly health education sessions at the ANC
- Promotion of voluntary testing among women
- Identification and training of rural leaders of women groups in health education activities is carried out in the villages and in the refugee camps
- Using the results of data analysis to identify risk groups targeted for new public health activities.

In addition, the project has been advocating adoption of its methodology of data collection and analysis by other ANCs in Northern Uganda. The aim is to facilitate creation of a universal information database. It has also helped to set up screening services in other ANCs in Northern Uganda in an effort to promote and coordinate the material and human resources contributed by these other institutions.

Outcomes/outputs

Hospital personnel have been collecting data since 1993 and entering the information into a computer database. Data analysis was conducted by the expert in epidemiology working in collaboration with scientific staff in Rome. The analysis process was monitored, and the results obtained were discussed locally and in Italy during technical staff meetings.

Among the outcomes revealed by the data were the following:

- An increase in the number of women screened for HIV/AIDS (from 1,013 in 1993 to 3,269 in 1997)
- An increase in voluntary HIV/AIDS testing among women

- An increase in the number of women tested for syphilis (from 2,169 in 1994 to 3,268 in 1997)
- Increased access by pregnant women in Northern Uganda to information concerning HIV/AIDS and STDs
- Activities started at the hospital level have now been shifted to the community level, utilizing the hospital as referral centre.

Evaluation Findings

The project team has selected an indicator for each planned activity. Every indicator identified must be able to monitor and evaluate the matched activity. The project has thus far evaluated activity efficiency; efficacy and impact will be evaluated in the near future.

Lessons Learned

An important lesson is that integration of activities in different areas of HIV/AIDS prevention among women – that is, bringing together in the ANCs the activities of diagnosis, counselling, health education, and surveillance of the HIV/AIDS epidemic – can be of strong benefit to community health and to institution building. The project has also learned from its experience that:

- The use of collected data for identifying risk groups and planning public health activities has an extra benefit beyond the expected one of programme effectiveness. It has also increased the appreciation and commitment of hospital management and has help to stimulate preventive activities at the community level.
- Coordination with other institutions working in the area has increased the demand for preventive activities to be run at the ANC level. Furthermore, such collaboration has enabled implementation of the same activities within other ANCs with resources contributed by different institutions.

It is necessary to stress that more effort should be undertaken in those activities aimed at promoting voluntary HIV/AIDS testing (as opposed to the anonymous screening of samples taken for STD diagnosis). There is still a large disparity between the total number of women found to be seropositive by the screening and those asking for testing and counselling.

Further Reading

Fabiani M, Blè C, Grivel P, Lukwiya M, Declich S. 1989–1996 HIV-1 prevalence trends among different risk groups in Gulu District, North Uganda. *Journal of acquired immune deficiency syndromes and human retrovirology* 1998, 18(5).

Human rights, ethics, and law

Since HIV/AIDS is a problem that profoundly affects most aspects of people's lives, it raises many social, economic, and cultural issues that relate to human rights, ethics, and law. Some focus on technical questions, such as the task of designing ethical protocols for HIV-related research involving human subjects. Others are broad issues that pre-date the epidemic, such as protecting the rights of commercially exploited children (a group especially vulnerable to HIV), guaranteeing the reproductive and sexual health rights of girls and women, and adopting legal or legislative instruments to ensure full integration and acceptance in society of persons living with HIV/AIDS.

Many people with HIV/AIDS suffer discrimination, intolerance, and prejudice. Creating an environment in which there is respect for the human rights of people living with the virus or affected by it in other ways (AIDS orphans, for example) will help them live a life of dignity without discrimination and also will reduce the numbers of people vulnerable to infection.

Strengthening the human rights of women, children, and marginalized groups is an important first step. For a variety of economic, social, and cultural reasons, human rights of such groups have been eroded in a number of countries. These groups are disproportionately affected by HIV/AIDS and have more limited capacity and access to resources to prevent or treat infection. In a climate of discrimination, people are less likely to present themselves for voluntary HIV testing and are thereby unable to access treatment, care, and support. This in turn hinders efforts by public health authorities to develop targeted policies and programmes to control the epidemic.

It is against this background that UNAIDS and the Office of the High Commissioner for Human Rights have jointly published International Guidelines on HIV/AIDS and Human Rights. These guidelines – which constitute an important framework for all best practices in the field of human rights and HIV/AIDS – offer concrete measures to protect human rights as an effective response to HIV/AIDS. They are important not just for people living with HIV/AIDS but for society in general.

In broad terms, as set out in the guidelines, best practice in this area includes three main approaches:

- ◆ Improving the capacity of governments to take on responsibility for dealing with the issues; encouraging them to coordinate their action across ministries, non-governmental organizations, and communities and to promote a supportive environment for groups vulnerable to HIV/AIDS
- ◆ Reforming laws and legal support services, focusing on anti-discrimination, protection of public health, and the improvement of the status of women, children and marginalized groups
- ◆ Increasing private-sector and community participation in the response to HIV/AIDS, including building capacity and responsibility of civil society to respond ethically and effectively.

The Canadian HIV/AIDS Legal Network (Canada)

Starting Year: 1992

Main Topic Area: Human rights, ethics, and law

Contact Person:

Ralf Jürgens

Phone: (514) 397-6828

Fax: (514) 397-8570

Email: info@aidslaw.ca

Web Site: <http://www.aidslaw.ca>

Address:

Canadian HIV/AIDS Legal Network

484 McGill Street

4th Floor

Montreal, QC H2Y 2H2

Canada

Funding

Health Canada (the federal Ministry of Health) provides funding. Some funding is also contributed by governments and charitable foundations.

Objectives

The Canadian HIV/AIDS Legal Network seeks:

- To educate decision makers and the public, and promote policy and legal responses to HIV/ AIDS that respect human rights
- To facilitate access to accurate and up-to-date legal information, particularly for persons living with or affected by HIV/AIDS
- To link people working with or concerned by relevant social and legal issues (and thereby, ultimately, to limit the spread of HIV/AIDS and reduce the impact on those affected by HIV/AIDS).

Background

The network is the only national, community-based charitable organization in Canada working exclusively in the area of policy, legal, ethical, and human rights issues raised by HIV. It was formed in 1992 with the mandate to advance education and knowledge about legal, ethical, and policy issues raised by HIV and to promote responses to HIV infection and AIDS that respect human rights.

Main Activities

In addition to its published and widely distributed discussion papers and reports on a wide number of topics, the network's main activities include:

- National and regional workshops
- Publishing information sheets on various topics
- Working on legal issues relating to specific population groups
- Providing analysis and recommendations regarding the legal and ethical issues associated with drug use
- Strategic planning to develop a work plan on HIV-related legal, ethical, and human rights issues in Canada for the period 1998–2003.

The network publishes and distributes the quarterly Canadian HIV/AIDS Policy and Law Newsletter, which has worldwide distribution; maintains a website of resources on current legal, ethical, and human rights issues related to HIV; and acts as a

resource centre on these issues. The network has entered into partnerships with other national and international organizations, including the AIDS Law Project of South Africa.

Outcomes/outputs

A number of documents have been produced to date, including discussion papers and final reports dealing with HIV/AIDS in prisons; criminal law and HIV/AIDS; gay and lesbian legal issues and HIV/AIDS; HIV testing and confidentiality; and HIV/AIDS and discrimination. As well, several issues of the Canadian HIV/AIDS Policy and Law Newsletter and many news bulletins have dealt with specific topics.>

The network's efforts have assisted in achieving, among other things, increased prevention, care, and treatment in prisons; changes in laws and policies regarding drug use and treatment of addictions; and changes to law and policies that discriminate against gay men, lesbians, bisexuals, and transgendered people. The national AIDS consultations undertaken in 1997 confirmed the need for continuing efforts in legal, ethical, and human rights issues and HIV. Under the current Canadian Strategy for HIV/AIDS, a new component on legal, ethical, and human rights issues is included with an separate funding allocation for related activities. This measure has received wide support from stakeholders working on AIDS issues.

Evaluation Findings

All projects and activities undertaken by the network have an attached evaluation component. The network also regularly conducts reader surveys and tracks requests for the documents it produces.

Lessons Learned

The benefits achieved by the network demonstrate that the presence of a highly motivated advocacy group with a professional or thematic focus such as the law can be highly effective in creating change.

While the central role of the network has continuously received wide support and recognition, the stakeholders in the AIDS community recognize the need to strengthen the capacity of other organizations to undertake activities in this area and the need to integrate discussion of legal, ethical, and human rights issues into the work of other players in this area.

Further Reading

For a variety of useful information and downloadable publications in both French and English, see the network's web page at <http://www.aidslaw.ca/elements/descrE.html>. The documents are also available from the Canadian HIV/AIDS Clearinghouse at +613 725-3769.

Republic of the Philippines AIDS Prevention and Control Law (Philippines)

Starting Year: 1997

Main Topic Area: Human rights, ethics, and law

Other Topic Areas: Persons living with HIV/AIDS • Sex workers and clients

Phone:

+632 743-8301 loc. 2254-2257

Fax: +632 711-6693

Email: aidsunit@pworld.net.ph

Web Site:

<http://www.doh.gov.ph/aids/index.htm>

Address:

National AIDS/STD Prevention and
Control Service

Department of Health

3rd Floor, Building 12

San Lazaro Compound

Santa Cruz, Manila

Philippines

Implementers

The project was implemented by the Government of the Philippines, with multisectoral participation facilitated by the Philippines National AIDS Council (PNAC).

Objectives

The aim is to create coherent and comprehensive legislation dealing with important aspects of HIV/AIDS epidemic.

Background

The Philippines' AIDS law (RA 8504) is an example of best practice both in the process that was followed and in its final content.

Main Activities

The law was drafted with extensive multisectoral involvement, including the involvement of people living with HIV/AIDS. Multisectoral participation in the development of the law was facilitated by the Philippines National AIDS Council. PNAC is a multisectoral group composed of representatives of government agencies and NGOs charged with advising the president on HIV/AIDS issues.

Support for the draft law was marshalled by building commitment among influential stakeholders, notably then-President Ramos. President Ramos raised the profile of the draft law by declaring 1997 the Philippines' year for HIV/AIDS prevention and by designating the passage of the law as an urgent measure for consideration by Congress.

While the content of the law sometimes reflects compromises that were needed to ensure support for the law among conservative senators and members of congress, as a whole provisions in the law clearly demonstrate best practice.

Outcomes/outputs

Measures in the law include:

- A complete nation-wide education and information campaign to promote public awareness of HIV/AIDS, including its causes, modes of transmission, consequences, and means of prevention and control
- Full protection of the human rights and civil liberties of every person suspected or known to be infected with HIV/AIDS
- Promotion of universal precautions in practices and procedures that carry the risk of HIV/AIDS transmission
- A role for the state in addressing conditions that promote the spread of HIV/AIDS infection
- Provision for utilizing the experience of affected individuals in warning the public about the disease.

Lessons Learned

A wide variety of lessons have been learned during the process of introducing this legislation, and in the short time following its adoption.

- Long-term commitment to continued engagement and debate is necessary to ensure the passage of HIV/AIDS legislation.
- Opponents who may at first seem unreachable can sometimes be convinced by good arguments and through gaining the support of influential stakeholders. One important example of the latter was the Catholic Bishops Conference of the Philippines.
- It is sometimes necessary to be flexible in negotiations, but it is vital that the areas of compromise are carefully selected.
- Having a good law can be empowering. With very limited promotion of RA 8504, sex workers in Davao, a regional city in the Philippines, were able to quote the law to local authorities who were arguing in favour of mandatory testing.
- Having a good HIV/AIDS law is just one step. There is a need for continued efforts to ensure that the law is fully implemented.

Further Reading

The complete text of the law is available at <http://www.doh.gov.ph/aids/index.htm>

Injecting drug use

In many parts of the world, injecting drug use is the major mode of HIV transmission. This is the case in a number of Asian countries, including Malaysia, Vietnam, Yunnan province in China, and the north-eastern states of India; parts of eastern Europe and several of the Newly Independent States; several Latin American countries; and some western European countries such as Spain and Italy. In Russia, more than half of all reported HIV cases to date have been among injecting drug users.

Drug use has an intimate connection with HIV. The connection occurs when drugs are injected, using contaminated injecting equipment. Furthermore, it is recognized that some drug use can lead to sexual risk behaviour, which can also result in HIV transmission.

As of 1998, there are at least five and a half million – and possibly up to 10 million – injecting drug users. They range across 128 countries and territories, up from around 80 six years ago. Some 700,000 people in the United States alone currently inject. In Russia, there are estimated to be between 350,000 and 700,000 injecting drug users, a figure over 20 times higher than the estimate in 1990.

Given that HIV infection is one of the most serious possible consequences of injecting drugs, the most effective approach is to advocate for and strengthen HIV prevention programmes among drug users. Such prevention initiatives must be implemented early, while HIV prevalence is still low, not later on, when the epidemic is widespread.

Experience from around the world indicates that a comprehensive package of measures must be used to prevent HIV spread among injectors. Such measures include providing sterile injecting equipment; raising awareness among and educating injectors and their sex partners about HIV risks and safe practices; making available drug treatment programmes; providing access to counselling, to care and support for HIV-infected injectors, and to STD and other health-care services; and providing condoms. Moreover, local communities – including the drug-user community itself – must be mobilized and participate fully for such a package of measures to work.

No single element of this package will be effective if practised on its own.

- ◆ The single most important measure (if operated in conjunction with other parts of the package) is a needle exchange programme. In these programmes, a clean needle and syringe are given out in exchange for a used set. The exchange can be done by a person, or by a dispensing machine. There are now many needle exchange projects around the world, including a few in prisons, where there is often a particularly acute problem of drug injecting. Many studies have now established that needle exchange programmes, if properly run, reduce the number of new cases of HIV infection – *but at the same time do not increase drug use*.
- ◆ Outreach work and peer education are important. Outreach workers are trained people from outside the community of injectors – though they may themselves be

former injectors. Peer educators are existing drug injectors who have been trained to work with their community.

- ◆ Laws and government policies on drugs are crucial too. In most places drug use is illegal. Without proper policy and legislative support – whether at the national or local level – *and* the necessary resources, there will be little hope of launching, or successfully sustaining, comprehensive HIV prevention programmes.
- ◆ A supportive environment is difficult to create but can make a major contribution if successful. This includes reducing poverty and creating opportunities for education and employment, the lack of which often leads people, out of utter despair, to inject drugs. Another aspect of creating a supportive environment is to keep on doing everything possible to educate and inform people – and especially young people – about drugs, and their implications for health and social well-being, in language that can readily be understood.
- ◆ Parallel with reducing the harm caused, the demand for drugs must be reduced. A particular goal must be to stop young people from starting to take drugs in the first place and to encourage existing users of all ages to stop, by participating in treatment programmes.

National Action Plan on HIV/AIDS and Injection Drug Use (Canada)

Starting Year: 1997

Main Topic Area: Injecting drug use

Other Topic Areas: National strategic planning

Contact Person:

Keith Walls

Phone: +613 954-5155

Fax: +613 941-2399

Email: Keith_Walls@hc-sc.gc.ca

Web Site: www.hc-sc.gc.ca

Address:

Prevention and Community Action Programs

Health Canada

Jeanne Mance Building

Address Locator 1918B1

Ottawa, ON K1A 1B4

Canada

Implementers

Health Canada (the federal Ministry of Health) funded and supported a Task Force of leading Canadian voices concerned with the issues of HIV, AIDS, and substance abuse. Coordination of the various activities was provided through a partnership between the Canadian Public Health Association (CPHA) and the Canadian Centre on Substance Abuse (CCSA).

Funding

Health Canada's HIV/AIDS Prevention and Community Action Programs and the Office of Alcohol, Drugs, and Dependency Issues funded the National Action Plan.

Objectives

The National Action Plan has a range of objectives. These include stimulating action on the public health crisis concerning HIV/AIDS and injecting drug use – specifically, to identify the most pressing issues related to HIV and injecting drug use in Canada, to recommend strategies to address the issues, and to identify the stakeholders who are in a position to implement changes.

Background

This is a national project carried out in Canada with the support and collaboration of federal agencies, provincial and territorial governments, health authorities, community agencies, and injection drug users and their advocates.

Following the Second National Workshop on HIV, Alcohol, and Other Drug Use in 1994, a Task Force was established with the support of CPHA and CCSA to develop a National Action Plan on HIV/AIDS and Injection Drug Use. The development of the plan was completed in May 1997 with the publication of the document *HIV/AIDS and injection drug use: A National Action Plan*. Implementation is ongoing.

Main Activities

Activities to create the plan included:

- Research with 80 stakeholders, review of documents, and development of recommendations
-

- Review of draft document by stakeholders and international participants in the issue
- Publication and distribution of the National Action Plan.

Recommendations include:

- To address policy and legislative issues, enhance governmental and community leadership, change the laws to favour a medical approach, improve conditions in correctional settings and base decisions on emerging evidence
- To enhance prevention and interventions efforts to deal with discriminatory attitudes, improve needle exchanges and disposal services and address issues of methadone programming
- To improve and expand the alternatives for treatment of substance use and HIV/AIDS, improve the quality of professional training, and boost research on treatment
- Address the specific needs of aboriginal injecting drug users, (IDUs) improve the data describing the problem, culturally appropriate strategies and better coordination of those providing services
- To address the unique issues of women IDUs.

Outcomes/outputs

Major outcomes of the process include:

- The creation of accepted principles to address the issue of HIV/AIDS among IDUs
- The identification of recommendations, suggestions on how these could be implemented, and the creation of a list of those in the best position to participate in the changes. This encourages leadership to take action on these issues.
- Widespread support within both the community and the federal, provincial, and territorial agencies for recommendations of the National Action Plan. Commitment to the directions provided by the plan has grown as communities and agencies work with recommendations.

Initiatives related to recommendations are ongoing. For instance, a federal interdepartmental committee has been struck and has identified actions that each department has taken and is planning to take. The Federal Provincial Territorial Advisory Committee on HIV/AIDS has established the implementation of the National Action Plan as part of their work plan. Provincial governments have identified action plans for their provinces. The National Action Plan has influenced actions to deal with local situations.

Evaluation Findings

No separate evaluation is planned. However, addressing HIV among IDUs is a major issue of the new Canadian HIV/AIDS Strategy and it will be a component of a planned evaluation of the strategy.

Lessons Learned

A major lesson provided by this planning process was the importance of inclusiveness as an organizing principle. Despite the controversial profile of the HIV/AIDS and IDU issue, thorough attention to getting all useful viewpoints and “buy-in” (i.e., a sense of ownership) enabled the process to succeed and useful work to result.

Participants in the process must include people from all the various sectors with an interest and stake in the issue, including former and current IDUs; addiction, law enforcement, and HIV/AIDS community organizations; and provincial and public health representatives. The organizers believe that representation from the judiciary would be a valuable asset to such planning in the future.

As well, organizers emphasize two other important lessons:

- A skilled and credible chair is needed to guide the process in which the values and perspectives of people from the various sectors are discussed in a safe and respectful environment.
- Implementation of a National Action Plan requires champions from various sectors who are credible in their own sector and committed to facilitating communication and change.

Further Reading

HIV/AIDS and injection drug use: A National Action Plan. Canadian Centre on Substance Abuse and the Canadian Public Health Association, May 1997. See also the Centre's website at <http://www.ccsa.ca> (in both French and English).

HIV/AIDS Prevention among IDUs (Ukraine)

Starting Year: 1996

Main Topic Area: Injecting drug use

Other Topic Areas: NGOs and networks

Contact Person:

Tatjana Semikop

Phone: +380-482-234-767

Fax: +380-482-268-248

Address:

Tatjana Semikop (Head)

Public Movement "Vera, Nadeshda, Ljubov"

sq. Molodi, 17

Odessa, Ukraine

Implementers

Public Movement "Vera, Nadeshda, Ljubov" is a locally-based NGO.

Funding

Funding was provided by UNAIDS, UNICEF, and the Lindesmith Center (a US-based research centre on drug policy).

Objectives

The objectives of the programme were:

- To prevent and reduce the spread of HIV/AIDS and drug-related harm among injecting drug users (IDUs) and potential groups at risk in Odessa
- To promote and facilitate self-help organizations and peer support among IDUs and persons living with HIV/AIDS (PLWHAs)
- To promote advocacy and awareness of IDUs and PLWHAs among policy-makers, in public opinion, and in the community at large.

Background

HIV/AIDS Prevention among IDUs was initiated in 1996, the first joint pilot project of the National AIDS Committee and UNAIDS in Ukraine. The objective was to explore the opportunities for implementing a harm-reduction strategy. Information was to be gathered and analysed, and effective strategies were to be disseminated throughout Ukraine. In May 1997, the NGO called Public Movement "Vera, Nadeshda, Ljubov" of Odessa took over the responsibility for the pilot project. During the project implementation, the NGO has gained recognition for using highly innovative approaches and methods.

Main Activities

The project has three main activities:

- Raising awareness among drug users on modes of HIV/AIDS transmission and prevention activities and the development of safer behaviour skills
 - Providing IDUs with individual means of protection such as needles and syringes, disinfecting agents, and condoms
 - Developing a supportive social environment by providing services such as psycho-social and medical support to IDUs.
-

Outcomes/outputs

According to behavioural studies carried out in August 1996, summer 1997 and December 1998, drug users' awareness of HIV/AIDS has risen, and safer behaviours have been. The use of single-use needles and syringes appears to have doubled, and the purchase of ready-made drugs (often already contaminated) was reduced from 50 to 14 per cent in the intervention areas. There is also anecdotal evidence that dealers have started using clean syringes instead of used ones.

Lessons Learned

The experience of the project indicates that prevention activities among IDUs are effective in reducing risk behaviours among this population. Two elements have been crucial to the success of the project: the participation of NGOs and the active involvement of drug users in information and education activities aimed at both users and dealers.

Lessons gained from this project can be passed on to other groups. For instance, experience with this project has been used to sensitize militia and the staff of other Ukrainian law enforcement institutions. In addition, harm-reduction strategies have been incorporated into the majority of regional and city HIV/AIDS prevention plans. Nevertheless, insufficient political support and a shortage of financial resources endanger the sustainability of the programme. Especially disturbing is the limited availability of new syringes and IEC material.

These limitations point to another important lesson learned: advocacy and ongoing networking is essential in an environment of limited resources such as exists in Ukraine. Although there are indications of increasing support from the city administration, ongoing international assistance is necessary to assure the programme's continuity and further development. Based on this lesson, the programme has adopted as future priorities (a) strengthening the position of the programme within the local political arena, and (b) promoting continuity and long-term planning.

Further Reading

MAP. *The determinants of the HIV/AIDS epidemics in Eastern Europe*, Geneva, 1998. Available from UNAIDS Secretariat or website, and the websites of Family Health International website (www.fhi.org) and François Bagnoud Center for Health and Human Rights (www.hri.ca/partners/fixbcenter).

Male condom

Used properly and consistently, condoms are one of the leading methods of protection against HIV infection. They are relatively cheap and generally have no side effects. And they can readily be made available on a mass scale through regular commercial sales, free distribution, and social marketing – promotion and use of marketing techniques to make products or social services available at an affordable price. In many countries, condom sales through social marketing have increased ten-fold or more since the early 1990s, reaching levels of several million condoms a year.

Along with STD management and condom use, strategies that help prevent or reduce the likelihood of HIV transmission through sex are mutual monogamy and safer sexual practices, such as non-penetrative sex. And abstinence offers a 100 per cent reliable method of protecting against HIV and other STDs.

For a person already infected with HIV, condom use during sexual intercourse is still very important, both to avoid onward transmission, as well as to prevent the person being reinfected with HIV, which could make their condition more serious.

There is a range of obstacles hindering the effective consistent and widespread use of condoms. At the present time, the number of condom-users as a proportion of those who are sexually active remains low in many countries. In addition, those who use condoms often do so irregularly or only with selective partners. In many places, it is difficult to obtain condoms for a variety of reasons including high price, limited outlets, inadequate promotional efforts, and a lack of privacy or discreetness at the point of sale or distribution. As well, unequal power relations between men and women often result in women being forced to engage in unsafe sex, even if they would prefer their partner to use a condom.

Best practices in condom programming include:

- ◆ Stressing the benefits of condom use, and working to reduce cultural and social barriers to their use
- ◆ Informing, educating, and empowering people to change their behaviour and attitudes, including educating them about HIV and STDs, and teaching skills around condom use
- ◆ Providing easier access to condoms by reducing the price or distributing them free, making more distribution outlets available, and ensuring privacy and confidentiality at the point of individual acquisition
- ◆ Maintaining good quality standards for condoms
- ◆ Carrying out further research into behaviour as regards condom use, quality control and standards of condoms, and distribution policy
- ◆ Promoting condoms more effectively as part of normal culture so that using them is seen as acceptable, fashionable, and responsible.

It Takes Two: Pill and Condom (Canada)

Starting Year: 1993

Main Topic Area: Male condoms

Other Topic Areas: Reproductive health • Counselling and voluntary counselling and testing

Phone:

+780 482 2626

Fax: +780 482 5445

Email: gg@amda.ab.ca

Web Site: www.amda.ab.ca

Address:

Alberta Medical Association

CMA Alberta House

12230 - 106 Avenue

Edmonton, AB T5N 3Z1

Canada

Implementers

The project was facilitated by the Alberta Medical Association with the cooperation and support of Health Canada; the Alberta Medical Association; the Provincial AIDS Program, Alberta Health; Continuing Medical Education, University of Calgary; the College of Family Physicians of Canada – Alberta Chapter; Calgary Health Services; Edmonton Birth Control Clinic; and Sexually Transmitted Disease Services, Alberta.

Funding

Health Canada (the federal Ministry of Health) provides project funds, and the other agencies provided both support and in-kind contribution to the project, including staff time and expertise.

Objectives

The objective of the project is to encourage physicians to counsel women currently using the pill or other forms of birth control about the importance of using condoms as protection against HIV/AIDS and other STDs.

Background

It Takes Two: Pill and Condom was developed and implemented in Alberta, a province in western Canada of just over 2,000,000 people. The project, which started in 1993, is ongoing. The primary target audience is the medical professionals who provide birth control, family planning advice, and STD services. The secondary audience is the patients or clients of these physicians.

Main Activities

In preparing and implementing the programme, an advisory committee made up of members of the participating agencies was first established. This was followed by focus groups with physicians and lay women and men to investigate attitudes toward safer sex and sexual counselling. Only then were project materials drafted, which were also tested by focus groups. Ninety physicians received pilot materials for evaluation.

Physician kits include an information package (*Counselling Guidelines for HIV Testing*, a condom fact sheet, and a community resource list), a colour poster, and patient kits.

Patient kits include a self-assessment tool, a condom box with two condoms and a condom-use guide, and an information brochure.

Following province-wide implementation, evaluation was undertaken.

Outcomes/outputs

According to evaluation research (see below) the intervention increased patients' condom use, empowered women to insist on condom use, increased STD testing, and increased the likelihood of discussions with partners regarding HIV/AIDS and condom use.

Physicians supported use of the kit and said they would recommend it to colleagues. They also found the information useful and said that the resources increased efficiency of discussion with patients.

Evaluation Findings

The patient kits included a two-sheet questionnaire with a postage-paid return envelope. Evaluations were received from 105 patients. About 80 per cent of the responses were received from Edmonton and Calgary, with 20 per cent from rural Alberta. Patient responses indicated:

- 71 per cent believed condom use is important, even while on the pill; only 14 per cent reported holding this belief after "pre-kit" physician visits
- 67 per cent will insist that partners get HIV antibody tests; only 18 per cent would have insisted upon this previously
- 66 per cent will insist that partners use condoms; only 19 per cent report they would have insisted on this prior to participating in the project
- 54 per cent reported being more likely to get tested for HIV.

In May 1996, all participating physicians were sent a questionnaire. A physician response rate of 40 per cent (145 of 358) was achieved. Participants were predominantly family physicians and general practitioners, with 10 per cent from other specialities. About half were from urban areas with populations over 100,000, and the remaining half from smaller cities, towns, and rural areas. Physicians strongly supported the project in its province-wide phase. At the end of this phase, 92 per cent of respondents said they planned to continue to use the materials, and 83 per cent wanted the project to continue.

Physician respondents were asked if they thought project materials were useful for specific sub-groups of patients. Their responses follow:

- 93 per cent thought the materials were suitable for sexually active women at risk
- 76 per cent for women at risk even if the appointment were not for sexual or contraceptive counselling
- 54 per cent for all women with appointments for sexual or contraceptive counselling regardless of risk
- 24 per cent for all women regardless of risk.

A significant factor in the success of the project among individual physicians was their perception of the effort involved to implement the project. Those physicians who found that the kits enhanced their efficiency and effectiveness tended to support the project. Physicians who either did not participate or were less enthusiastic about the project reported concerns about time constraints and "adding on" to a full work load.

However, physician responses indicated:

- 98 per cent thought the project enhanced their counselling activities
- 90 per cent found it made it easier to give patients safer sex messages
- 68 per cent found it made it easier to give out condoms
- 62 per cent reported that their awareness had been heightened about HIV and STD risk factors
- 58 per cent thought it increased their awareness of alternative counselling services
- 35 per cent reported a greater effectiveness in working with other community groups.

Lessons Learned

In addition to the accomplishments noted in Outcomes/inputs, the project has found that, given appropriate materials and information, physicians will intervene consistently to encourage women to use dual protection of both condom and pill. Patients will accept both the materials and the physician's advice in a positive way, and take actions to increase their sexual safety.

An important lesson learned is that collaboration of various stakeholders and the participation of professional groups and colleagues was an important element in "selling" this intervention to physicians. Their acceptance and use of the materials would likely have been less widespread and effective without the credibility afforded by the collaborative process.

Further Reading

The evaluation is available on the Alberta Medical Association website at www.amda.ab.ca/general/pc-info/evaluation-condom-pill.html

Men who have sex with men

Sex between men frequently involves anal intercourse, which carries a very high risk of HIV transmission for the receptive partner and a significant risk, though a lesser one, for the penetrative partner. HIV prevention programmes aimed at men who have sex with men (MSM) are therefore vitally important in the response to HIV/AIDS. However, they are often seriously neglected, for reasons including the relative invisibility or stigmatization of MSM in many societies, ignorance, or lack of information.

One complicating factor in programming for MSM is that sexual identity is different from sexual behaviour. Many men who have sex with other men do not regard themselves as homosexual. Worldwide, a large percentage of men who have sex with men are married, or have sex with women as well. The development of self-identified gay communities is widespread in industrialized countries, but is far less so in most other parts of the world.

Most same-sex behaviour results from natural preference. However, there is also a considerable amount of male-to-male sex in institutions or working situations where men are obliged to spend long periods in all-male company. These include the military, prisons, and all-male educational establishments, and also places where large numbers of male migrant labourers congregate. While this behaviour represents only a small proportion of male-to-male sex, it can nonetheless be an important factor in the spread of the epidemic, particularly in prisons.

Effective responses include a combination of the following:

- ◆ Commitments by national AIDS programmes and donor agencies to include the issue of MSM in their programmes and funding priorities
- ◆ Outreach programmes by volunteers, professional social or health workers, and peer educators drawn from among MSM
- ◆ Promotion and ensured availability of high-quality condoms and lubricants
- ◆ Safer-sex campaigns and skills training, including the use of condoms and promotion of lower-risk alternatives to anal sex
- ◆ Strengthening organizations of self-identified gay men, enabling them to promote HIV prevention and care programmes
- ◆ Education among health staff (including those within STD clinics), and among the general public, in order to break down stigmatization, stereotyping, and cultural barriers to discussing male-to-male sex.

MSM Outreach Programme (Hong Kong)

Starting Year: 1990

Main Topic Area: Men who have sex with men

Other Topic Areas: Community mobilization • Male condoms • Sexually transmitted diseases

Contact Person:

Mr Graham Smith,
Senior Education Officer

Phone: +852 2898 4411

Fax: +852 2505 1682

Email: keigo@netvigator.com

Address:

AIDS Concern Community-Based AIDS
Prevention and Support Services

3 Lok Man Rd, Block F., 17B

Chai Wan, Hong Kong

Implementers

The MSM Outreach Programme was implemented by outreach workers employed by AIDS Concern, a Hong Kong NGO.

Funding

Fundraising activities were conducted by AIDS Concern, with partial sponsorship from the Hong Kong Government's AIDS Trust Fund.

Objectives

The programme has two main objectives:

- To raise AIDS awareness among men who have sex with men (MSM) in Hong Kong in different identified venues (particularly saunas, gay bars and clubs, and public toilets) used by MSM for sexual encounters
- To promote and facilitate safer sex among this vulnerable group by distributing information and safe sex kits.

Background

AIDS Concern had been involved in ad hoc activities to promote safer sex and HIV/AIDS awareness among MSM since the organization began in 1990. In 1994 it was able to secure funding to produce some safer sex leaflets for MSM. Since that time, the organization has been regularly distributing safer sex kits to gay venues.

The sauna outreach programme began in earnest in 1996, but achieved its major breakthrough in February 1998, when one sauna approached AIDS Concern directly with the idea of putting condoms in the locker rooms rather than having workers distribute them to clients. This new delivery approach was the key factor in getting other saunas to participate as well.

In the coming years, the project will be concentrating on outreach to MSM who frequent public toilets, which will hopefully give AIDS Concern more direct contact with MSM, and on trying to interest more gay groups and young people to get involved in the outreach work.

Main Activities

Among the programme's many activities are:

- Promoting safer sex behaviour to sexually active MSM
- Making condoms and lubricant readily available in environments where sex takes place
- Encouraging and mobilizing gay community groups in the fight against HIV/AIDS
- Securing the participation of MSM, especially young MSM, in the delivery of services and information
- Producing and distributing information materials in consultation with community members
- Liaising with gay venue owners and staff to secure their cooperation in promoting safer sex and HIV/AIDS awareness. Part of this intervention involves regular visits by outreach workers to saunas to establish a relationship with staff and regular customers, to distribute condoms and lubricant, and to provide a range of safer sex information materials produced by and for MSM
- Liaising with police to ensure that AIDS Concern's interventions will not bring trouble to the saunas
- Helping to bridge the gap between the government and community in the development of HIV/AIDS prevention strategies.

The organization's recent outreach to MSM who use public toilets includes the following activities:

- Mapping all existing toilets used for casual sex by MSM
- Selecting a group of toilets for a pilot outreach project
- Assessing each toilet for outreach opportunities, characteristics of clientele, busy hours, layout, and so forth
- Direct dialogue with toilet users to determine HIV/AIDS and sexual health education needs, responses to existing outreach programmes, sexual behaviour patterns (risk assessment), attitudes to condom use, and counselling and referral needs
- Keeping anonymous records of outreach sessions and the number of contacts and referrals made
- Liaising with the police to ensure safety of outreach workers and to ensure that the intervention will not bring trouble to toilet users
- Negotiating with urban and regional councils to have condom machines installed in the remaining public toilets.

Outcomes/outputs

Of the 17 saunas known to AIDS Concern, 10 are openly distributing the free condoms and lubricant that AIDS Concern provides for their customers. It is still too early to usefully describe outcomes of the outreach programme in public toilets.

Evaluation Findings

There has been no formal evaluation to date, although criteria have been drawn up for assessing the effectiveness of the interventions.

Although hard data are not available, AIDS Concern's experience indicates that increasing condom usage in saunas for Hong Kong's MSM requires more than just providing condoms and lubricant. It requires that customers feel comfortable with condoms and lubricant, and are motivated to dispose of used condoms thoughtfully. Furthermore it requires that owners and staff feel obliged to make condoms and

lubricant available, and assurances from the government that these items will not be used as evidence to prosecute the establishment.

Lessons Learned

A basic lesson learned by AIDS Concern is that if an organization is not able to reach the target group directly (as AIDS Concern tried with its earlier, non-outreach activities), it has to reach it indirectly. This means changing the environment in places that the target group frequents rather than trying to change or provide services to individuals.

Initially, convincing sauna owners to make condoms available to their customers met with a lot of resistance – primarily, it seems, because of the “newness” of the idea rather than any substantive problems or fears. Therefore, building up relations with venue staff and showing that AIDS Concern workers are committed to their job were very important in gaining the owners’ confidence. Once a few saunas had come on board, others quickly followed suit.

Newer establishments have been much easier to persuade than older ones, and the saunas that have yet to commit are mostly run by older men in a more discreet fashion. There is reluctance on the part of some owners and users to openly admit that the establishment primarily functions as a place for men to meet and have sex.

Project MSM (Switzerland)

Starting Year: 1994

Main Topic Area: Men who have sex with men

Other Topic Areas: Male condoms • Children and young people

Contact Person:

Matthias Tischhauser

Outreach worker

Phone: +41 71 223 68 08

Fax: +41 71 223 66 07

Email: mptischhauser@hivnet.ch

Web Site: www.hivnet.ch/ahsga

Address:

AIDS Hilfe St Gallen-Appenzell,

Project MSM

Tellstr. 4, pf 8

9001 St Gallen

Switzerland

Implementers

The AIDS Federation of Switzerland implemented the project.

Funding

Funds are provided by the AIDS Federation of Switzerland, AIDS Hilfe St Gallen-Appenzell, and the Federal Office for Public Health.

Objectives

Project MSM has three main objectives:

- To reduce new HIV infection among young gay men
- To support the gay community and gay pride, and in this way to increase the accessibility and appeal of prevention programmes to young men who are coming out.
- To support and encourage solidarity among men who have sex with men (MSM) and HIV-positive MSM, as well as solidarity between MSM and heterosexual men.

Background

The St Gallen-based Project MSM tries to provide young MSM with HIV information in places like bars and parks. The project is part of the AIDS Federation's outreach programme in all major regions or large cities in Switzerland. The project is based on the principle that helping young MSM to accept their sexual preference is a condition of making them aware of the risk of HIV.

Main Activities

The first activity was to find young MSM at venues like bars, parks, and cruising areas in order to inform them about HIV/AIDS and to hand out leaflets, condoms, and stickers. Most young people are reached through the gay youth club, Jackpoint, where an outreach worker is available to distribute information and condoms. The club also allow letters from the outreach worker to be sent out to their members with information on HIV. An outreach worker supports the homepage of the Gay University Club as well as a databank on the university's email system. The databank is a virtual meeting place for self-identified gay men, and those who have not yet come out – a place to discuss issues, give and receive advice, and obtain safe sex information.

The second main activity is to support young MSM when they decide to come out – to be identified with their own sexuality. This support is crucial for prevention work. As Project MSM workers have put it, “How should young MSM be aware of AIDS and its risk when they cannot even accept what they are doing?”

The project runs a special telephone line providing daily support and counselling and lots of information. People can, for example, have faxes sent to them with safe sex information or the location of coming-out clubs. Similar information is provided on the project's website, which presents all its publications and has an electronic bulletin board where people can ask questions and receive answers. Special brochures have been produced for a variety of subgroups (young gays, s/m, lesbians, deaf gays, gay fathers, and so on). Stickers with safe-sex information have been widely distributed in the city, including in the toilets of almost every bar and club. The project also has a Stop-AIDS bus, which takes volunteers to concerts and other events where information can be handed out.

Outcomes/outputs

It is hard to measure direct results. Nation-wide evaluation shows a decreasing rate of infection among MSM, but it is hard to relate this to any single intervention.

Some in the target group shifted their social focus from frequenting places for fast, anonymous sex, and instead tended toward long-term and, as they call them, “faithful” relationships.

Evaluation Findings

Nation-wide evaluation using various methods is done regularly by different people and by the government, as well as by some universities. There are no formal evaluation results yet from St Gallen.

Lessons Learned

The project illustrates once again the value of outreach among vulnerable populations, and provides some useful guidelines for doing outreach among this particular group.

On an operational level, the organizers emphasize that it is much more cost-efficient to do prevention with outreach workers than to wait for these young people to come to clinics or other centres.

They add that the most important effect of the intervention is to help young people to accept their sexuality. This is the road by which the young people may come to accept the value of protecting themselves and their sex partners, and otherwise avoiding risky behaviour.

Further Reading

A description of the MSM project is available from the AIDS Federation of Switzerland, Konradstrasse 20, Zurich.

Mother-to-child transmission

Transmission of HIV from mother to child can occur during pregnancy and delivery, as well as through breastfeeding. Such mother-to-child transmission of HIV represents a major cause of morbidity and mortality among young children, particularly in developing countries with a high prevalence of HIV infection. Interventions to prevent mother-to-child transmission of HIV, including recent breakthroughs in antiretroviral therapy, offer immediate opportunities to save children's lives, reduce the impact of HIV on families and communities, and strengthen maternal and child health services.

In addition to the long regimen (ACTG 076) proven effective in 1994, a CDC - sponsored trial in Thailand demonstrated in February 1998 that the use of a shorter zidovudine regimen, which is more feasible and affordable in developing countries, is also effective. This shorter regimen, involving the administration of zidovudine to mothers during the last four weeks of pregnancy and during delivery, has been shown to reduce mother-to-child transmission by half among women who do not breastfeed. An integrated prevention programme that combines the use of this regimen and the use of safe alternatives to breastfeeding would be effective in reducing mother-to-child transmission of HIV among breastfeeding populations. Recent cost-effectiveness data suggest that in many developing countries this intervention is comparable to other public health interventions. It is clear that there is an urgent need to begin to implement such interventions to reduce the transmission of HIV from mother to child.

Any national strategy to prevent mother-to-child transmission of HIV should be part of broader strategies to prevent the transmission of HIV and STDs, to care for HIV-positive women and their families, and to promote maternal and child health. The ability to make widely available, and as soon as possible, the interventions to reduce HIV transmission from mother to child depends on political will, affordability of the interventions, and the strength of existing human resources and infrastructures. Powerful means of effecting change lie in demonstrating the success of interventions to reduce mother-to-child transmission of HIV, as well as the costs of not acting to prevent this kind of transmission.

Four factors that affect the affordability of interventions to prevent mother-to-child transmission are: the cost of drugs; the cost of safe alternatives to breastfeeding; the cost of HIV tests; and the cost of service delivery. WHO has added zidovudine for mother-to-child transmission to the Essential Drug List. Glaxo-Wellcome has recently offered zidovudine at substantially reduced prices. Further negotiations are planned to minimize the cost of the first three of these components.

The following parameters describe the optimum context in which to implement effectively the interventions necessary to reduce transmission of HIV from mother to child:

- ◆ All women should have knowledge about HIV, and should have access to the information necessary to make appropriate choices about HIV prevention and about sexual and reproductive health and infant feeding in the context of HIV.

- ◆ HIV counselling should be available for pregnant women and those contemplating pregnancy. Such counselling should address the needs of pregnant women and women living with HIV, including reproductive health issues such as family planning and safe infant feeding. Active referral and/or networking for follow-up counselling, comprehensive care, and social support should be available for the HIV-positive woman and her family.
- ◆ Pregnant women, and those contemplating pregnancy, should have access to voluntary HIV testing, to test results with the least possible delay (requiring that appropriate laboratory services be available to process such tests), and to counselling.
- ◆ All pregnant women should have access to antenatal, delivery, and post-partum care, and to a skilled attendant at birth. For the shorter zidovudine regimen to be effective, at least one antenatal visit with follow up is needed before 36 weeks, and preferably before 34 weeks, of gestation. In order to benefit from this intervention, women who access antenatal services prior to 36 weeks should have access to HIV voluntary counselling and testing. Skilled care during delivery is also needed: the shorter zidovudine regimen also involves administration of the drug during labour and delivery.
- ◆ There should be follow-up of children at least until 18 months, especially for nutrition and for childhood illnesses.

Short-Course ZDV to Prevent Mother-to-Child HIV Transmission during Routine Health Care (Thailand)

Starting Year: 1996

Main Topic Area: Mother-to-child transmission

Other Topic Areas: Health reform and HIV • Access to drugs

Contact Person:

Vallop Thaineua or

Agnes Soucat

Phone: +662 279-8039

Fax: +662 591-8413

Email: asoucat@mozart.inet.co.th

Address:

Royal Thai Ministry of Public Health

Tivanond Road

Nonthaburi 11000

Thailand

Implementers

The programme was implemented by the Royal Thai Ministry of Public Health (MOPH).

Funding

The Ministry provided the funding.

Objectives

The main objective is to reduce high rates of mother-to-child transmission of HIV in the Phayao region through the systematic use of ZDV in pregnant women in all hospitals in the region.

Background

Thailand has made remarkable progress in battling the HIV epidemic, as the decreases in HIV prevalence and changes in sexual behaviour in the country attest. Yet, in Phayao, a northern province severely affected by HIV, approximately 280 HIV-infected women – 5 per cent of all pregnant women in the province – gave birth to an estimated 70 infected children in 1997. As many of these infants die within their first year of life, the infant mortality rate is on the rise after years of decline. The province, however, responded quickly to this crisis.

Main Activities

Since July 1997, the MOPH has offered through Phayao's seven public hospitals a short regimen of zidovudine (ZDV) to all consenting HIV-infected women to prevent mother-to-child transmission of the virus. In less than a year, the MOPH had implemented this programme on a large scale in this relatively poor province. Women receive pre-test counselling at their first prenatal visit, are offered HIV testing and, if they accept, return for post-test counselling two weeks later. In the case of a positive test result, a confirmation test is performed at the provincial hospital. HIV-infected women are offered zidovudine during the 34th week of pregnancy or as soon as possible thereafter.

Before starting treatment, a complete blood count of the woman is carried out. Infants begin taking oral zidovudine shortly after birth and continue until they are one week old.

Subsequently, health centres regularly follow the infants, and volunteers provide case management of childhood illness, nutrition problem-solving, childhood immunizations, and home visits. Mothers feed the infants breastmilk substitutes; women with insufficient income receive the substitutes free of charge.

Outcomes/outputs

Between June 1997 and February 1998, 525 of 684 pregnant women who tested HIV-positive were put forward as possible participants in the MOPH programme. (Others may have chosen to terminate the pregnancy or joined another ZDV study.) Of these, 447 (85.1 per cent) consented to join the study. Up to 31 March 1998, 228 of the women on the programme had delivered, with excellent compliance with the regimen.

The overall prophylactic coverage for the province reached 68 per cent of all HIV-infected pregnant women in the fourth quarter of 1997, either through the MOPH programme or through the North Thailand Perinatal HIV Prevention Trial, the parallel clinical trial conducted by the MOPH and the Ministry of Universities. Analysis of the data collected showed that compliance to the intervention was excellent, around 90 per cent. The annual per capita cost of this programme to the people of Thailand is US\$0.13, which is affordable even in the context of the current economic crisis. This cost represents less than 1 per cent of public health expenditures in Thailand. The cost per Disability Adjusted Life Years saved is approximately US\$35, making the programme highly cost-effective.

Lessons Learned

In addition to the accomplishments noted in Outcomes/inputs, one of the most important lessons provided by the project was that high compliance with the intervention was possible among the target population. This puts to rest one of the main fears about trying to introduce the simplified regime into routine mother and child health services. The project also proved that this type of intervention could be decentralized to the provinces.

Other lessons include the following:

- The provision of the HIV test free of charge for low-income pregnant women, from a special MOPH fund, has proven to be essential.
- In programme management, a key to success has been the participation of all parties involved since the first phases of planning, including teams at the regional, provincial, and hospital levels. In particular, planning and implementation of a proper flow in each facility has proved essential, as has promotion of team spirit and teamwork. In each unit, the hospital director, the head nurse, obstetricians, and paediatricians are the key figures in establishing and promoting teamwork and proper flow of HIV-positive pregnant women.
- The training of health personnel in counselling techniques has been crucial to obtaining the maximum benefits of making HIV tests widely available in health facilities. Periodic refresher courses are important to maintain high quality of pre- and post-test counselling.
- When introducing the systematic use of ZDV, preparation of personnel with proper local planning exercises and training is also clearly needed. The counselling process is one of the most important aspects of this preparation. The public health community in Thailand feels that focus on the counselling process for HIV/AIDS is producing valuable pay-offs in the general improvement of the quality of health services. In fact, attitudes and skills consistent with the principles of non-judgemental listening and combined support to physical and mental health used in this

counselling are needed to make more effective a wide range of health activities in which the client's attitudes and behaviours play an important role

- The substantial impact of the HIV epidemic on breastfeeding promotion in Thailand cannot be avoided. The national governmental policy to discourage breastfeeding of babies born to HIV-positive mothers and to provide free formula to such mothers in low-income families has a sound basis. Nevertheless its proper implementation is crucial, including a significant component on breastfeeding education and formula provision in the refresher courses on HIV counselling.

- Local referral systems, based on the existing network of facilities and personnel, have to be set up for coverage of care and continuation of the ZDV short course in pregnant women, especially considering that they may, for a number of reasons, be referred to other hospitals for the delivery. Confidentiality must be respected and proper care and use of ZDV complied with in such cases.

- High turnover of health personnel is one of the main obstacles to maintaining the desired standards in implementing HIV counselling and use of ZDV in antenatal clinics. In each of the smallest units that provide ZDV, the community hospitals, at least two or three health workers should be trained in HIV/AIDS counselling. In addition, refresher courses and pre-service training have to be included in the regular qualifying courses.

Further Reading

Thaineua et al. From research to practice: Use of short course zidovudine to prevent mother-to-child HIV transmission in the context of routine health care in northern Thailand. Presentation poster, 12th World AIDS Conference, Geneva, 1 July 1998.

National strategic planning

Far from being a uniformly distributed epidemic across the globe, the HIV/AIDS pandemic is at any one time made up of very different HIV/AIDS situations. Furthermore, these can and do evolve rapidly over time, driven by socio-economic, cultural, and other determinants that differ between countries and even within national boundaries.

Given this wide range of HIV/AIDS situations in place and over time, and especially the unpredictable and often rapid course of the epidemic, planning effective national responses calls for approaches that take into account the unique dynamics of HIV and the many different and – in the case of social and economic factors – changing determinants. In the last fifteen years much has been learned about the range of HIV prevention and care measures that can be effective in general. Equally, much is known about the importance of supporting measures or combinations of measures that are adapted to *specific and changing* situations. Hence the critical importance and relevance of strategic planning.

Strategic planning for HIV/AIDS implies and includes processes and approaches that allow all those concerned – central and local governments, non-governmental organizations and communities, national and international partners – to define strategies that are tailored to the different and changing contexts within which HIV/AIDS evolves.

A strategic planning process involves assessing and analysing the situation and the response; identifying obstacles to effective interventions and looking out for opportunities; setting priorities and objectives in priority areas; formulating strategies to accomplish these objectives; and defining targets and indicators for monitoring and evaluation. It is particularly critical to ensure at all stages of the process the participation and involvement of all relevant partners and stakeholders. This will help in securing national ownership and in mobilizing the human and financial resources needed for sustainable responses.

National strategic planning for HIV/AIDS is understood to high-level planning processes that lead to the development and implementation of programmes at different levels and in different areas. Together, these constitute a country's response to HIV/AIDS. These may include:

- ◆ National strategic plans or frameworks that set out a country's fundamental policies, broad strategies, and an institutional framework
- ◆ Provincial, state, or district-level plans
- ◆ Strategic plans addressing specific thematic areas such as care, STD prevention, drug use, vulnerable populations in general, and so on.

Accordingly, there are multiple levels or entry points presenting opportunities at different times for strategic approaches to HIV/AIDS planning.

National strategic planning for HIV/AIDS is best thought of as an iterative process that allows countries to adapt to changing situations and to plan for and implement effective, sustainable, relevant, and expanded responses.

National Consultation to Renew Canada's Strategy for HIV/AIDS (Canada)

Starting Year: 1997

Main Topic Area: National strategic planning

Contact Person:

David Hoe

Phone: +613 954 1008

Fax: +613 952 3556

Email: David_Hoe@hc-sc.gc.ca

Web Site: www.hc-sc.gc.ca

Address:

HIV/AIDS Policy, Coordination and Programs Division Health Canada

Tunney's Pasture,

Postal Locator 1018B1

Ottawa, ON K1A 1B4

Canada

Implementers

The consultation was initiated by Health Canada (federal Ministry of Health)

Funding

Health Canada provided the funds.

Objectives

The purpose of the consultation was to establish the future direction of HIV/AIDS programming in Canada.

Background

The Minister of Health called for national consultation to frame a new direction for HIV/AIDS in Canada coordinated by the HIV/AIDS Policy, Coordination, and Programs Division. The consultations aimed at involving external stakeholders and were led by a national stakeholder group of 11 national associations. The consultation took place in the late summer and fall of 1997.

Main Activities

A preparatory consultation package was created including consultation workbook, guide to holding public meetings, and a discussion paper providing current status of HIV/AIDS in Canada.

Activities in the consultation included:

- Five meetings in large cities
- Focus groups for hard-to-reach populations
- Targeted outreach to "unheard populations"
- Primarily bilateral meetings with provinces and territories
- Research paper discussions
- Private-sector workshops; professional associations discussion paper
- A variety of internal government processes.

Outcomes/outputs

The consultation resulted in recommendations to the Minister of Health on:

- The goals, objectives, themes, and guiding principles of the renewed strategy
- Priorities and policy focus
- Management of the renewed strategy.

Evaluation Findings

Following the consultation, opinions were sought from nine individuals who were either directly involved in creating, managing, and delivering the consultation process or were people living with HIV/AIDS. All of the respondents said that the successful use of large-scale, inclusive, multisectoral consultations was a major shift in defining public policy for HIV/AIDS in Canada. The consultation resulted in setting the trend for increased stakeholder involvement in decision-making and in forming the values and principles for the renewal of a national strategy for HIV/AIDS. Respondents said significantly more emphasis was needed on organizational design, planning, and resource allocation for the consultation process. They also said all key players should be involved from the onset, allowing more time to be spent on the consultation rather than ongoing, energy-draining negotiations over management of the process.

Lessons Learned

Success of this approach depends on:

- Full involvement and “buy-in” by organizations and individuals affected by the policy development
- Commitment by all levels of government
- Fully collaborative planning throughout the process
- Readiness and willingness of all players to change the way they do business
- Strong communication channels and full sharing of information.

Further Reading

Health Canada. *Reviewing Canada's Strategy on HIV/AIDS: Successes, barriers and lessons learned*. Health Canada, 1998. This document is available at http://www.hc-sc.gc.ca/hppb/hiv_aids/strategy/strategy.html

Prisons

The prevalence of HIV is much higher in many prisons around the world than it is in outside society. There is usually also a much higher rate of certain other diseases, such as hepatitis B and C, syphilis, and tuberculosis. Often, there is co-morbidity of two or more of these conditions.

Many of those who are HIV-positive in prison were already infected on the outside. Many come from segments of the population that carry a heavier than average burden of HIV infections. In addition, many inmates are in prison because of drug use or trafficking, and they will try to continue to use drugs inside. Whether the authorities admit it or not – and however much they may try to repress it – drugs are introduced and consumed by prison inmates in many countries, and men commonly have sex with men in all-male prisons. Denying or ignoring these facts will not help solve the problem of the continuing spread of HIV – and both forms of behavior are HIV transmission risks.

Specific factors responsible for the transmission of HIV in prison settings include injecting of drugs with shared, unsterilized needles and syringes; unprotected penetrative sex between men; and tattooing with shared, unsterilized equipment. Isolation of prisoners on the grounds of their HIV status does not generally help reduce transmission of the virus.

Prisoners are often in a highly vulnerable position – vulnerable to the power of prison authorities (as well as others in authority with whom they may come into contact, such as the police), and to the sexual and other demands of fellow prisoners, many of whom are violent offenders. Prisons are often overcrowded and operate within a “culture” of punishment and violence, sometimes including virtual systems of enslavement within prison hierarchies. Prison officers are also open to infection with HIV. They risk infection, for instance, by accidentally being pricked by a drug-injection needle while making routine searches of prisoners' beds and lockers. They can also be exposed to HIV through sexual contact with prisoners.

The high prevalence rates of HIV, tuberculosis, and hepatitis in prisons should be of the greatest concern to the community at large. The prison population, after all, is a fluid one, with people regularly moving in and out. Most prisoners are released into the community at some point, and some are imprisoned and released a number of times. If for no other reason than self-interest, the community and its leaders should react quickly and wisely to the problem of HIV in prisons.

Specific responses to the challenges of drug injecting and sex between men in prison include:

- ◆ Demanding reduction and treatment for drug-dependent prisoners, including substitution or maintenance therapy (e.g., with methadone)
- ◆ Making full-strength liquid bleach available for sterilizing needles and syringes (including those used for tattooing), together with instructions as to its proper use
- ◆ Providing sterile needles on an exchange basis – one clean needle for a used one

- ◆ Introducing peer education among injecting prisoners, using former prisoners and former injectors
- ◆ Providing discreet and easy access to condoms
- ◆ Providing education on the risks of HIV transmission to prisoners and prison staff alike.

Equally important are general responses that can help reduce HIV transmission, such as ensuring that all prisoners' basic rights to health care are observed (including provision of care comparable to what they would get outside); an end to overcrowding; and measures to reduce the climate of violence.

An important structural change that would facilitate many of the specific responses is to have health in prisons transferred under the control of public health authorities.

Sustainable HIV/AIDS Prevention Activities in Prisons (Ukraine)

Starting Year: 1997

Main Topic Area: Prisons

Other Topic Areas: Injecting drug use

Contact Person:

Olexander Gunschenko

Phone: +380-44-291-3522

Fax: +380-44-291-3182

Address:

Olexander Gunschenko

Deputy Head of Medical Department,

Ministry of Interior Ukraine, Bogomolza Street 10

Kiev 252024,

Ukraine

Implementers

The Ministry of Interior of Ukraine, with the technical support of UNAIDS.

Objectives

The main objectives were to:

- Reduce the risk of HIV/AIDS/STD transmission in Ukrainian prisons
- Raise awareness on HIV/AIDS/STD among prison staff , inmates, local authorities and civil society organizations involved in the project implementation
- Promote efficient and effective interventions focused on harm reduction and safer sexual behaviour
- Improve access to counseling, psychological support services and STD treatment.

Background

The Ministry of Interior of Ukraine developed and approved an Action Programme on HIV/AIDS Prevention at the end of 1997. With technical and financial assistance provided by UNAIDS, a series of activities were conducted focusing on three pilot regions. The project was first carried out in Schitomir, Kiev, and Odessa, and then in a second phase Dnepropetrovsk, Poltava, and Nikolajiv.

Main Activities

The first step was to conduct seminars (training sessions for trainers. These were followed by separate training sessions for staff and inmates at the local level. KAPB studies were also carried out among staff and inmates, along with regular epidemiological monitoring. Other activities included:

- Dissemination of information and educational materials on transmission routes and prevention
 - Providing staff and inmates with individual means of protection (disinfectants, condoms, special gloves for staff and protective glasses for dentists)
 - Establishing regular access to high-quality STD treatment and counseling to reduce the risk of HIV/AIDS/STD transmission
-

- Improving access to psychological assistance and counseling in order to promote non-discriminative approaches towards HIV/AIDS infected inmates. Specifically, this included training for psychologists who treat inmates.

Outcomes/outputs

Major outcomes are:

- A group of trained experts on HIV/AIDS/STD prevention in prisons has been established who can then be used as trainers
- Provision of access in the prisons to STD treatment and counseling for prison inmates on a regular basis
- Improved psycho-social support service in prisons and use of conflict management strategies to avoid discrimination against PLWHAs in prisons.

As well, behavioural studies have been conducted (see below), and indicate reduced risk of STD and HIV transmission among prison staff and inmates.

Evaluation Findings

KAPB studies and epidemiological monitoring have been conducted among prison staff and inmates on a regular basis. For the final evaluation a technical working group (including representatives from the Ministry of Health, Ministry of Justice, Ministry of Education, NGOs, journalists, religious groups and representatives of the UN Theme Group on HIV/AIDS in Ukraine) will be established in order to carry out the final evaluation of the project. Main objectives of the final evaluation are:

- To assess the efficiency of the project
- Identify project constraints and achievements
- To elaborate a framework for continuing preventive measures in prisons.

Lessons Learned

The experience teaches that, in order to implement a general strategy for reduction of the HIV/AIDS infection risk in prisons, the following are required:

- Unbiased information on HIV/AIDS levels in prisons and the general population
- Availability of a group of dedicated authoritative persons within the government and among prison officials and public opinion leaders, who are aware of the problem and intent on improving the situation
- Familiarization of as many senior decision makers in prisons as possible with information on HIV/AIDS prevention
- Creation of clear plans of action coordinated with prison departments. These plans should have supporters in both governmental and non-governmental structures.

Implementers feel it is essential to expand the project to ensure the sustainability of HIV/AIDS prevention measures in prisons and to disseminate accumulated information on experiences throughout Ukraine and other CIS countries.

Further Reading

MAP. *The determinants of the HIV/AIDS epidemics in Eastern Europe*, Geneva, 1998. Available from UNAIDS Secretariat or website, and the websites of Family Health International website (www.fhi.org) and François Bagnoud Center for Health and Human Rights (www.hri.ca/partners/fxbcenter).

Religion

In many countries, HIV/AIDS continues to be perceived and treated exclusively as a health or medical problem. However, it is becoming increasingly evident that successful national AIDS programmes are those that have broadened their focus from the urgency of encouraging individual behavioural change to include the necessity of addressing how societies behave towards persons living with or affected by HIV/AIDS, and towards vulnerable individuals in general.

A number of institutional settings provide opportunities for collective action to strengthen HIV/AIDS prevention and care efforts. These include schools, health care facilities, the military, and the workplace. One of the most important, however, is religious institutions. This is because of the moral leadership that such institutions provide to hundreds of millions of people worldwide, the trust they have gained over generations, and the excellent channels of communication and organization that many have built up.

Around the world, individual places of worship within communities (including churches, mosques, synagogues, temples, hospitals with religious affiliations) have undertaken their own initiatives to deal with HIV/AIDS and its impacts at a local level. These initiatives have included advocating changes in local community attitudes, speaking out against prejudice, raising money, and organizing home-based care.

At the same time, regional and national religious hierarchies in some countries have shown themselves ready to undertake wide-ranging activities, sometimes moving well ahead of many local members. In Africa, religious leaders confronted HIV/AIDS early on in the epidemic, and religious institutions were among the first to care for the sick and dying. In many parts of Asia, Buddhist monks and nuns and other religious leaders are very much involved in caring for people living with HIV/AIDS. In many parts of the world, spiritual leaders have grappled with the difficult questions that the epidemic poses to theology, and found that discussion and research of these questions can have beneficial effects on faith and religious teaching.

A two-pronged focus appears to be developing in the engagement of the religious sector in various parts of the world:

- ◆ To promote the exchange of ideas and training for community-based prevention and care programmes. This has been done through conferences and symposia, as well as the creation of “inter-faith alliances” both at local and higher levels
- ◆ To encourage religious institutions to strengthen life-skills training for HIV/AIDS education in schools operated by their congregations.

Madarasa AIDS Education and Prevention Project (Uganda)

Country: Uganda

Starting Year: 1995

Main Topic Area: Religion

Other Topic Areas: Community mobilization • Schools • Children and young people

Contact Person:

Dr Magid Kagimu, Director

Al Haj Rashid Munyagwa,

Secretary General

Phone: +256 42 251-443 or 272-812

Address:

Islamic Medical Association of Uganda

P.O. Box 2773

Kampala

Uganda

Implementers

The project was implemented by the Islamic Medical Association of Uganda (IMAU) and UNICEF. For a description of IMAU, see AIDS Education through Imams.

Funding

UNICEF provided the funding.

Objectives

The objectives of the Madarasa AIDS Education and Prevention Project (MAEP) are:

- To provide HIV/AIDS education to young people in Muslim religious schools
- To teach young people both to empathize with persons living with HIV/AIDS (PLWHAs) and to help people in their own communities suffering from HIV/AIDS.

Background

In 1995, IMAU developed an HIV/AIDS education programme for Muslim youth to address a lack of information in the most vulnerable sector of Uganda's population: young people. IMAU and UNICEF developed an HIV/AIDS education curriculum with 36 lessons, each of which can be covered in a 40-minute session on a Saturday or Sunday morning. The curriculum is tailored for classes of mixed age groups. The HIV/AIDS education session is taught in addition to the religious topic addressed that day.

Main Activities

MAEP works with 350 Madarasa schools in Kamuli and Mpigi Districts. Madarasa schools are informal schools attached to mosques; they teach young people important principles of Islamic culture and behaviour. Each school is attended by approximately 50 children ranging up to 15 years of age. Classes include in-school as well as out-of-school children. Madarasa teachers are Imams or Assistant Imams, and some are members of the Uganda Muslim Teachers Association.

Madarasa students learn about HIV/AIDS transmission, prevention, and control. They are taught how to care for HIV/AIDS patients and are encouraged to help people in their own communities who are living with HIV/AIDS. Teachers and their

assistants organize activities that include music, drama, and games. Parents and guardians are encouraged to talk to their children about HIV/AIDS.

The curriculum includes the following subjects: understanding adolescence; adolescent friendships; peer pressure; understanding sexuality; facts and myths about HIV/AIDS; Islamic teachings on safe sex; responsible healthy living; breaking the stigma; peer counselling; building positive dreams; discussing HIV/AIDS with parents.

IMAU gives training in the use of the HIV/AIDS education curriculum to 24 supervisors in each district. The supervisors – who themselves are Imams, county sheikhs or selected assistants – pass on their training to two Madarasa teachers from ten different mosques.

Outcomes/outputs

Overall, 20,000 Muslim children have been given HIV/AIDS education in Madarasa schools since 1995.

Lessons Learned

MAEP proves that religious institutions responsible for the spiritual education of children can be a highly effective and motivated conduit for HIV/AIDS information.

Further Reading

UNAIDS and IMAU. *AIDS education through Imams: A spiritually motivated community effort in Uganda* (Best Practice Case Study). Geneva: UNAIDS, 1998.

Community Action for AIDS Prevention (Uganda)

Starting Year: 1992

Main Topic Area: Religion

Other Topic Areas: Community mobilization

Contact Person:

Dr Magid Kagimu, Director

Al Haj Rashid Munyagwa,

Secretary General

Phone: +256 42 251-443 or 272-812

Address:

Islamic Medical Association of Uganda

P.O. Box 2773

Kampala

Uganda

Implementers

The project was implemented by the Islamic Medical Association of Uganda (IMAU). For a description of IMAU, see AIDS Education through Imams (Uganda).

Objectives

The objective of the project is to jointly train religious and community leaders of many faiths on issues surrounding HIV/AIDS.

Background

The Community Action for AIDS Prevention project (CAAP) in Kampala is the second of IMAU's AIDS Education activities. It works within the urban setting to provide HIV/AIDS training to religious and community leaders.

Main Activities

CAAP presents workshops in Kampala to a variety of religious leaders. In addition, CAAP reaches beyond religious leaders and trains groups of bicycle taxi drivers (*boda boda* boys) and market vendors to pass on information about HIV/AIDS through their interaction with the public at market stalls and while delivering passengers to their destinations.

Outcomes/outputs

To date, the 70 organizations that have participated at CAAP's Kampala workshops have included: 19 mosques, 29 Catholic and Protestant churches, 4 evangelical churches, 16 local council parishes, 1 group of *boda boda* boys, and 1 group of market vendors.

Lessons Learned

The approach taken to train urban religious leaders must be different from that given to rural ones. This is mainly due to the density of the population in their communities.

In Kampala, the trained Muslim and Christian leaders place less emphasis on home visits and more on HIV/AIDS education messages disseminated through group talks at mosques, churches, and local council meetings.

Further Reading

UNAIDS and IMAU. *AIDS education through Imams: A spiritually motivated community effort in Uganda* (Best Practice Case Study). Geneva: UNAIDS, 1998.

Family AIDS Education and Prevention through Imams Project (Uganda)

Starting Year: 1992

Main Topic Area: Religion

Other Topic Areas: Community mobilization • Male condoms

Contact Person:

Dr Magid Kagimu, Director

Al Haj Rashid Munyagwa,

Secretary General

Phone: +256 42 251-443 or 272-812

Address:

Islamic Medical Association of Uganda

P.O. Box 2773

Kampala

Uganda

Implementers

The project has been implemented through the Islamic Medical Association of Uganda (IMAU). For a description of IMAU, see AIDS Education through Imams.

Funding

Funding for the pilot stage of the Family AIDS Education and Prevention through Imams Project (FAEPTI) was provided by USAID through World Learning, a US-based NGO, with technical assistance from the US Centers for Disease Control and Prevention. Support from the United Nations Development Programme (UNDP) has made it possible to expand the FAEPTI project from 2 to 11 districts.

Objectives

The goal is to provide education, basic counselling, and motivation for behaviour change through individual home visits to persons living with HIV/AIDS.

Background

FAEPTI was launched in two districts in 1992 and had spread to ten districts within five years.

This project helps Imams incorporate accurate information about HIV/AIDS prevention into their spiritual teachings and trains teams of community volunteers to provide education, basic counselling, and motivation for behavioural change through individual home visits.

IMAU's HIV/AIDS education efforts begin with the understanding that preventive interventions in Muslim communities are more likely to succeed if the message-bearers are trusted members of the community, such as religious leaders. IMAU also acknowledges the important role of parents, teachers, and peers in discouraging high-risk behaviour. Although mass information campaigns and group education help some people modify their behaviour, it is clear to IMAU that others need a more personal approach. Overall, individuals are more likely to adopt safer sex practices if they are perceived as the norm prevailing among their peers and in their community. It is crucial to work at the community level to personalize social norms, such as mutual fidelity and the moral responsibility not to endanger others.

As a respected community leader and head of the mosque, the Imam is the recognized teacher and model for social behaviour within the Muslim community. His teaching occurs during congregational prayers and at intimate family ceremonies

such as marriage, birth, and burial. For this reason, IMAU committed itself to promoting behavioural change at the community level, using the mosque, the Imam, and selected community volunteers as the focus of their activities.

In the planning phase, Imams requested that community volunteers be trained as their assistants, to help take the project to the household level. Imams also requested bicycles, to help their team move around the community, and income-generating activities to sustain volunteer motivation. IMAU agreed that frequent supervision of project activities would be necessary to ensure volunteer motivation and to check that accurate public health messages were being passed on.

Main Activities

The first step was a baseline study to determine knowledge, attitudes, practices, and behaviour related to HIV/AIDS in the project area. Mpigi and Iganga districts were selected for the pilot project as they are the districts in Uganda with the densest concentration of Muslims. Nearly 2,000 people responded to the survey. The results revealed that, although most Muslims in the project area understood that HIV/AIDS is transmitted sexually, there was a lack of knowledge regarding transmission from mother to child, as well as the protective value of the condom. The survey also found that Muslim leaders and their communities needed further education about risk factors of particular importance to Muslim communities. The baseline survey helped to focus project activities and provided indicators for comparison at a follow-up evaluation.

In each district, five-day training workshops were designed for Imams and their selected team of volunteers: two assistants (male and female) and five family HIV/AIDS workers (FAWs). The district khadis and county sheikhs also participated. IMAU involves women at every level of its HIV/AIDS education activities. The Imam is required to have a female as well as a male assistant, and FAWs are constituted of equal numbers of men and women.

The workshop curriculum was supplied by the Ministry of Health, with special modifications made for the Muslim community based on the findings of the baseline survey. Twenty-three IMAU trainers were trained to conduct the workshops. Workshop participants studied basic facts about HIV/AIDS, as well as STDs, risk perception, principles of behaviour change, safer sex, HIV/AIDS in relation to gender and adolescence, principles of communication and counselling, and the role of the community in sustaining HIV/AIDS prevention activities. The workshops also trained participants in how to conduct home visits to discuss HIV/AIDS-related issues with members of their communities.

Teams from each of the 200 mosques in Mpigi attended a workshop, as did teams from half of the 400 mosques in Iganga. Each team member was made responsible for visiting 15 homes each month to pass on HIV/AIDS information and to make themselves available for counselling and consultation.

In order to facilitate movement, a bicycle was given to each Imam for his use and that of his team. The district khadis, the county sheikhs, and their assistants were also given bicycles. Each FAW was given two local hens, or the financial equivalent, to start an income-generating activity (IGA). IGAs provided incentive for the volunteer work demanded by the project.

Outcomes/outputs

The project has worked with leaders at 850 mosques and has trained 6,800 community volunteers who have made personal visits to 102,000 homes. Support from UNDP has made it possible to greatly expand the FAEPTI project.

After two years, a follow-up survey indicated significant increases in correct knowledge about HIV/AIDS in the project area, including mother-to-child transmission and risks involved with unsterile circumcision and ablution of the dead. In addition, community members who were exposed to the project reported a significantly lower number of sexual partners and increased condom use.

Although condom education received initial resistance and this component was left out of the curriculum's first year in the district of Iganga, knowledge of the protective value of the condom increased overall. Condom distribution was not heavily emphasized, but over 200,000 condoms were distributed informally, and the topic of condoms spontaneously arose at most workshops.

Evaluation Findings

Unlike many community-mobilization projects, FAEPTI has benefited from a planned evaluation component (see Outcomes, above.) The results indicate the effectiveness of the project in improving awareness and contributing to some degree of behavioural change. The research design does not permit definitive attribution of impact between FAEPTI and the other interventions underway in Uganda, but it appears clear these programmes are mutually reinforcing.

Lessons Learned

Important lessons learned can be divided into themes:

– Participation of women: Project staff agree that women volunteers are highly interested and effective participants. Female FAWs find that women in their communities are willing to confide important issues regarding HIV/AIDS that they would never raise with their husband or the Imam. Female FAWs also play a critical role in reaching out to and educating teenage girls, who in Uganda are considerably more likely to be infected with HIV/AIDS than boys their own age. (The numbers balance out as they grow older.)

- Condom education: Perhaps the most difficult issue has been sensitizing Islamic leaders to the important role that the condom plays in preventing transmission of the HIV/AIDS virus. Some religious leaders argued that condom education would promote sex outside marriage, which is against Islamic law. They refused to accept this topic in the project curriculum.

In order to encourage wide participation in the FAEPTI Project, IMAU took a cautious approach and removed the topic of the condom from the workshop curriculum in the first year where necessary. In its place, IMAU held a dialogue with Islamic leaders to listen to and address their concerns about condoms. In this dialogue, IMAU stressed that the condom was being promoted as HIV/AIDS protection only after the failure of a first and second line of defence: abstaining from sex and having sex only within marriage. IMAU argued that the third line of defence should not be ignored because human beings have their weaknesses, as witnessed by girls becoming pregnant before marriage and the many cases of STDs. Married people who fail to use condoms often leave orphans behind, and this destroys communities.

IMAU argued further that knowing about condoms does not mean that people will use them indiscriminately (e.g., "Muslims know about alcohol but that does not mean that they drink it.") IMAU emphasized that the condom not only protects against STDs but can be used for family planning by married couples. IMAU noted that several Muslim countries manufacture condoms for their own reproductive health programmes.

Although the Islamic leaders feared that knowledge of the condom would bring promiscuity, IMAU made it clear that many things used irresponsibly are harmful,

even food. Using this analogy, IMAU made the important point that communities need to understand responsible eating so that they do not endanger their lives.

At the end of the dialogue, the Islamic leaders agreed that education on the responsible use of the condom was acceptable within Islamic teachings and necessary to defend communities against HIV/AIDS. The condom education component was re-inserted in the second year of the workshops.

Further Reading

UNAIDS and IMAU. *AIDS education through Imams: A spiritually motivated community effort in Uganda* (Best Practice Case Study). Geneva: UNAIDS, 1998.

AIDS Education through Imams (Uganda)

Starting Year: 1988

Main Topic Area: Religion

Other Topic Areas: Community mobilization • Communications programming

Contact Person:

Dr Magid Kagimu, Director
Al Haj Rashid Munyagwa,
Secretary General
Phone: +256 42 251-443 or 272-812

Address:

Islamic Medical Association of Uganda
P.O. Box 2773
Kampala
Uganda

Implementers

The project was implemented by the Islamic Medical Association of Uganda (IMAU).

Funding

Various funder bodies both within and outside Uganda sponsor the project. External funders include USAID, UNDP, and UNICEF.

Objectives

The purpose of AIDS Education through Imams is:

- To provide support to Muslim health professionals
- To improve the health of the people of Uganda in general, and the Muslim community in particular.

Background

The Islamic Medical Association of Uganda (IMAU) was established in 1988 to provide support to Muslim health professionals. It aims to improve the health of the people of Uganda in general and the Muslim community in particular.

The idea for the association originated with three Muslim doctors who shared the experience of professional alienation in a country where Muslims are a minority. The doctors had worked with medical associations in the United States, Europe, and Arab countries and had noted how these groups had helped to reduce an individual's sense of isolation.

A meeting in a private home with 30 health professionals from across the country grew into an association that today has over 300 members.

Main Activities

As its first project IMAU established Saidina Abubakar, a modest nursing home and medical unit next to its headquarters in Kampala. Since then, IMAU has laid the foundation for an Islamic hospital, supported family planning services in 17 Islamic health centres, organized conventions on topics related to Islam and medicine, provided financial support to medical students, and pioneered the first HIV/AIDS prevention programme for Uganda's Muslim community.

In September 1989, IMAU took the lead in uniting the Ugandan Muslim response to the HIV/AIDS epidemic by holding a National HIV/AIDS Education Workshop. This workshop, funded by the Ministry of Health's HIV/AIDS Control Programme and the

WHO, shaped the role of the country's Muslim community in responding to the HIV/AIDS epidemic. The National Workshop boasted the attendance of every district khadi in Uganda, representatives from WHO and the Ministry of Health, and many Muslim health professionals. Perhaps the most important participant was His Eminence the Chief Khadi, who was prompted to declare a jihad on HIV/AIDS. This declaration of support from the highest level of Uganda's Muslim community was a critical first step in mobilizing the Muslim community in the fight against HIV/AIDS.

Following the national workshop, IMAU organized HIV/AIDS education workshops for Imams in several districts. Extensive dialogue between health professionals and religious leaders at these early workshops revealed the need to design an HIV/AIDS education project to reach Muslim families through educators trained with and sanctioned by Imams. (See the three IMAU projects described in this summary: Family AIDS Education and Prevention through Imams Project, Community Action for AIDS Prevention, and Madarasa AIDS Education and Prevention Project.)

IMAU has over 300 Islamic medical practitioners, all of whom are conversant in the teachings of Islam and are able to quote verses from the Qur'an to make scientific explanations of HIV/AIDS relevant to people. Although IMAU does not offer material support or clinical services to families suffering with HIV/AIDS, it helps communities network with other organizations that do offer these services.

Outcomes/outputs

Since 1992, IMAU has trained and supervised over 8,000 religious leaders and their teams of volunteers. These spiritually motivated community members have made repeated home visits to over 100,000 families in 11 districts across Uganda, offering accurate information on HIV/AIDS and motivation for behaviour change.

Evaluation Findings

Baseline and follow-up surveys in 1992 and 1994 respectively revealed that community members in IMAU project areas showed significant increases in correct knowledge of HIV transmission and prevention, as well as increased knowledge of risk associated with the Muslim practices of ablution of the dead and (when unsterile instruments are used) circumcision. The surveys also show a significant reduction in self-reported sexual partners and an increase in self-reported condom use.

Lessons Learned

The Muslim faith in Uganda is a highly respected, broadly based structure with clear lines of communication and strong organizational discipline. The involvement of such a structure in the fight against HIV/AIDS is highly relevant to a developing country like Uganda with its high prevalence of the virus and limited (though highly focused) state resources for medical interventions.

The support of official Islam for care of persons living with HIV/AIDS is a formidable counterweight to stigmatization, which can be as devastating to the lives of PLWHAs (economically, socially, and morally) as are the actual medical symptoms of HIV/AIDS. Since effective prevention of HIV/AIDS transmission depends on mass behavioural change, it is highly appropriate for Imams to be involved. They are almost the only people qualified to talk to people both individually and in groups about the most intimate details in their lives.

Further Reading

UNAIDS and IMAU. *AIDS education through Imams: A spiritually motivated community effort in Uganda* (Best Practice Case Study). Geneva: UNAIDS, 1998.

School-based interventions and services

There are more than one billion adolescents in the world. Their number in developing countries – over 800 million – will increase by 20 per cent in the next 15 years. Young people are very valuable to society. It is worth investing heavily in them so that they can protect their own health and influence and educate their peers. This can be done by promoting effective AIDS education programmes in school alongside preventive efforts in the community and the media.

Education is a national concern in all parts of the world, and so cooperation at the highest levels of government is important in making school AIDS education programmes work. Experience in various parts of the world indicates that, working in collaboration with ministries of education and with health and social services, each country's national AIDS programme should aim to provide 100 per cent of schoolchildren with AIDS education.

Good AIDS education covers effective prevention, care and support for people with HIV/AIDS, and non-discrimination. Education of this kind has been shown to help young people to delay sex and, when they become sexually active, to avoid risk behaviour. However, AIDS education in school is often denied to children and young people for a variety of reasons, including the sensitive or controversial nature of the subject in some societies, and the difficulty of finding time for AIDS education in an already overcrowded curriculum. In some places, schools may teach information on AIDS but not the behavioural skills needed for prevention and support.

Best practices in school-based interventions include:

- Creating a partnership between policy-makers, religious and community leaders, parents, and teachers, and using this partnership to set sound policies on AIDS education
- ◆ Designing a good curriculum and/or a good extracurricular programme, adapted to local culture and circumstances, and with a focus on life skills rather than biomedical information
- Teaching primary and secondary students to analyse and respond to social norms, including understanding which ones are potentially harmful and which ones protect their health and well-being
- Good training, both for the teachers themselves and for peer educators – young people from the same age group, specifically selected to educate their friends and acquaintances about AIDS
- ◆ Starting HIV prevention and health promotion programmes for children at the earliest possible age, and certainly before the onset of sexual activity. Effectively, this means that age-appropriate programmes should start at the primary school level.

Skills for Healthy Relationships (Canada)

Starting Year: 1990

Main Topic Area: Schools-based interventions and services

Other Topic Areas: Children and young people

Contact Person:

Diane Aubry

Phone: +613 954 5163

Fax: +613 941 2399

Email: Diane_Aubry@hc-sc.gc.ca

Web Site: www.hv-sc.gc.ca

Address:

HIV/AIDS Policy, Coordination and
Programs Division

Prevention and Community Action
Program

Health Canada

Jeanne Mance Building

Address Locator 1918B1

Ottawa, ON K1A 1B4

Canada

Implementers

Skills for Healthy Relationships (SHR) is the result of a partnership between the nation-wide Council of Ministers of Education and the federal Ministry of Health (Health Canada). Health Canada provided support to in-service training to all provinces wishing to implement the curriculum within their schools. The northern adaptation for Aboriginal people was undertaken by the Northwest Territories Association for School Health.

Funding

Health Canada provided funds toward the development of the curriculum and assisted the provinces with in-service costs.

Objectives

The curriculum was developed specifically:

- To support decisions by non–sexually active young people to delay having sex
- To change the sexual behaviour of sexually active young people so that they revert to abstinence
- To increase protective measures taken by sexually active young people
- To encourage students to develop tolerance toward homosexuality and compassion toward people with HIV/AIDS.

Background

SHR is a curriculum providing HIV/AIDS education and prevention for junior high school students. Initiated in 1990, it includes components aimed at delaying sexual activity, increasing protective measures taken by sexually active youth, creating compassion for persons living with HIV/AIDS (PLWHAs), improving communications and negotiating skills, as well as combating homophobia.

The curriculum development began in 1990 with funding provided by Health Canada and the Council of Ministers of Education (in the Canadian federal system, each province has its own ministry of education).

Grade 9 students (mostly 14-year-olds) have been the target group for the SHR programme since its inception. The curriculum was designed to meet the needs of this age group and fit with the curriculum objectives for students at this grade level.

Main Activities

Health Canada provided funding to assist provinces with the costs of undertaking provincial or territorial in-service training for the implementation of SHR. Workshops for teachers to introduce the curriculum were provided. As well, Health Canada funding was provided to the Northwest Territories Association for School Health to develop a specific aboriginal adaptation of the curriculum.

The programme also included an evaluation that consisted of two distinct phases: the implementation evaluation and the impact/outcomes evaluation. Both of these phases of evaluation had two separate components. The implementation evaluation comprised feasibility assessment and implementation monitoring. The impact evaluation sought the stakeholders' reactions to the programme through focus groups, interviews, and questionnaires. The outcomes evaluation assessed not only outcome behaviours but also the extent to which factors such as relevant attitudes, knowledge, and motivational supports and skills had been attained to enable students to act in a health-conscious manner.

Outcomes/outputs

The programme produced a well-tested manual for teachers, with a set of classroom activities for students and a booklet for parents.

Evaluation Findings

The evaluation indicated that the SHR programme was very well received by participants (students, teachers, parents, administrators) in the evaluation. Knowledge of HIV/AIDS was significantly increased in the students. Two years after participating in the programme, a majority of the demonstration group students reported that they had gained in assertiveness, compassion, confidence, and comfort in talking about personal rights and condoms.

Participants in the programme gained in the following areas using pre- and post-intervention testing:

- More compassion toward people with HIV/AIDS
- Increased intention and ability to communicate with a sexual partner about past sexual experiences
- Refusing sex if not ready, and communicating about using condoms
- Responding assertively when pressured unwillingly into having sex
- Learning how, when, and where to obtain condoms, to purchase them without embarrassment, and to use them properly.

Lessons Learned

One of the most important lessons learned was that a programme like SHR requires regular reinforcement in succeeding years to create a lasting change in attitudes and behaviours. Career and life management courses that have a focus on relationships, health promotion, and disease prevention have been developed and implemented in some provinces. Other school subjects provide information and exploration of these issues.

The project made clear the powerful roles played by parents and peers in reinforcing behavioural change aimed at helping young people avoid risk behaviours. The

impact of the curriculum was stronger when parents participated in the programme by following home activities suggested in the curriculum.

The federal government is presently conducting a national survey that will provide baseline data on policies and practices in Canadian schools at all grade levels, as well as the support provided to youth by the public health system around issues of sexuality education and HIV prevention. Policy, curriculum, and practices are examined at the provincial government level, the regional level, and the service deliver level in both the health and education systems.

Intersectoral STD and HIV/AIDS Prevention through Training of Secondary School Leaders (Colombia)

Starting Year: 1996

Main Topic Area: Schools-based interventions and services

Other Topic Areas: Children and young people • Sexually transmitted diseases

Contact Person:

Edgar Jimenez or Luis Angel Moreno

Phone: +571- 2220165 ext 3090

Fax: +571- 2224530

Address:

Ministerio de Salud

Programa ETS/SIDA

MOH-NAP

Carrera 13 No 32- 76, Piso 11

Bogotá, Colombia

Gisela Olivera or Mauricio Polanco

Ministerio de Educación

Viceministerio de la Juventud

Proyecto Nacional de Educación Sexual

C.A.N.

Bogotá, Colombia

Implementers

The project was implemented by the Ministry of Health's AIDS and STD Programme; the Ministry of Education, Vice-Ministry for Youth; and the Colombian Red Cross.

Funding

Funding was provided by the Ministry of Health (MOH), the Ministry of Education (MOE), and the Colombian Red Cross.

Objectives

The overall objective was to involve high school students in creating their own projects that would effectively disseminate STD and HIV/AIDS prevention messages to their peers.

On an organizational level, the objectives were:

- To create an intersectoral structure bringing together the health, education, and volunteer sectors
- To design and implement a training strategy that would permit a flow of information from the national level down to the provincial, local, and individual school levels
- To spread the benefit of the students' projects through a national contest that showcased the best of the projects.

Background

This project was implemented as a component of the National Programme for Sex Education (NPSE), and has been carried out in 10 Colombian provinces. (Geographic selection was made on the basis of reported incidence of HIV/AIDS.) The NPSE, designed by the MOE, started in 1994. Its initial phase of implementation included the participation of health professionals from MOH and social sciences

professionals from the Ministry of Education. However, the NPSE did not grow much during 1995 and 1996, due to administrative and political problems.

In 1996 a concentrated effort was made to recover and redevelop the NPSE, and the project for training of secondary school leaders was an important part of this effort. The training was supported with educational packages that contained posters, pamphlets, and videos containing STD and HIV/AIDS messages, along with manuals for the trainers. These packages were designed and distributed to all regional public education and public health institutions involved in the project. As well as school leaders, the project involved parents and teachers and also benefited from the participation of health professionals and volunteers from the Colombian Red Cross.

A second phase is scheduled to start in 1999, building on the lessons learned in Phase 1.

Main Activities

The first activity was to establish and train provincial coordinating teams, usually consisting of three members representing the Red Cross, MOH, and MOE. These teams received their training in mid-1996. They in turn trained local teams, all of whom were volunteers.

The training of secondary school leaders started in the third trimester of 1996, and was carried out by the local teams. Following the training, students and local teams worked together to design their own prevention projects and educational materials. Finished products included murals, plays, videos, brochures, and events such as festivals that carried a prevention message.

At the end of the process, each province selected several projects and submitted them in a national contest, prizes for which were donated by the Phillips corporation and the government of Spain.

Outcomes/outputs

A total of 231 persons from the local teams were trained as trainers. They in turn trained 1,888 school leaders at 451 schools, and as a result almost 132,000 students received information or were involved in prevention projects. Subsequently, 84 projects designed by local school teams were entered in the contest for the best project. The first prize was awarded for a video entitled "AIDS: The Adventure of a Lifetime" (Sida: La aventura de la vida) produced by students from Nuestra Señora de Belén school in North Santander.

Evaluation Findings

During the first trimester of 1998, the National Coordinating Team held a series of meetings to review the project. Phase 1 was evaluated using data from the regional reports, which were used to create a matrix of achievements and difficulties. Evaluation of impact has not yet been carried out.

Analysis of the finished projects indicated that, despite the training packages and orientation that all teams received, students tended to associate HIV/AIDS with sin and stereotypical perceptions of marginalized populations such as sex workers, transvestites, and injecting drug users. Death was a constant theme in most projects, indicating that the idea of "living positively" with HIV has not filtered through the training.

In some provinces, and frequently at the local level, there were severe problems of continuity when members of the coordinating teams changed jobs or went on sick leave. Lack of communication and even some rivalry was experienced within some teams. In general, the evaluation indicated that the overall project was underfunded

and that the provincial and local training did not devote enough time to be as effective as they should have been. Some provincial and local teams were able to overcome these obstacles and produce impressive products and activities, while others produced nothing at all. In some cases, the latter might have been avoided if local teams had attempted to work with fewer schools, thereby devoting more “quality time” to a smaller number of projects.

The use of volunteers was also problematic in some places: many of them were university students or had full-time jobs, which meant they had limited time to devote to the project. The evaluation suggests that a profile of the volunteers developed before the start of the training would have been useful in order to find ways to encourage the continuity of their participation.

The project provided a great deal of information about students’ perceptions of HIV/AIDS and STDs, and a variety of lessons that can be used to make Phase 2 more effective.

Lessons Learned

The most important lesson learned was that secondary school students are a very suitable and receptive population for HIV/AIDS and STD preventive projects when they are involved directly in projects that encourage them to use their imagination and youthful enthusiasm. However, it is essential that they receive guidance and advice from skilled and knowledgeable adult trainers when carrying out their projects, and that the information provided to them be reinforced in a variety of ways to make sure the essential messages are understood.

As regards organization, it was learned that great efforts must be made to achieve continuity and coordination between different levels (national, provincial, local, school) when different sectors (health, education, volunteer) are supposed to work together. When this continuity was achieved, the results were impressive; when it was not, nothing was achieved. An important part of this continuity is ongoing monitoring of progress, combined with supervision or consultation if required: had this been built into the process and provided more consistently, it is likely that more schools would have completed their projects.

Finally, training of trainers – particularly when these trainers are volunteers – requires solid planning and a considerable investment of time and resources if the trainers are to be sufficiently motivated, informed about the subject matter, and skilled in facilitating student projects. Even if supporting materials such as training manuals and videos are of a high quality, training workshops that are too short and lack follow-up are less effective than they should be in equipping trainers to work with young people.

Further Reading

Proyecto Intersectoral de Educacion para la Prevencion de las ETS y SIDA mediante la capacitacion de lideres escolares. 6 May 1998. This final report for Phase 1 contains complete analysis of project results along with descriptions and contact details.

Sex workers

Sex workers have existed since time immemorial, with a long history of moral and socio-economic conflicts, persecution, stigma, and violence surrounding sex work. HIV/AIDS is a new issue that has fuelled concern over sex work and how societies think about and dealt with it. It has, however, also brought to light many of the underlying factors that feed this trade and make it unsafe.

There are several categories of sex workers among the women, men, and transgendered persons in the trade. Most often the sex trade is thought of in terms of full-time sex workers found in brothels. Those working in these situations are frequently called prostitutes or “call girls,” and are in working relationships with pimps, madams, or owners. A second category comprises “casual” or “indirect” sex workers who exchange sex for money or for favours or gifts, either on an ad hoc basis or as a second employment. Such sex workers are less inclined to have a “business manager.” In a third category are those sex workers who are forced into sex work and may be held in bondage for short or long periods of time. All of these categories include to greater or lesser degrees the sexual exploitation of young people and women. The category that the sex worker finds herself in, as well as her age, may determine the extent to which she can protect herself from HIV and STD transmissions (this is also true so for males in the trade).

In many countries HIV was first identified in the sex work population. As the epidemic grew, international agencies, governments, and NGOs recognized the need to create interventions for this vulnerable group who engage in risk behaviour and do not often have the means or knowledge to reduce their risk of infection. At the same time, negative social and political views of sex work have used and continue to use HIV/AIDS as a reason to create and enforce laws that marginalize and criminalize sex workers.

Initial responses were primarily promotion and distribution of condoms to sex workers, and dissemination of information. Most of these programmes are targeted to the sex worker, ignoring the clients and the brothel owners or managers. Educational and enabling strategies are the two main elements used when addressing sex work and STD/HIV/AIDS, but the most successful projects include components of both. They also involve people who influence commercial sex activity: clients, owners and managers, police and law enforcers, health officials, community leaders and the media, neighbours and families.

The most effective comprehensive projects are frequently those carried out by men or women who are or have been sex workers. This approach is usually referred to as peer education, but can and should go beyond the educational aspects of HIV/STD education. Other important methods used in HIV/STD sex work programmes are:

- ◆ Outreach or fieldwork – going to sex workers and their bosses in their workplace, at informal meeting places, or at times in their homes, speaking with clients in bars and clubs
- ◆ Group education sessions through outreach work
- ◆ Distribution of educational material for sex workers, bosses, and clients

- ◆ Promotion and distribution of, and easy access to, condoms and lubricants (again this needs to address all parties concerned and not only the sex worker)
- ◆ Provision of and access to health services, especially appropriate management of STDs and confidential counselling services
- ◆ Networking of sex workers – locally, nationally, and regionally – to advocate for protective laws, working conditions, and safer services and to exchange information and experiences
- ◆ Economic development programmes, including skills training, that offer alternative means of employment to sex workers
- ◆ Strategies for drug-using sex workers, including needle-exchange programmes, non-injectable drugs, harm-reduction methods
- ◆ Advocacy for a socially and legally supportive environment – working with communities to change social norms and with policy-makers and law-enforcers to address legal issues that affect sex workers
- ◆ .

Study in Social Organizations of Three Illegal “Red Light” Districts (People’s Republic of China)

Starting Year: 1997

Main Topic Area: Sex workers and clients

Other Topic Areas: Migration

Contact Person:

Professor Pan Suiming
Director

Fax: 86-10-6251-3380

Email: pansimin@public3.bta.net.cn

Address:

Institute for Research on Sexuality and
Gender

Renmin University of China

Beijing 100872

People’s Republic of China

Implementers

The project was implemented by Professor Pan Suiming, with the assistance of local anthropologists.

Funding

One visit was supported by a Ford Foundation study on "floating population" women from Rural Areas. The other four were at Pan Suiming’s own expenses.

Objectives

The basic research objectives were to understand four main sets of questions, each of which has a bearing on modes of HIV transmission and on creating interventions to prevent its spread.

1. How are the illegal red light districts organized and what are the relationships between the bosses and “mothers” (female leaders of the sex workers) and the “hen head”(male controllers of the sex workers); between the mothers, hen heads, and the sex workers and their “boyfriends” (most of whom are actually hen heads); and between the sex workers and the clients?
2. How do the red light districts continue to flourish despite the government’s stringent policy of punishing prostitution? What are the relationships between prostitution leaders and local police, local government, other traders, the local common people?
3. How and why do the young women become sex workers? Do they make a great deal of money, as so many Chinese believe? What is their everyday life? What are their relationships with their families, relatives, friends, and each other?
4. Who are the clients? How do they buy sex? Why do they do so? Is there any affective relationship between the sex workers and the clients?

Background

The first illegal “red light” district studied was the town of Qiaotou, Guangdong province, where the sex trade serves mainly foreign visitors. The second was an economic zone near the city of Liuzhou, Guangxi province, serving mainly tourists. The third was the village of Laziping, Guizhou province, where most business is with local clients. These three areas have never been checked for rates of HIV infection, but all are near areas known to have high rates of infection: Yunnan, Guangxi, and

Guangdong. The generally low level of education in the areas of study suggests that knowledge levels about HIV/AIDS are low.

Five research visits were made, with a total of 65 days spent in the field. The visits were carried out 7–19 January, 13–25 March, and 20–27 July 1997, and 13–26 February and 13–29 July 1998. Follow-up visits were made in 1998.

Main Activities

The researcher managed to live in a room by himself in the same house as the sex workers. He made friends with 6 bosses, 7 mothers, 5 hen heads, 3 shop-guards, 27 sex workers, and 9 clients. As well as people directly involved in prostitution, groups interviewed included local policemen, officials, leaders of women's groups, medical workers, bosses in general shops, woman labourers in factories, drivers, and so on.

The researcher undertook formal interviews featuring a questionnaire. Most of the data however, were drawn from conversations with targeted persons and observations made on the spot. Official statistics on local economic development and on the "prohibition of prostitution" were also collected.

In order to evaluate the information, the researcher returned to each location three times. Each time, he would talk to 10–20 people whom he had met before. On each occasion, one-quarter to one-half of their histories and stories were changed, supplemented, even reinvented. Many other people would afterward tell the researcher the particular individual's true story. The mothers knew the sex workers very well and liked to talk about their histories.

Today, there are still connections between the researcher and eight persons who were connected with the sex trade.

Outcomes/outputs

The study shows how the Chinese sex trade system works; what the daily life of the sex workers is like outside of their business; what the difference is between the central government and the local officers in the field of "prostitution prohibition," and why; and how to use a sociological method to study the red light districts in order to develop meaningful interventions.

Information collected by the study that is most directly related to HIV infection includes: average number of customers per sex worker during a given period of time; effectiveness and frequency of condom use and problems related to that use; rates and frequency of anal sex; factors related to practising or rejecting risky sex, including the price of sex transactions.

Lessons Learned

A wealth of information was gained about the sex industry, despite the practical difficulties of researching an activity that is against the law.

The researcher found four organization systems in the red light districts:

1. Alliances between the sex trade and local authorities. In fact, fines levied against sex workers and their clients were the main source of support for the local "security team" (quasi-official policemen). The fine was US\$370 per sex worker, a figure equal to half a year's income for a local factory labourer. The fine against the client was US\$610. The security team attempted to apprehend sex workers and clients only when it needed money for its salaries. Immediately after a sex worker or client paid the fine, that person was free to go. If a sex worker or client did not pay the fine within seven days, she or he could be sent to a "labour reform camp."

2. Market-like relationships between the landlords or bosses and the mothers or hen heads. In south China, they were independent of each other. In central China, they were employees/employers.

3. The economic exchange between the mother or hen head and the sex workers. In south China the sex worker was like a partner with her hen head or mother. In central China, the relationship was much more like that of master and slave.

4. The love-like relationship between the sex workers and their boyfriends. This was the sex workers' main psychological supporting system, and also a factor in their vulnerability. They gave all their money, attention, and affection to their so-called boyfriends. Nearly all these men will eventually abandon the young women.

A rural girl's becoming a sex worker depended upon three factors. A young woman is more likely to become a sex worker if:

- she lacks a social network which can help her depart from her hometown, wait for a job, or to become a factory labourer
- she has already lost her virginity, has been abandoned by her boyfriend, or is divorced
- meets a mother or a hen head or has a friend who is already a sex worker.

The clients were not very rich. Their decision to visit sex workers depended upon their estimation of their disposable income. Many clients are male labourers from rural areas, with quite low earnings.

Understanding the context of the sex work market is a critical step to developing interventions. The lessons learned in this study suggest that several aspects of the Chinese sex trade are similar to those in other countries, where HIV/AIDS interventions aimed at sex workers have been successful. (See, for example, the Wanchai Night Club Outreach Programme (Hong Kong), TADA (Poland) and the 100 Percent Condom Policy (Thailand) for possible approaches.)

Further Reading

A Chinese-language description of this study is found in the 1999 book *Research in the underground sex trade in China*.

Wanchai Night Club Outreach Programme (Hong Kong)

Starting Year: 1996

Main Topic Area: Sex workers and clients

Other Topic Areas: Migration • Female condoms • Communications programming

Contact Person:

Mr Graham Smith,
Senior Education Officer

Phone: +852 2898 4411

Fax: +852 2505 1682

Email: keigo@netvigator.com

Address:

AIDS Concern,
Community-Based AIDS Prevention and
Support Services

3 Lok Man Rd., Block F., 17B,

Chai Wan

Hong Kong

Sr Ann Gray,
Co-ordinator, Action for Reach-Out

Phone: +852 2770 1065

Fax: +852 2770 1201

Email: afro@iohk.com

Action for Reach Out

P.O. Box 98108

Tsim Sha Tsui Post Office

Kowloon

Hong Kong

Implementers

Two local NGOs called AIDS Concern and Action for Reach Out implemented the programme.

Funding

The two NGOs' fundraising activities have been augmented by partial sponsorship from the Hong Kong Government's AIDS Trust Fund.

Objectives

The Wanchai Night Club Outreach Programme seeks to reduce the transmission of HIV/AIDS within the context of a particular segment of Hong Kong's sex industry. It aims to make this environment more supportive of safer sex practices by:

- Bringing the AIDS issue to the attention of night club owners, employees, and customers
 - Making condoms available in night clubs
 - Securing the approval of night club staff and owners for the programme's efforts
 - Developing HIV/AIDS awareness campaigns to be conducted within the night clubs
 - Distributing materials that inform sex workers and their clients on how to avoid infection with HIV/AIDS and other STDs
 - Designing and developing activities that target sex workers in the night clubs and promote safer sex practices, improve negotiation skills, and increase clinic attendance
-

-Involving "mama-sans" (female authority figures in the night clubs) and other key figures by encouraging them to support, encourage, and endorse safer sex behaviours.

Background

The programme reaches out to young women working in the sex industry – many of whom are Filipinas - by operating through the night clubs with the support of their owners, sex workers, and other employees. By so doing it hope to reduce the transmission of HIV/AIDS within this particular segment of Hong Kong's sex industry and to make this environment more supportive of safer sex practices.

Women working in the sex industry in Hong Kong are usually there for only six months as they are limited to a six-month "entertainer's visa." Many women come back for a second or third stint. Financial reward appears to be the main incentive. Some women report not knowing what the job involved before their arrival. The women are sent through an agency, which usually tests the women for STDs, including HIV/AIDS, before they arrive in Hong Kong.

Most women will not visit a doctor unless they get sick. If symptoms are minor, they will defer seeking treatment until they get back to the Philippines because it is cheaper there, although some women have reported difficulties in accessing sexual health services in the Philippines. Many women seem unaware of the free medical services available to them in Hong Kong and unclear about the risks of HIV/AIDS transmission.

Main Activities

The support of the mama-sans and owners is crucial, so a bilingual outreach team is used, with a Tagalog speaker to talk to the dancers and sex workers and a Cantonese speaker to talk to the mama-sans and owners.

Major activities include:

- Paying regular visits to night clubs (each club to be visited at least once a month) to develop recognition
- Keeping (strictly confidential) records of names of contacts and their positions
- Identifying the hierarchy within the establishment and the state of relations among the employees
- Identifying key permanent workers in the clubs – mama-sans and "guest relations officers" – and establishing relations with them, introducing the programme to them, and recording and assessing their responses to it
- Building relations with the dancers and sex workers so as to create opportunities to discuss HIV/AIDS and sexual health
- Assessing young women's needs with regard to support and medical services
- Counselling female sex workers on issues of sexual health
- Assessing opportunities for campaigns and activities (plays, poster campaigns, leaflet distributions). Discussing these with people who already have good relations with programme participants
 - Distributing materials (leaflets, condom key chains, fans, hankies) to elicit good will, promote safer sex, and disseminate Action for Reach Out and AIDS Concern's contact information
- Sounding out the reactions of key staff (especially managers) to making condoms available in the night clubs; if amenable, supplying them with free condoms

- Liaising with the police, as necessary, to ensure that intervention will not entail any negative outcomes for the establishment
- Promoting awareness of the female condom as an alternative way of practising safer sex.

Outcomes/outputs

Thirteen establishments are fully cooperating and are receiving free supplies of condoms and leaflets. All thirteen agreed to participate in the 1998 World AIDS Day Condom Coaster Campaign, which ran for three weeks. Several establishments have agreed to continue to use the coasters, which promote safer sex and give contact numbers for Action for Reach Out and AIDS Concern's hotlines.

Establishments that have participated in the programme are now referring it to new establishments, ensuring a firm base of goodwill. The women contacted are becoming much more open in discussing their concerns with regard to HIV/AIDS and sexual health.

AIDS Concern and Action for Reach Out have discovered a great interest in the female condom, and are promoting its use.

Evaluation Findings

On-going records are kept. A report is scheduled to be submitted to the Council of the AIDS Trust Fund in March 1999.

Lessons Learned

In addition to the accomplishments detailed in the Outcomes/outputs section, the organizers stress the importance of the lesson that "perseverance is paramount." It takes a long time to gain acceptance in the clubs, but once it comes, momentum builds, and suddenly the programme moves forwards in great leaps.

A major lesson has been the importance of gaining the support of the mama-sans and owners. To this end, a bilingual Tagalog-Chinese outreach team is used. This combination has been crucial.

TADA: Prevention of HIV and STDs among Sex Workers (Poland)

Starting Year: 1996

Main Topic Area: Sex workers and clients

Other Topic Areas: Sexually transmitted diseases • Men who have sex with men • Migration

Contact Person:

Dr Anna Nowak
Programme Coordinator

Phone: +48 91 22 56 75

Address:

Polskie Towarzystwo Oświaty Zdrowotnej
ul. Spedytorska 6/7
70-632 Szczecin
Poland

Implementers

The programme is coordinated from Szczecin, where the local work is carried out by the NGO Polskie Towarzystwo Oświaty Zdrowotnej. The other participating organizations are Towarzystwo Rozwoju Rodziny (in Zielona Góra), Społeczny Komitet ds AIDS (Warsaw), Stowarzyszenie “Jeden wiat” (Poznan), and Powrót z U (Gdansk).

Funding

Funding was originally provided by the Ministry of Health through local public health offices. The coordinated national programme has since begun to receive support from UNDP, and UNAIDS has also provided resources for the programme, though neither of these two sources are seen as permanent funders.

In each city, local programme coordinators were responsible for mobilizing local resources in support to the programme. In Warsaw, for instance, Społeczny Komitet ds AIDS arranged a small office in the centre of the town, where clients can meet with the TADA staff and can get information, condoms, and assistance.

Objectives

The general objective of the TADA programme is to prevent HIV infection and other STDs through promotion of safer sex behaviours among communities who engage in increased risk behaviours (male and female sex workers and their clients, men who have sex with men, and students).

Background

In several larger cities of Poland, street worker (outreach) programmes were initiated by HIV/AIDS activists in 1993–94. The coordinated national street workers programme TADA came to existence in 1996, when a group of HIV/AIDS and health promotion activists (sociologists, doctors, nurses, police officers, and volunteers) took the initiative to design and implement the programme. The conceptual framework of the project was developed in Szczecin and Zielona Góra.

The acronym TADA comes from the names of the outreach workers – TAtiana and DArek – who first took outreach services to sex workers in Szczecin.

Main Activities

In each city a group of three to five street workers distributes condoms and information leaflets along with counselling and referral to specialist services. Specifically, the main activities are:

- Provision of condoms, lubricants, and leaflets to sex workers in the street
- Conversation and counselling in the street on topics such as safer sex, health problems and possible medical assistance, legal problems, drug use, and HIV/AIDS testing
- Meetings with prostitutes in the so-called agencies where they work (positive contacts with pimps)
- Services delivered to sex workers at Polish–German border crossings (leaflets in Polish, Russian, and Bulgarian)
- Arranging HIV/AIDS and STD information stands in gay clubs and discos, complete with distribution of condoms and leaflets
- Information stands at concerts and other events for young people
- Creation of support groups for people involved in high-risk behaviours
- Cooperation with international NGOs and regional programmes on cross-border HIV and STD prevention (Poland/Germany).

Every two months all local coordinators meet and report on their activity. Monitoring of the work of colleagues is also possible during site visits to particular local programmes by more experienced outreach workers (mainly from Szczecin and Zielona Góra). A consultant from the similar programme in Amsterdam (TAMPEP) is often invited to coordinators' meetings in order to assess programme effectiveness and review methodology used.

Outcomes/outputs

Since 1996, the programme has expanded and proved to be effective and highly valued by clients. The most visible outcome has been the increased use of lubricants in all groups of programme clients. Before the programme began, lubricants were practically unknown in Poland, and many sex workers were using other greasy substances, often leading to damaged condoms. As well, condom use among sex workers and gay groups has increased. Finally, numerous sex workers are being provided with access to permanent medical services and can count on support and assistance regarding most of their health problems.

In the first ten months of 1998, programme outputs included:

- Counselling sessions for about 9,000 female sex workers, 3,000 men having sex with men, and 12,000 students
- 20,000 condoms and lubricant kits distributed among sex workers
- Leaflets printed in Bulgarian for migrant sex workers on HIV and STD matters
- International cooperation between the TADA Programme and others such as Polska Rada Społeczna in Berlin, and Belladonna in Sachen.

Evaluation Findings

Evaluation of the project was undertaken through focus group discussions in October 1998. It was recognized that a major area for improvement was the need to work more closely with local governments. This is necessary to ensure ongoing support and funding from the municipalities and other local government structures.

Lessons Learned

A major lesson learned from this programme is the effectiveness of delivering certain types of highly sensitive services through NGOs rather than through more formal institutions – in a manner which resulted in an increase in condom use and access to medical services. In a situation where the government's approach is conservative, as is currently the case in the cities covered by TADA, services delivered by NGOs are generally the only organized assistance that sex workers receive. Even so, in such a context, constructive contacts with sex workers and their “bosses” (pimps and agency owners) require a great deal of careful and systematic work to build trust and familiarity.

The coordinators have also found that cooperation with police, the local community, and municipal administration is very helpful in delivering health services to large populations of people engaging in high-risk behaviours.

Sexually transmitted diseases

In the last decade, sufficient knowledge and expertise have been gathered in the fight against HIV/AIDS and other sexually transmitted diseases (STDs) to enable effective prevention and care interventions to be established. No single strategy will work on its own, and no one nation can work in isolation in the fight against these diseases. A unified approach based on sound principles needs to be implemented globally, regionally, and locally in order to have an appreciable impact.

WHO has estimated that in 1995 around 340 million new cases of curable STDs occurred throughout the world in men and women 15–49 years old. In developing countries, STDs and their complications rank in the top five disease categories for which adults seek health care. In women of childbearing age, disease and death/healthy life lost due to STDs – even excluding HIV – are second only to maternal causes. The scale of the STD problem is too great to be dealt with in specialized STD centres alone, and steps must be taken to expand and integrate STD management in primary health and other health centres (see *Global Prevalence and Incidence*, WHO, 1995, pp. 3–4).

There are several reasons why STDs continue to spread, and why their complications and long-term health effects continue to be a burden on individuals and communities. Several factors hinder the effective prevention and control of STDs. Many cases are asymptomatic, and there is widespread ignorance of STDs' causes, symptoms, cures, and possible consequences. Many people showing symptoms are reluctant to seek health care, and find it difficult to notify their spouse or sex partner(s) of their health status. As well, in many places STD services are unavailable or unsuitable for many potential clients, and prescribed treatments are often substandard.

However, effective prevention and control of STDs can be achieved using a combination of responses, including the “public health package.” STD service delivery should be expanded to embrace this package, which includes the following components:

- ◆ Promotion of safer sex behaviour
- ◆ Condom programming, encompassing a full range of activities from promotion to the planning and management of supplies and distribution
- ◆ Promotion of health care-seeking behaviour
- ◆ Integration of STD control into primary health care, reproductive health care facilities, private clinics, and other health institutions
- ◆ Specific services for populations with high risk behaviours for acquiring and transmitting STD and HIV infections
- ◆ Comprehensive case management of STDs
- ◆ Prevention and care of congenital syphilis and neonatal conjunctivitis
- ◆ Early detection of symptomatic and asymptomatic infections.

Training and Promoting Syndromic Management of Sexually Transmitted Diseases (Philippines)

Starting Year: 1997

Main Topic Area: Sexually transmitted diseases

Other Topic Areas: Health system personnel and training

Phone:

(632) 895-1580

Fax: (632) 899-5561

Email: pathphil@skynet.net

Web Site: <http://www.path.org>

Address:

PATH

395 Sen. Gil Puyat Avenue

Makati City, Metro Manila

Philippines 1200

Implementers

The programme has been implemented by the Program for Appropriate Technology in Health (PATH), an international non-profit organization working to improve the health of women and children.

Funding

Funding for the programme is provided by the United States Agency for International Development (USAID).

Objectives

The training objectives are:

- to integrate STD management into the primary health care system
- to improve the quality of services provided in the formal health structure.

Background

PATH Philippines manages the education component of the AIDS Surveillance and Education Project (ASEP). It has trained public- and private-sector health care providers in STD syndromic management for eight city health departments throughout the Philippines.

Main Activities

While many projects on STD management have focused on public-sector health care and on sex workers, PATH has been promoting syndromic management of STDs to pharmacies and private clinics, where most patients among the general population seek treatment for STD. PATH has developed three versions of flow charts for STD case management: for clinicians, for drug providers, and for community health outreach workers.

It also has developed and begun marketing Triple-S, which stands for "Solusyon sa Sikretong Sakit" (Solution for a Secret Sickness), a STD management kit that includes a complete drug regimen for each major syndrome (vaginal discharge, urethral discharge, genital ulcers, swollen scrotum, lower abdominal pain, and eye discharge), directions for taking the medication, condoms for the duration of treatment, information about STDs, and partner notification cards.

Operational research is being conducted to determine the feasibility of marketing the kits to private pharmacies and NGO clinics in cities around the country. It has already shown that most patients who seek health care at these pharmacies and NGO clinics will pay for the cost of the drugs. The cost of the drugs in the kits is set at half the actual price when sold in pharmacies, and at one-fifth the actual price when sold by NGO clinics.

To meet the increasing demand for STD care generated by mass media and NGO activities, PATH and local city health officials trained 1,200 caregivers in STD syndromic case management. Trainees included community pharmacists, NGO front-line workers, and medical and para-medical personnel stationed in government social hygiene clinics and peripheral health centres.

Outcomes/outputs

Results of surveys conducted before and one year after training show an increase in the proportion of trainees providing STD care (from 44 to 69 per cent) and those using syndromic management approaches (from 0 to 62 per cent). At some sites, caregivers are managing cases using STD syndrome selective kits (Triple-S kits), which were introduced by PATH in 1997 to facilitate the four C's of case management – compliance, condom use, counselling, and contact tracing/partner notification.

Lessons Learned

In addition to the accomplishments noted in Outcomes/inputs, a variety of lessons have been learned which aid in realizing the greatest level of public health benefits from this approach to STDs.

It is important to collaborate with public- and private-sector stakeholders, particularly city health offices/STD clinics in the public sector, and physicians and pharmacists' associations in the private sector. STD management is not always seen as a priority, and people with STDs continue to be stigmatized in the community. Stakeholders must value STD management as an integral approach to HIV/AIDS prevention.

Patients presenting with STD symptoms at pharmacies and NGOs are not the same as those reached by the STD clinics. Most Triple S patients are male clients of sex workers; some are female or male freelance sex workers. Therefore, the provision of STD management in Triple S settings increases and improves STD control overall.

Triple-S kits need promotion. Outlets with slow movement of the kits are those with little or no promotional activities or training. In order to increase the pilot project's reach, marketing expertise and planning are necessary.

Further Reading

More information on ASEP, including an in-depth discussion of lessons learned, can be found at <http://www.path.org/html/asep.htm>

Surveillance and reporting (epidemiology)

The surveillance of a communicable disease is a fundamental activity required for an effective disease prevention and control programme. Surveillance is defined as the “ongoing systematic collection, collation analysis of data and the dissemination of information to those who need to know in order that action may be taken.” In other words, surveillance provides information that leads to action being taken to prevent and control an infectious disease. Surveillance is mainly aimed at:

- ◆ Estimating the size of a health problem
- ◆ Detecting outbreaks of an infectious disease
- ◆ Characterizing disease trends
- ◆ Evaluating interventions and preventive programmes
- ◆ Assisting with health planning
- ◆ Identifying research needs.

Many countries have set up surveillance systems to track the spread of HIV through their populations, systems that have largely been pioneered by the countries of sub-Saharan Africa. But far fewer have collected any information on the sexual and drug-taking behaviours that are central to the spread of HIV. Since these behaviours precede infection, information about them can act as an early warning system. Such behavioural data can indicate how exposed a community may be to HIV. The information can identify groups who are especially vulnerable and can pinpoint particular risk behaviours that threaten to drive the spread of the virus. When collected over time, it can also indicate trends in risk behaviour and vulnerability, validating existing prevention approaches or suggesting what changes need to be made for greater impact.

Behavioural data can be especially crucial in the early stages of the epidemic, when the virus may be spreading largely among people with well-defined behaviours such as drug injecting or commercial sex. Only behavioural information can identify the links between such people and others in the general population, links that may, if identified early enough, suggest practical ways of preventing general epidemic spread.

Better behavioural surveillance is an important component of the tracking of the epidemic. It contributes to predicting trends, to planning for change, and to recording success or failure. But it will always make its greatest contribution when it is used in conjunction with better monitoring of the spread of the virus itself.

The surveillance systems currently in use have in some cases failed to keep up with the needs and the development of the HIV epidemic. This is partly because of the peculiar nature of HIV infection, which on average takes many years to develop into a symptomatic disease, but which can kill people at any time from a few years to more than a decade after infection. This means that the percentage of the population alive with HIV at a given time – the prevalence rate – reflects both newly infected

individuals and those who became infected at any time over the past decade or more.

Behavioural data can help to explain this kind of serosurveillance data. But the fact remains that such prevalence rates are difficult to interpret and are slow to reflect changes in the pattern of new infections. In the early stages of the epidemic, when infections in all age groups are growing simultaneously and few HIV-infected people have yet died, all-age prevalence information is helpful in tracking the epidemic. But as the epidemic matures, and the number of people entering the HIV-infected population (by acquiring the virus) is increasingly balanced by the number leaving it (through AIDS deaths), all-age prevalence becomes less useful.

Because of these inherent difficulties, it is useful especially when tracking mature epidemics to make changes in the way serosurveillance data are collected. For example, concentrating resources on better surveillance of teenagers and people in their early 20s, who if seropositive are likely to have become infected only recently, can give a better picture of HIV incidence trends. In addition, instead of spreading precious resources very thinly – for instance, by regularly testing anonymous blood samples from all pregnant women even when infection in the general population is barely detectable – countries may find it more useful to focus on tracking the virus in groups with greater risk or vulnerability to HIV. The type of surveillance necessary will of course be dictated by the general pattern of infection in a country. Behavioural data will help identify these groups, signal possible changes in them, and pinpoint potential bridges between these and other parts of the population.

Data Collection and Analysis (Uganda)

Starting Year: 1997

Main Topic Area: Surveillance and reporting (epidemiology)

Other Topic Areas: Local-level responses • TB and HIV/AIDS

Contact Person:

Dr Silvia Declich

Reparto Malattie Infettive, ISS

Phone: +39 06 49387217 or 49902820

Fax: +39 06 49903111

Email: silvia@iss.it

Web Site: www.iss.it

Address:

Reparto Malattie Infettive

Laboratorio Epidemiologia e Biostatistica

Istituto Superiore di Sanità (ISS)

Viale Regina Elena, 299

00161 Rome

Italy

Implementers

The project was implemented by St Mary's Lacor Hospital, Gulu, Northern Uganda, with Italy's Istituto Superiore di Sanità (ISS).

Funding

The ISS in Rome provided supplies and equipment, while the Italian Ministry of Foreign Affairs provided laboratory equipment, data management and expert personnel.

Italian NGOs International College for Health Cooperation in Developing Countries (CUAMM) and Associazione Volontari per il Servizio Internazionale (AVSI) operating in Uganda provided resource persons and access to data for future analysis concerning other districts of Northern Uganda. Lacor Hospital contributed its data from 1992 to 1998 and the involvement of its personnel.

Objectives

The four major objectives were to:

- Evaluate the impact of HIV/AIDS and related diseases on the health care system
- Describe disease patterns and trends in hospital admissions
- Provide information for improving the cost-effectiveness of intervention
- Provide data on vulnerable groups and new public health activities.

Background

This project is part of the Istituto Superiore di Sanità's programme called Global Support to the National Plan for HIV/AIDS Control in Uganda (see also Support to Antenatal Clinics (Uganda) in the section on Health system personnel and training). Managed in Uganda, the project is a collaborative effort of the ISS, the Italian Ministry of Foreign Affairs, and the Uganda Ministry of Health.

The main activity was to use available hospital discharge data to describe disease patterns and trends in hospital admissions and to combine them with data from a newly developed sentinel surveillance system for HIV/AIDS and STD testing in North Uganda in order to monitor trends and compare data in other areas. The data collection and analysis was carried out at St Mary's Lacor Hospital, Gulu, Northern

Uganda, a teaching hospital with 446 beds, more than 15,000 admissions, and 120,000 out-patient visits per year. The practice also involved health organizations in other districts of North Uganda.

Main Activities

Hospital personnel have collected the following data since 1992: age, year of testing, area of residence, syphilis serostatus, and HIV-1 serostatus. These data are now computerized.

The data analysis was made by the expert in epidemiology in collaboration with the scientific staff in Rome. The analysis process was monitored and the results obtained were discussed locally and in Italy during technical staff meetings.

Activities included:

- Training of local personnel in data collection, management, and analysis; use and integration of data available (hospital records, surveillance, and epidemiological studies); situation analysis and indicators evaluation through the use of simple graphics and figures to be easily understood by those who are not epidemiological experts
- Use of the results for identifying risk groups that could be targeted for new public health initiatives, and to identify new local priorities
- Organization of a seminar aimed at comparing the data collected from those arriving at the hospital with other areas of the country.

Monitoring of the project included quantifying the volume of some activities (for example, total HIV tests performed during the duration of the project), monitoring the skills of personnel involved, and evaluating the efficacy of the training activities.

Outcomes/outputs

The data collection objectives were accomplished with the completion of the database covering 70,000 patients hospitalized from 1992 to 1997. This permitted analysis of morbidity, mortality, and a variety of service indicators. A second database has been created using data on 9,500 pregnant women who were tested for HIV/AIDS from 1993 to 1997. The data have been analysed for trend analysis.

Results obtained have been published in the document *Coping with the Impact of the AIDS Epidemic in Northern Uganda*.

Evaluation Findings

Among the findings of the project were:

- A remarkable upward trend in HIV and syphilis tests performed in the period of project activity
- The appropriateness (both for increasing knowledge and motivation) of the on-the-job training on data management for the hospital personnel involved: the personnel was able to computerize all the hospital data collected from 1992 and 1997, and they are motivated enough to continue updating the database themselves;
- The benefit of health education. Health education activities were dedicated to the hospital patients, pregnant women attending the antenatal clinic (ANC), and school students. The data analysis shows the benefit of these activities and the need to extend the health education to the young women not attending the ANC (because of the high HIV prevalence come out for this group) and to young people, especially those living in rural areas.

Lessons Learned

One of the most important lessons learned was that, while totally new routines might have met with resistance, utilizing data routinely collected by a health facility does not require much extra work and is accepted by local personnel.

Feedback – that is, keeping people informed after the data were collected – was appreciated by personnel involved in the project:

- Both the hospital medical personnel in charge of the data collection and patient care and those in charge of data entry have often been involved in meetings for discussing data analysis and publication, and for utilizing the results obtained for planning new activities
- The project has carried out an ad hoc seminar for the medical staff of the hospital aimed at presenting and discussing the data and the results in order to improve clinical activities
- Discussion with hospital administration has led to evaluation of hospital performance and identification of areas of improvement.

A benefit of coordination with other institutions working in Northern Uganda has been to spread understanding of study aims. This has led to other health facilities becoming interested in analysis of data available in their own operations. Other hospitals located in North Uganda (Arua, Matany, Hoima) have requested the collaboration of the project for analysing their databases, and this collaboration is now underway. A workshop has been planned for late spring 1999, aimed at presenting all the relevant results that have emerged from the hospitals in North Uganda and comparing them with those available from the South.

Finally, the involvement of representatives from the Ugandan Ministry of Health has promoted discussion and evaluation of local priorities at the national level. The lesson to be drawn is the value of widely promoting a project's results and methodologies.

Further Reading

Accorsi S, Fabiani M, Lukwiya M, Corrado B, Onk PA, Declich S. Coping with the impact of AIDS epidemic in Northern Uganda. Analysis of six years of activities of Lacor Hospital, Gulu (1992–1997). Istituto Superiore di Sanità, Rapporti ISTISAN, 1998.

Vaccines

With more than 90 per cent of all new HIV infections occurring in developing countries, these countries are in desperate need of better prevention methods, including a safe and effective HIV vaccine. However, the financial resources, the pharmaceutical industrial base, and most of the expertise and human resources needed to develop HIV vaccines are located in industrialized countries. It is therefore essential that multiple partners – the scientific community, national and international AIDS research agencies, the pharmaceutical industry, private foundations, member states, and the affected communities – all participate in the search for a vaccine, with changing roles as appropriate.

There is an urgent need to move forward on HIV vaccine research. In the absence of a full understanding of the pathogenesis of HIV/AIDS and of immune correlates of protection, it is unlikely that vaccine trials will be conducted with full consensus of the scientific community. It is necessary to maintain an appropriate balance between the theoretical and the empirical approach to vaccine development, after careful analysis of risk/benefit, scientific, logistical, and public health considerations. And it is essential that vaccine research, and particularly trials, be conducted to the highest scientific and ethical standards and with respect for human rights.

Vaccine research should have a long-term perspective, which will require the formulation of a comprehensive product development strategy, including the parallel development of different vaccine concepts. It should also promote capacity-strengthening in developing countries, where vaccine development activities are taking place, and be conducted respecting national sovereignty of host countries. This means that trials must be discussed, approved, and conducted through the appropriate channels and institutions in the host country and that final decisions will belong to the host country.

Vaccine-related practices can be categorized according to three main goals:

- ◆ Vaccine development – promoting the development and manufacture of candidate vaccines that are appropriate for developing countries (i.e., antigenically relevant to prevalent strains, easy to administer, capable of inducing long-term protection)
- ◆ Vaccine evaluation – facilitating the evaluation of appropriate candidate vaccines with the highest scientific and ethical standards. Preparatory field research will include monitoring HIV variability at potential vaccine-evaluation sites, development of cohorts of HIV-negative volunteers and related social and behavioural studies, and repeat of Phase I/II (safety and immunogenicity) trials of selected candidate vaccines
- ◆ Vaccine availability – ensuring the availability of future HIV vaccines for public health use, especially in developing countries. This requires identifying and addressing potential disincentives for vaccine development (e.g., liability issues, regulatory bottlenecks). It also requires planning well in advance the strategies for future use and procurement of vaccines for developing countries, including negotiations with the pharmaceutical industry and potential funding/donor countries/agencies.

Thailand's National Plan for HIV/AIDS Vaccine Development (Thailand)

Starting Year: 1993

Main Topic Area: Vaccines

Other Topic Areas: National strategic planning

Contact Person:

Vipa Thiamchai

Phone: +66 2 590 32 09

Fax: +66 2 591 84 13

Email: vipa@health.moph.go.th

Web Site:
<http://203.157.40.134/html/vaccine.html>

Address:

AIDS Vaccine Coordinating Unit

Department of Communicable Disease Control

Ministry of Public Health

Tivanond Road

Nonthaburi 11000 Thailand

Implementers

The plan was implemented by the AIDS Division of the Thai Ministry of Public Health, the World Health Organization (WHO), and UNAIDS.

Funding

The Thai Ministry of Public Health (MOPH) and its AIDS Division have financed some of the activities and developed proposals for public- and private-sector funding. WHO and UNAIDS have financed some activities for the implementation of the plan and have provided technical support.

Many specific activities, including the conduct of six clinical trials of HIV candidate vaccines, were funded by international partners, including the Walter Reed Army Institute of Research, the US National Institutes of Health, and the US Centers for Disease Control and Prevention.

Objectives

The objectives are:

- To implement a comprehensive strategy aimed at promoting the development, evaluation, and future availability of safe, effective, and affordable HIV/AIDS vaccine(s) for the people of Thailand and neighbouring countries
- To promote infrastructure strengthening, training, and transfer of knowledge and expertise in technical, managerial, and operational areas, to support the long-term involvement of Thailand in HIV vaccine research
- To foster and coordinate collaboration on HIV/AIDS vaccine research within different institutions in Thailand as well as with international institutions
- To make a contribution to the global effort to develop HIV/AIDS vaccine(s) with particular consideration to other countries in the region.

Background

The Thailand National Plan for HIV/AIDS Vaccine Development originated from discussions in 1991 between WHO and Thai scientists, institutions, and authorities from the Thai MOPH. The first National Plan for HIV/AIDS Vaccine Development

was approved by the MOPH and endorsed by the WHO Steering Committee on Vaccine Development in January 1993.

Considering the important achievements of the first plan for the period 1993–96, and the rapidly evolving area of vaccine research, the MOPH requested in 1997 the collaboration of UNAIDS to revise and update the first national plan.

Main Activities

Main activities include:

- Development of a long-term strategy for the evaluation of HIV/AIDS vaccine
- Establishment of an HIV/AIDS vaccine development and evaluation collaborating centre
- Identification of Thai HIV/AIDS researchers and institutes
- Development of policy and procedures for the planning, implementation, administration, and evaluation of HIV/AIDS–vaccine related activities in Thailand
- Organization of multiple consensus-building and training workshops in different areas (virology, clinical trials, Good Clinical Practices, data management, and communications).

Technical and administrative support have been provided for:

- HIV molecular epidemiological studies
- Establishment of cohorts for HIV incidence
- Social behavioural research
- Conduct of HIV vaccine clinical trials.

Outcomes/outputs

Five Phase 1–2 trials of preventive HIV vaccine and one therapeutic trial have been conducted in Thailand since 1994. One Phase 3 clinical trial to evaluate the efficacy of a preventive HIV candidate vaccine is planned to start in early 1999.

Lessons Learned

Three important lessons have been learned. First, the implementation of a national plan for HIV/AIDS vaccine development requires national consensus. This includes willingness and commitment of the government, scientists, and the general population.

Second, the successful implementation and conduct of HIV vaccine trials require well-coordinated collaboration of different corporate bodies responsible for specific activities. The procedures for submission/review/approval of HIV/AIDS–vaccine related research should be clearly defined.

Finally, it is important for assistance from international experts and organizations to have a part in the external review of proposed HIV/AIDS–vaccine related research.

Workplace

With the rising prevalence of HIV/AIDS, businesses are increasingly concerned about the impact of the disease on their organizations. These concerns are well founded. At the broadest level, businesses are dependent on the strength and vitality of the economies in which they operate. HIV/AIDS raises the costs of doing business, reduces productivity, and lowers overall demand for goods and services. It therefore makes sense to invest in prevention, care, and support programmes to stem declining business productivity and profitability.

Businesses face enormous challenges in responding to AIDS. For the most part, business managers want to do the right thing for their employees, but when it comes to AIDS they often feel they don't know how, or are afraid it will be too expensive. Businesses may be reluctant to set up workplace HIV/AIDS programmes because they feel they lack the resources, do not have adequate in-house knowledge, or consider the matter too sensitive. They may also lack links with the wider community and thus miss out on ways in which community and other outside groups could help them in dealing with HIV/AIDS issues – and vice versa. Many companies setting up workplace programmes do so without clear policies on how to deal with HIV/AIDS. Even when companies do have policies, these are often unconnected to national HIV/AIDS policies, or else are limited in scope or short-term in nature. Educational programmes, for instance, often consist of single-session courses, with poor and unsustainable results.

Effective workplace programmes can be set up by a company at a fraction of the current, rising financial cost of AIDS to the business. Companies should not wait for the government or health sector to take action for them. In a growing number of countries including Brazil, South Africa, Thailand, and the United States, companies have formed business coalitions to pool resources and help each other to respond better to the crises in their workplaces and communities.

Workplace HIV/AIDS programmes are most effective when their planning and monitoring processes involve representatives from a wide range of sectors. Thus, there should be included representatives from the workforce, from management, from the company's health clinic (if there is one), as well as a representative concerned with human rights issues and representatives from the wider community, including non-governmental organizations, especially if the company does not have an in-house clinic or support service.

While mandatory HIV testing is strongly discouraged, employers may choose to offer voluntary, informed, and confidential testing and counselling for employees and their partners as part of the employee education programme.

The recommended components of a workplace AIDS programme are:

- ◆ An equitable set of policies that are communicated to all staff and are properly implemented
- ◆ Ongoing formal and informal education on HIV/AIDS for all staff
- ◆ Availability of condoms

- ◆ Diagnosis, treatment, and management of sexually transmitted diseases, for employees and their sex partners
- ◆ HIV/AIDS voluntary testing, counselling, care, and support services for employees and their families

The effectiveness and sustainability of workplace HIV/AIDS programmes are enhanced if they are periodically monitored, re-evaluated, and updated. As well, workplace programmes should be constantly evolving. Knowledge of employee culture – and of such factors as the incidence of STDs, violence (including rape), and drug and alcohol use among employees and in their community – is essential for making programmes as relevant and effective as possible.

Raising HIV/AIDS Awareness among UN Employees and Their Families (Azerbaijan)

Starting Year: 1998

Main Topic Area: Workplace

Contact Person:

Ercan Murat

Phone: +99 412 980581 or 922379

Fax: + 99 412 98 32 35

Email: Office@un.azeri.com

Address:

Chair, UN Theme Group on HIV/AIDS

UN Resident Coordinator in Azerbaijan

UNDP/UNFPA Office

3 UN 50th Anniversary Street

Baku

Azerbaijan

Implementers

The Azerbaijan Charity AIDS Association (ILHAS) was subcontracted to conduct the seminars. The brochure containing basic facts on HIV/AIDS infection was prepared and distributed jointly by the UNAIDS Focal Point and the UNDP HIV Focal Point in the field office in Baku.

Funding

Funding was provided from UN Resident Coordinator funds. Human resources and administrative support were provided by United Nations Development Programme (UNDP) and United Nations Population Fund (UNFPA) field offices.

Objectives

The main objective was to increase UN staff awareness about HIV/AIDS, and thereby to reduce vulnerability of staff and their dependants to infection.

Background

In 1995, UNDP conducted a survey among its various country offices concerning the HIV/AIDS epidemic and the measures being taken against it. Many offices reported that they had found it useful to organize sessions to brief staff regarding the UN Personnel HIV/AIDS Policy, in addition to simply distributing the document. Upon learning the results of the survey, staff in Azerbaijan asked to have a similar learning event to improve staff awareness and understanding of the disease.

Main Activities

The two-hour seminar was structured as follows:

- Presentation of the HIV/AIDS epidemic situation (global, European, in Azerbaijan)
 - Basic facts about HIV/AIDS (transmission, prevention)
 - HIV/AIDS and the workplace (risk of HIV/AIDS infection, travelling, dismissal, discrimination, first aid)
 - Discussion: questions and answers
 - Seminar evaluation with questionnaires.
-

As well, a bilingual (English–Russian) brochure, “AIDS and HIV infection: Information for United Nations employees and their families,” was prepared and distributed among UN staff.

Finally, four informal follow-up sessions were held two to three months later to reinforce the information given in the seminar, and to find out how information had been retained and whether behaviour had changed.

Outcomes/outputs

Informal follow-up discussions indicated a change in hygiene practices. For instance, many staff members reported that, following the seminars, they started to take precautions during their visits to those clinics and hospitals that have inadequate or uncertain safety conditions, or during cosmetic procedures involving skin-piercing.

Because of reports that some medical establishments in Azerbaijan are reusing disposable syringes, some staff reported that they now always carry disposable syringes with them. Similarly, because the former Soviet practice was for all children to receive vaccination in schools, and cases had been reported that this was often carried out reusing the same syringe for several children, parents arranged vaccinations for their children in local clinics with properly sterilized equipment.

Evaluation Findings

Evaluation was conducted through anonymous completion of pre- and post-seminar questionnaires to test the knowledge on the participants. Analysis of the results suggest that most people increased their level of knowledge about HIV/AIDS (ways of transmission and preventive measures) and modified their attitudes toward HIV/AIDS-infected persons.

Lessons Learned

The experience indicated that the seminars should be conducted in small groups of no more than 10 persons. This helps keep the question-and-answer part of the session manageable, allowing the lecturer to supply full answers to all queries.

Another lesson was that the highest degree of openness was achieved when seminars were composed of people of the same gender and age bracket. In such groups it was easier to create an atmosphere of informal warmth and privacy since people of the same age are often friends and share more common concerns than people with a 20–25 year age difference. Moreover, due to cultural traditions, women who are in the presence of men are not always ready to talk freely and openly about sexual practices, and vice versa. Other criteria to be taken into consideration when organizing groups are overall educational level and existing knowledge of the subject.

Finally, the experience suggests strongly that follow-up of this kind of activity is important. Single events tend to lose their impact quickly unless reinforced by additional activities at a later date.

Further Reading

The bilingual (English–Russian) brochure “AIDS and HIV Infection: Information for United Nations employees and their families” is available in both paper and electronic versions.

PHILACOR Corporation: Private Sector HIV/AIDS Response (Philippines)

Starting Year: 1996

Main Topic Area: Workplace

Other Topic Areas: Communications programming

Contact Person:

Dr Efren T. Llarena

Phone: +632 829-4921 to 40

Fax: +632 826-7465, 826-2731

Email: ederick@philacor1.mozcom.com

Address:

Philippine Appliance Corporation

8377 Dr A. Santos Avenue,

Paranaque 1700, Metro Manila,

Philippines

Postal Address: P.O. Box 1704 Makati

Implementers

The project was implemented by the Philippine Appliance Corporation (PHILACOR).

Funding

Funding for the project is provided by PHILACOR.

Objectives

The goal of the project is to increase PHILACOR employees' knowledge about HIV/AIDS.

Background

While the initial efforts by the private sector in HIV/AIDS in the Philippines were confined to multinational companies (Shell, Levi Strauss, etc.) whose mother companies had adopted policies that supported non-discrimination and workplace education, some Philippine-owned companies such as PHILACOR have developed their own initiatives. The company's initiative complies with the National Workplace Policy on Sexually Transmitted Diseases and HIV/AIDS as framed by the government's Department of Labour and Employment.

PHILACOR is the leading manufacturer of freezers and refrigerators in the Philippines. It has approximately 1,500 employees, 96 per cent of whom are male. Their average age is about 27 years, and half are single.

Responding to demand for knowledge on HIV/AIDS by their workers, PHILACOR introduced HIV/AIDS education in 1996.

Main Activities

The company took the initiative and invited people from NGOs working for HIV/AIDS programmes and also people living with HIV/AIDS to talk to their workers. With the support from both management board and the labour union, the invited people created their own IEC materials and trained six peer educators. The peer educators attended a two-week seminar provided by NGOs and the Department of Health (DOH) and were certified as HIV/AIDS educators by DOH. The peer educators, who were drawn from different levels within the corporation, gave short seminars during the breaks of meetings they were attending.

PHILACOR has also incorporated HIV/AIDS education into other programmes, such as their first aid programme, new staff orientation, worker reorientation, and so forth. The company publishes a quarterly newsletter in which advocacy articles on HIV/AIDS are written both in English and the local language.

In 1996 PHILACOR developed its own policy statement on HIV/AIDS that was approved by both the management board and the union. The policy covers the issues of employment, discrimination, reasonable accommodation, and workplace education. It is based on the principles that respect the individual rights and dignity of people with HIV/AIDS and on non-discriminatory employment practices regardless of HIV/AIDS status, gender, and sexual orientation.

Outcomes/outputs

According to a survey done by the company's medical director, after implementation of the education programmes 90 per cent of workers had accurate knowledge regarding HIV/AIDS transmission.

Lessons Learned

For a variety of reasons, the workplace can be an extremely important location to promote HIV/AIDS education and prevention. First, the target population in this particular company is rather homogeneous, with the majority being young men of sexually active age, both single or married. In other companies, there may be a similar homogeneity, but among women. In either case, it can simplify the task of providing appropriate messages and educational materials if the target population is not diverse.

A second advantage is that HIV/AIDS issues can be added to existing staff training, orientation, and other regular programmes. Such procedures are efficient means of providing the information.

The project staff emphasizes that it was very important that both the labour union and management understood the importance of the HIV/AIDS. This shared knowledge was key to promoting and expanding the various activities of the initiative.

Further Reading

National workplace policy on sexually transmitted diseases and HIV/AIDS.
Department of Labour and Employment, Manila.

ANNEX 1: Making a proposal for the Summary Booklet

UNAIDS welcomes proposals for inclusion in the Summary Booklet of Best Practices. Sample forms are shown on the following pages.

Please send completed forms to the nearest UNAIDS representative or to the Secretariat in Geneva, together with any documentation that will help us understand the practice better. The forms can also be submitted in electronic format by e-mail. To download the electronic forms, go to the UNAIDS website or contact your nearest UNAIDS representative.

Best Practice Submission Form (page 1 of 2)

Please mark the topic areas that the proposed practice fits into:

◆ Access to drugs	◆ Antiretroviral therapy
◆ Blood safety	◆ Children
◆ Communications programming	◆ Community mobilization
◆ Cost-effectiveness analysis	◆ Counselling and voluntary counselling and testing
◆ Determinants of the epidemic	◆ Estimates and projections (epidemiology)
◆ Female condoms	◆ Gender and HIV/AIDS
◆ Health reform and HIV	◆ Health system personnel and training
◆ HIV diagnostic tests	◆ HIV testing
◆ Human rights, ethics, and law	◆ Impact on agriculture and rural households
◆ Impact on children and families	◆ Indigenous peoples
◆ Injecting drug use	◆ Local-level responses
◆ Male condoms	◆ Men who have sex with men
◆ Microbicides	◆ Migration
◆ Military	◆ Mother-to-child transmission
◆ National strategic planning	◆ NGOs and networks
◆ Opportunistic diseases	◆ Paediatric AIDS
◆ Palliative care	◆ Persons living with HIV/AIDS
◆ Prisons	◆ Refugees
◆ Religion	◆ Reproductive health
◆ Resource mobilization	◆ Schools
◆ Sectoral impact (development)	◆ Sex workers and clients
◆ Sexually transmitted diseases	◆ Surveillance and reporting (epidemiology)
◆ TB and HIV/AIDS	◆ Theme Groups – UN system action at country level
◆ Vaccines	◆ Virology, immunology, and laboratory practices
◆ Young people	◆ Workplace

Best Practice Submission Form (Page 2 of 2)

Name	<i>Name of project, policy, law, or strategy</i>
Country	<i>Country where the practice is or was carried out</i>
Topic area	<i>Which of the 50 topic areas on the previous page apply to this practice? (Include up to 4.)</i>
Year	<i>When did it start, finish, or plan to finish?</i>
Contact person	<i>Name Title</i>
Contact information	<i>Mailing address Phone, fax, e-mail, website, etc.</i>
Implementers	<i>Who carried it out? If it was a partnership, who were the partners? Were people living with HIV/AIDS or their representative groups involved?</i>
Funding	<i>Who provided the funding and other resources?</i>
Objectives	<i>What was supposed to change or be accomplished as a result of the practice?</i>
Background	<i>What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?</i>
Main activities	<i>What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out?</i>
Outcomes	<i>What were the practical outcomes, including the measurable results or outputs of the practice? For example, numbers of condoms distributed, numbers of people trained, etc.</i>
Evaluation	<i>Was an evaluation done? If so, describe methodology used and results.</i>
Lessons learned	<i>What are the most important lessons that a reader should take from this practice? What are the keys to its success? What problems or obstacles were encountered, and how were they – or could they be – overcome?</i>

Please attach extra pages if you wish to give more information. Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings).

INDEX

- Access to drugs, 7, 11, 14, 24
- Access to drugs (topic area), 13, 22, 151
- Adolescents, 32, 33, 34, 36, 47, 165, 173
- AIDS Control and Prevention Project (AIDSCAP), 40
- AIDS Education through Imams, 171
- AIDS Research Center of the Thai Red Cross Society, 22
- Antenatal clinics, 122, 153
- Antiretroviral therapy (topic area), 17, 19, 22
- Antiretrovirals (ARVs), 14, 17, 18, 19, 20, 21, 73, 149
- Asian Red Cross/Red Crescent Youth Peer Education Programme, 44
- Associazione Volontari per il Servizio Internazionale (AVSI), 122, 199
- AusAID, 35, 44, 69
- Australian National Center in HIV Epidemiology and Clinical Research (NCHECR), 22
- Azerbaijan, 209, 210
- AZT. *See* Zidovudine (ZDV)
- Behavioural research, 197, 198, 205
- Belgium, 29, 30
- Brazil, 32, 81, 82, 117, 207
- Breastfeeding, 149, 153
- CAFOD, 81
- Canada, 120, 121, 126, 133, 140, 156, 157, 174, 175
- Canadian International Development Agency (CIDA), 61
- Care providers, 73, 101, 194
- Care-givers, 95
- CARITAS, 81
- Chiang Mai University, 57, 59, 61, 62, 98, 99, 100
- Children, 1, 7, 21, 27, 28, 33, 34, 42, 53, 56, 57, 58, 60, 61, 64, 81, 83, 85, 88, 91, 92, 100, 104, 112, 113, 117, 125, 149, 150, 151, 164, 165, 173, 194, 210
- Children and young people (topic area), 27, 29, 35, 38, 40, 42, 44, 46, 48, 50, 53, 55, 57, 59, 61, 64, 67, 69, 77, 147, 164
- China. *See* People's Republic of China
- Chirumhanzu Home-Based Care Project, 102
- Churches, 32, 85, 103, 163, 166
- Colombia, 13, 14, 177
- Communications programming (topic area), 29, 38, 40, 50, 67, 69, 73, 74, 75, 77, 81, 84, 102, 120, 171, 186, 211
- Community Action for AIDS Prevention, 166
- Community care, 7, 79, 83, 86, 90, 94, 95, 96, 97, 100, 101, 104
- Community mobilization (topic area), 46, 59, 79, 81, 84, 87, 91, 94, 98, 102, 111, 120, 144, 164, 166, 167, 171
- Condoms, 40, 41, 42, 47, 50, 51, 67, 68, 70, 71, 77, 78, 82, 88, 96, 104, 105, 107, 108, 109, 110, 117, 118, 119, 131, 136, 139, 140, 141, 142, 143, 144, 145, 146, 147, 160, 161, 168, 169, 170, 172, 175, 181, 182, 184, 185, 186, 187, 188, 189, 190, 193, 194, 195, 207
- Cost-effectiveness analysis (topic area), 19
- Counselling, 27, 28, 42, 58, 62, 84, 85, 86, 90, 92, 94, 95, 96, 103, 105, 107, 108, 109, 110, 116, 117, 122, 123, 124, 131, 140, 141, 142, 145, 148, 150, 151, 152, 153, 165, 167, 168, 182, 190, 195, 207, 208
- Counselling and voluntary counselling and testing (topic area), 42, 84, 98, 105, 107, 109, 111, 122, 140
- Data collection, 123, 199, 200, 201
- Data Collection and Analysis, 199
- Demetra Social Diseases Consultation Centre, 109
- Denmark, 38, 39
- Department for International Development (DFID), 69
- Diocese of Kitui HIV/AIDS Programme, 84
- DKA (Austria), 81
- Doctors, 13, 23, 33, 51, 71, 88, 92, 99, 100, 102, 105, 115, 122, 140, 141, 142, 171, 187, 189, 195
- Doctors without Borders. *See* Médecins sans Frontières
- Drug use, 33, 36, 88, 89, 109, 110, 119, 126, 127, 131, 132, 133, 135, 155, 159, 190
- Drug User Project, Ikhlas Community Centre, Pink Triangle, 87

- Drug users, 111, 112
- ECO School of Life, 111
- Education Loan Fund Project, 64
- Effects of HIV Counselling on Sexual Behaviour of Men Attending STD Clinics, 107
- Employees, 185, 186, 187, 207, 208, 210, 211
- Epidemiology, 123, 200
- Ethics, 7, 13, 19, 75, 125, 126
- Ethiopia, 40
- European Commission (EC), 19, 87
- Family AIDS Education and Prevention through Imams Project, 167
- Family planning, 29, 30, 69, 70, 71, 140, 150, 169, 171
- Field Experiment: The Better You Know Yourself, the Better You Are Protected, 29
- Ford Foundation, 46, 183
- François Bagnoud Center for Health and Human Rights, 137, 162
- Fundraising, 81, 82, 96, 186
- Gay. *See* Men who have sex with men (MSM)
- Gender, 50, 51, 73, 168, 210, 212
- Generic drugs, 11
- German Foundation for World Population (DSW), 40
- German Technical Cooperation (GTZ), 40
- Germany, 42, 190
- Harm reduction, 87, 88, 89, 161
- HCW. *See* Health Care Workers
- Health care workers (HCWs), 115, 116
- Health promotion, 94, 95, 119, 120, 121, 173, 175, 189
- Health Promotion in Action, 120
- Health reform and HIV (topic area), 117, 151
- Health system personnel and training, 75, 115, 194, 199
- Health system personnel and training (topic area), 117, 122
- Heterosexuals, 117
- HIV prevention, 27, 31, 36, 37, 39, 42, 43, 47, 60, 67, 68, 77, 78, 87, 89, 95, 105, 108, 118, 124, 128, 131, 132, 137, 143, 145, 149, 155, 162, 163, 167, 168, 171, 173, 176, 177, 195
- HIV Prevention in First Year of Secondary School, 67
- HIV transmission, 19, 67, 73, 108, 117, 131, 139, 143, 149, 153, 159, 160, 162, 172, 183
- HIV/AIDS Prevention among IDUs, 136
- HIV/AIDS testing, 103, 123, 124, 190
- HIVOS (Holland), 87
- Holistic approach, 42, 95, 99
- Home care, 63, 81, 82, 84, 85, 94, 95, 96, 97, 99, 101, 102, 103, 104, 152, 163, 166, 167, 168, 172
- Homosexuals. *See* Men who have sex with men (MSM)
- Hong Kong, 144, 145, 185, 186, 187
- Human rights, 7, 13, 19, 27, 55, 56, 71, 75, 79, 80, 81, 91, 125, 126, 127, 129, 160, 175, 203, 207, 212
- Human rights, ethics, and law (topic area), 13, 19, 75, 125, 126, 128
- Imams, 105, 164, 165, 166, 167, 168, 170, 171, 172
- Impact on children and families (topic area), 98
- India, 44, 107, 108, 131
- Indigenous peoples, 134, 175
- Information, education and communication (IEC), 35, 36, 37, 40, 73, 109, 137, 211
- Injecting drug use (topic area), 87, 109, 133, 136, 161
- Injecting drug users (IDUs), 7, 87, 88, 89, 106, 109, 110, 131, 134, 135, 136, 137, 178
- Integrated Pilot Project for Prevention of STDs and HIV/AIDS among Rio's Low-Income Population, 117
- International AIDS Economics Network (IAEN), 19
- International Labour Organisation (ILO), 61
- Intersectoral STD and HIV/AIDS Prevention through Training of Secondary School Leaders, 177
- Istituto Superiore di Sanità (ISS), 122, 123, 199
- It Takes Two: Pill and Condom, 140
- Japan, 61, 62, 75, 76
- Joint United Nations Programme on HIV/AIDS (UNAIDS), 5, 6, 7, 8, 11, 15, 19, 27, 47, 54, 58, 63, 79, 83, 86, 90, 97, 101, 104, 109, 125, 136, 137, 161, 162, 165, 166, 170, 172, 189, 204, 205, 209, 213
- Kenya, 46, 47, 84
- Law, 7, 14, 43, 89, 125, 127, 128, 129, 135, 137, 169, 181, 182, 184
- Lindesmith Center, 136
- Lithuania, 109
- International College for Health Cooperation in Developing Countries (CUAMM), 122, 199
- Local-level responses (topic area), 199
- Madarasa AIDS Education and Prevention Project, 164
- Mahidol University, 53, 57
- Malaysia, 44, 87, 88, 131
- Male condom, 139

- Male condoms (topic area), 50, 67, 107, 117, 140, 144, 147, 167
- Mass media, 6, 75, 77, 78
- Mathare Youth Sports Association, 46
- Médecins sans Frontières, 77, 117
- Men who have sex with men, 148
- Men who have sex with men (MSM), 29, 30, 51, 87, 88, 91, 106, 127, 143, 144, 145, 147, 148, 174, 190
- Men who have sex with men (topic area), 29, 87, 143, 144, 147, 189
- Midwives, 115
- Migrants, 106, 109, 110
- Migration, 28, 85
- Migration (topic area), 183, 186, 189
- Military, 143, 163
- Ministers, 70, 105
- Monks, 99, 100, 163
- Mosques, 163, 164, 165, 166, 168
- Mother-to-child transmission, 7, 17, 149, 151, 169
- Mother-to-child transmission (topic area), 151
- MSM Outreach Programme, 144
- Myanmar, 44, 45, 48
- National Action Plan on HIV/AIDS and Injection Drug Use, 133
- National AIDS programmes, 143, 163, 173
- National AIDS Programmes, 14, 84, 118
- National Consultation to Renew Canada's Strategy for HIV/AIDS, 156
- National Institutes of Mental Health (NIMH), 67
- National Medicine Fund for High Social Impact Diseases, 13
- National Meetings for People Living with HIV/AIDS, 91
- National strategic planning, 11, 126, 155
- National strategic planning (topic area), 57, 133, 155, 156, 204
- National Strategies to Reduce Vulnerability of Thai Girls, 57
- Needle exchanges, 110, 131, 134, 159
- Needle-exchanges, 182
- Netherlands, 22, 44, 50, 77
- Netherlands National AIDS Therapy Evaluation Center (NATEC), 22
- Netherlands–Australia–Thailand HIV Research Collaboration, 22
- NGOs and networks (topic area), 19, 44, 91, 136
- Non-governmental organizations (NGOs), 1, 6, 11, 13, 14, 15, 18, 29, 32, 33, 40, 46, 47, 58, 59, 60, 62, 66, 77, 82, 83, 86, 87, 89, 91, 92, 95, 102, 105, 118, 120, 122, 128, 136, 137, 144, 162, 167, 181, 186, 189, 190, 191, 195, 199, 211
- Norwegian Agency for Development (NORAD), 46
- Nuns, 81, 163
- Nurses, 23, 82, 84, 85, 88, 94, 95, 96, 99, 100, 102, 103, 104, 105, 109, 115, 152, 189
- Online Conference on ARV Treatment in Developing Countries, 19
- Opportunistic infections, 11, 115
- Orphans, 27, 28, 82, 85, 86, 125, 169
- Outreach, 30, 37, 42, 60, 85, 87, 88, 89, 105, 119, 144, 145, 146, 147, 148, 156, 181, 187, 188, 189, 190, 194
- Palliative care (topic area), 94, 102
- Pan American Health Organization (PAHO), 13, 14
- Peer counsellors, 40, 109
- Peer education, 35, 36, 39, 41, 44, 45, 47, 48, 49, 50, 51, 52, 60, 74, 131, 132, 143, 160, 173, 181, 211
- Peer educators, 52
- Peer Educators for Young People, 38
- People's Republic of China, 35, 36, 37, 44, 45, 48, 131, 183, 185
- Persons living with HIV/AIDS (PLWHAs), 11, 13, 14, 15, 19, 27, 49, 59, 75, 81, 82, 83, 84, 85, 86, 87, 91, 92, 95, 98, 99, 100, 102, 104, 115, 116, 125, 128, 136, 157, 162, 163, 164, 167, 172, 174, 211
- Persons living with HIV/AIDS (topic area), 111
- Pharmaceutical companies, 11, 14, 22, 24, 91
- Pharmacies, 11, 119, 195
- PHILACOR Corporation: Private Sector HIV/AIDS Response, 211
- Philippines, 44, 128, 129, 187, 194, 211
- Physicians. *See* Doctors
- Poland, 91, 92, 111, 185, 189, 190
- Police, 58, 90, 109, 145, 159, 181, 183, 188, 189, 191
- Population Council, 46, 49
- Priests, 105
- Prisons, 127, 131, 143, 159, 160, 161, 162
- Prisons (topic area), 159, 161
- Private sector, 11, 20, 46, 62, 78, 91, 125, 156, 194, 195, 204, 211
- Program for Appropriate Technology in Health (PATH), 194
- Project Hope, 81, 82, 83
- Project MSM, 147
- Projeto Esperanca de Sao Miguel Paulista. *See* Project Hope
- Prostitutes. *See* Sex workers

- Public awareness, 35, 71, 84, 129
- Raising HIV/AIDS
Awareness among UN Employees and Their Families, 209
- Red Crescent, 35, 44, 45, 48
- Red Cross, 1, 22, 23, 35, 36, 37, 44, 45, 48, 85, 98, 99, 100, 105, 177, 178
- Red ribbons, 75, 76
- Refugees, 106, 123
- Refugees (topic area), 122
- Religion, 50, 163
- Religion (topic area), 164, 166, 167, 171
- Reproductive health, 44, 45, 48, 49, 69, 70, 149, 150, 169, 193
- Reproductive health (topic area), 32, 44, 140
- Republic of the Philippines AIDS Prevention and Control Law, 128
- Rural areas, 55, 63, 118, 119, 141, 183, 185, 200
- Russian Federation, 77, 78, 131
- Safe Sex, My Choice, 77
- Sanpatong Family Care Project, 98
- Save Your Generation Association, 40
- School-based interventions and services, 173
- Schools, 27, 32, 33, 40, 41, 48, 53, 54, 58, 59, 60, 61, 62, 64, 65, 66, 67, 68, 70, 71, 78, 82, 85, 106, 110, 117, 163, 164, 165, 173, 174, 175, 176, 177, 178, 179, 200, 210
- Schools (topic area), 38, 53, 57, 59, 61, 64, 164, 174, 177
- Sema Life Development Project, 53
- Sentinel surveillance, 58, 95, 122, 123, 124, 197, 198, 199, 200
- Sex workers, 7, 33, 42, 53, 54, 55, 57, 58, 61, 62, 63, 64, 88, 102, 105, 107, 108, 109, 110, 129, 178, 181, 182, 183, 184, 185, 186, 187, 189, 190, 191, 194, 195
- Sex workers and clients (topic area), 42, 53, 57, 61, 64, 107, 109, 128, 183, 186, 189
- Sexplain: Peer Education on Sexual Health for Young People, 50
- Sexual abuse, 32, 33
- Sexuality, 33, 34, 39, 50, 87, 118, 119, 148, 165, 176
- Sexually transmitted diseases (STDs), 27, 36, 38, 39, 44, 45, 48, 49, 50, 51, 57, 69, 70, 71, 77, 78, 81, 82, 85, 86, 88, 102, 104, 105, 107, 108, 109, 110, 117, 118, 119, 122, 124, 128, 131, 139, 140, 141, 142, 143, 149, 155, 161, 162, 168, 169, 177, 178, 179, 181, 182, 186, 187, 189, 190, 193, 194, 195, 199, 208, 212
- Sexually transmitted diseases (topic area), 32, 35, 38, 44, 46, 48, 77, 107, 109, 144, 177, 189, 193, 194
- Short-Course ZDV to Prevent Mother-to-Child HIV Transmission during Routine Health Care, 151
- Skills for Healthy Relationships, 174
- Social workers, 32, 33, 42, 43, 96, 118, 119
- SolidarMed, 102
- South Africa, 94, 127, 207
- State University of Rio de Janeiro, 117
- Street youth, 42, 60
- Study in Social Organizations of Three Illegal "Red Light" Districts, 183
- Support groups, 99, 101, 103, 104, 190
- Support to Antenatal Clinics, 122
- Surveillance and reporting (epidemiology), 197
- Surveillance and reporting (epidemiology) (topic area), 199
- Sustainable HIV/AIDS Prevention Activities in Prisons, 161
- Swiss Fund, 56
- Switzerland, 147, 148
- TADA: Prevention of HIV and STDs among Sex Workers, 189
- Tateni Home Care Services, 94
- Teachers, 53, 54, 58, 62, 63, 67, 96, 115, 164, 165, 167, 173, 175, 178
- Testing, 27, 37, 45, 62, 68, 85, 105, 106, 107, 108, 109, 110, 116, 117, 122, 123, 124, 125, 127, 129, 141, 150, 151, 152, 175, 198, 199, 200, 207, 208, 210
- Thai Women of Tomorrow Project, 61
- Thai Youth AIDS Prevention Project, 59
- Thailand, 20, 22, 23, 24, 44, 53, 55, 56, 57, 58, 59, 60, 61, 63, 64, 98, 101, 149, 151, 152, 153, 185, 204, 205, 207
- Thailand's National Plan for HIV/AIDS Vaccine Development, 204
- The AIDS Service Organization (TASO), 122
- The Canadian HIV/AIDS Legal Network, 126
- The Red Ribbon of Solidarity, 75
- Training, 22, 23, 33, 34, 35, 36, 37, 38, 44, 45, 47, 48, 49, 50, 52, 53, 54, 55, 56, 58, 59, 60, 61, 62, 63, 68, 82, 83, 85, 92, 95, 96, 98, 99, 100, 101, 103, 105, 115, 116, 118, 119, 120, 123, 134, 143, 152, 153, 161, 162, 163, 165, 166, 168, 173, 174, 175, 177, 178, 179, 182, 194, 195, 200, 204, 205, 212
- Training and Promoting Syndromic Management of Sexually Transmitted Diseases, 194
- Tuberculosis (TB), 19, 85, 86, 115, 159, 199
- Uganda, 85, 122, 123, 124, 164, 165, 166, 167, 168,

- 169, 170, 171, 172, 199, 200, 201
- Ukraine, 136, 137, 161, 162
- Umbrella Project, 42
- UNDP, 111
- United Nations (UN), 6, 162, 209, 210
- United Nations Children's Fund (UNICEF), 6, 11, 32, 35, 44, 48, 49, 53, 55, 56, 57, 59, 61, 69, 102, 136, 164, 171
- United Nations Development Programme, 6, 91, 92, 167, 168, 171, 189, 209
- United Nations Educational, Scientific and Cultural Organization (UNESCO), 1, 6
- United Nations Population Fund (UNFPA), 6, 69, 209
- United States Agency for International Development (USAID), 19, 61, 62, 167, 171, 194
- United States of America (USA), 67
- Urban areas, 141
- US Centers for Disease Control and Prevention (CDC), 167, 204
- Vaccine, 7, 22, 203, 204, 205
- Vaccines (topic area), 204
- Vanuatu, 69, 70, 71
- Videos, 63, 67, 69, 70, 71, 73, 104, 119, 178, 179
- Violence, 32, 33, 159, 160, 181, 208
- Virology, immunology, and laboratory practices (topic area), 22
- Volunteers, 43, 45, 59, 62, 63, 81, 82, 83, 87, 88, 89, 90, 92, 95, 96, 99, 100, 102, 103, 104, 143, 148, 152, 167, 168, 169, 172, 177, 178, 179, 189, 203
- Vulnerable populations, 7, 148, 155
- Wan Smolbag Theatre: Popular Theatre for Health Education, 69
- Wanchai Night Club Outreach Programme, 186
- Wandzin: A Village for People Living with HIV/AIDS, 111
- Women/Life Collective, 32
- Workplace, 163, 181, 207, 208, 209, 211, 212
- Workplace (topic area), 55, 207, 209, 211
- Workplaces, 85, 207
- World AIDS Day, 84, 188
- World Bank, 6, 19
- World Health Organization (WHO), 6, 11, 22, 149, 172, 193, 204, 205
- Young people, 7, 27, 28, 30, 31, 32, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 47, 48, 49, 50, 52, 55, 56, 58, 59, 60, 69, 70, 71, 77, 78, 82, 96, 104, 106, 118, 132, 144, 147, 148, 164, 173, 174, 175, 177, 179, 181, 190, 200
- Youth Career Development Programme, 55
- Zidovudine (ZDV), 14, 17, 21, 149, 150, 151, 152, 153
- Zimbabwe, 102, 103