

Annex IV : Plenary Presentations

1. The Epidemic in Asia - Implications for Young People

- Mr. Ton Smits, Director, Asian Harm Reduction Network

**Drugs,
HIV/AIDS, Health Care and
Development Problems in Asia**

**Environmental Obstacles to
Life Skills Development,
Responding to Challenges and Needs**

The Asian Harm Reduction Network

AHRN, June 2004

The Asian Harm Reduction Network

- Conceived out of the need to link people and resources involved in HIV/AIDS prevention among PUDs in Asia
- Current activities:
 - Advocacy
 - Information dissemination
 - Networking
 - Transfer of knowledge and skills: Network based solutions
 - Support to establishment of enabling policy environment (I.e. Indonesia, Myanmar)
 - Program development

AHRN, June 2004

AHRN Network-based Solutions (current)

- Crisis fund for harm reduction
- Research: Structural determinants of drug use among young people in selected countries in Asia (Indonesia, Pakistan, India, Iran)
- Planned Country offices expansion (Cambodia, India, Pakistan, Iran and Nepal)
- Continuation of programming in Indonesia and Myanmar
- Quad-media advocacy and training tools development (i.e project documentation of existing needs and capacity)
- Monitoring of regional epidemics (DU, HIV, Hep B,C, TB,) program and policy development & funding opportunities.
- Support to the establishment of new national and existing sub-regional HR networks (i.e., Vietnam, China, NE India, Central Asia),
- Co-development of Human Resource Development Centres for the prevention of HIV among and from People who use Drugs/ People recovering from using Drugs
- Development and implementation of large-scale pilot programmes in 5-8 countries

AHRN, June 2004

Growth of AHRN

Year	Membership	Countries
1996	62	9
1999	1350	62
2000	1557	65
2001	1879	67
2003	2482	69

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A Drug Free World by?

- 2005
- 2008
- 2012
- ????

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**Drugs
business,
profitable
business**

Adding Value	
Drug price per kg,\$	
Heroin*	
Farmgate (opium)	90
Domestic wholesale	2,870
US wholesale	80,000
US retail	290,000
Cocaine**	
Coca leaves	610
Cocaine base	860
Cocaine hydrochloride - export	1,500
- US wholesale	25,250
US retail	50,000
- crack cocaine	50,000
- cocaine powder	110,000

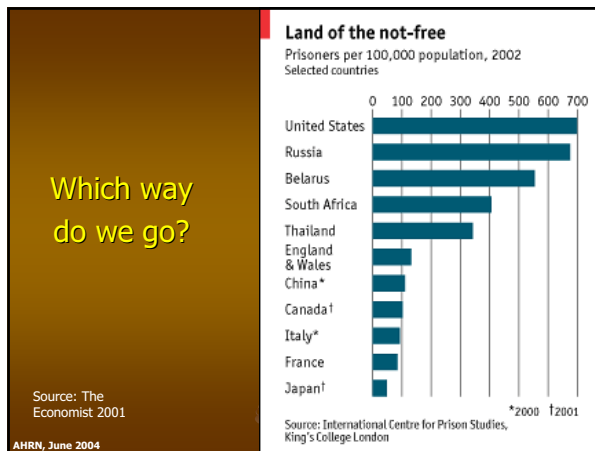
* Origin Pakistan, 1994
** Origin Bolivia, 1995-96

Source: The Economist 2001
Source: 1997 World Drug Report UNODCCP

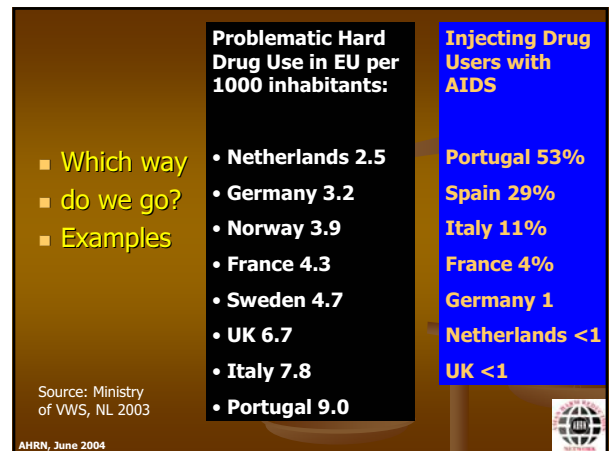
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Which way do we go?



Punishment:

- "Prisoners are sent to prison *AS* punishment, and not *FOR* punishment." (statement by Alexander Paterson, British Prison Commissioner in the 1930s)
- Exposing prisoners to often fatal diseases is not part of their sentences and is unacceptable.
- HIV/AIDS are a more concentrated and aggressive threat in prisons than outside, and prisons are serving as foci for the development of high levels of drug-resistant communicable diseases.

Source: HIV IN PRISONS; WHO Regional Office for Europe

Need to Review Punishment Paradigm

- Punishment & seclusion paradigms fail to understand the realities of drug addiction
- Continue to dominate policy & political decision-making
- Punishment & seclusion paradigms resulting in
 - School drop-out and exclusion
 - Overloading of prisons (with increased HIV risks for incarcerated persons)
 - Criminalizing individuals with a substantial impact on social cohesion; social, economic & health inequity & harmony, greater than that associated with use of the drug itself

Regional judicial overhaul: Greater focus needed on the causes of youth crime in the region

- "The vast majority of children in conflict with the law have suffered a history of abuse, including violence at home and at school, sexual exploitation, drug addiction and poverty.
- "These children need support services such as drug rehabilitation and family counselling rather than punishment in a criminal justice system which is designed for adults." (UNICEF May 2004)

Reference: "Justice for children, Detention as a last resort"



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Drug Policies & Public Health

- An important challenge is to secure an enabling legislative and policy environment for effective HIV prevention and to restate national security concerns around drugs in terms of public health and safety, harm reduction and community development



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Research Objectives: Through the Eye of a Needle *

- To formulate conclusions at the national and community level on drug use, drug careers and related interventions (*Insight & Knowledge*);
- To formulate recommendations at the national and community level on improvement of services and policy directions in relation to drug use (*Policy Formulation*);
- To demystify and de-stigmatise drug use and to empower local groups, including PUD-groups to conduct research on drug-related areas (*De-stigmatisation and Empowerment*);
- To develop and try out a research tool for further research in other countries (*Research Development*); and
- To set up and develop national networks that gather and analyse drug related data on a regular basis with the aim to develop, adjust and implement policy directions (*Infrastructure Development*)

* An Exploratory Research into the Environmental Factors that Shape the Drug Careers of Young People in Selected Cities in Asia – AHRN, UNODC, MoH Iran

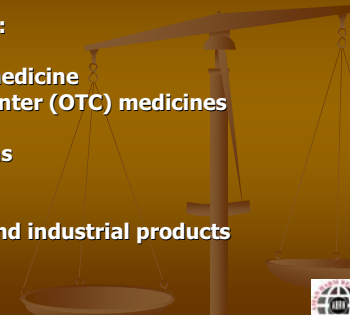


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What drugs?

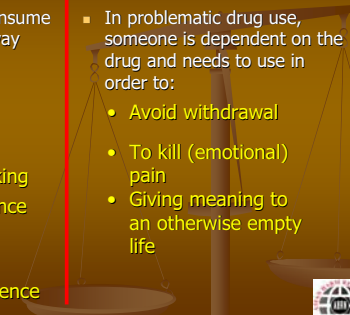
'Drugs' include:

- Prescribed medicine
- Over the counter (OTC) medicines
- Analgesics
- Hallucinogens
- Stimulants
- Depressants
- Household and industrial products



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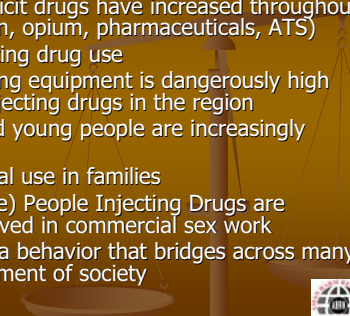
People using drugs	People dependent on drugs
<ul style="list-style-type: none"> People Using Drugs consume drugs in a controlled way and perceive low risk, because of: <ul style="list-style-type: none"> Curiosity Experimentation Adventure, risk taking Improve performance & body image Enjoyment To enhance experience 	<ul style="list-style-type: none"> In problematic drug use, someone is dependent on the drug and needs to use in order to: <ul style="list-style-type: none"> Avoid withdrawal To kill (emotional) pain Giving meaning to an otherwise empty life



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Epidemiology of Drugs in Asia

- Use of licit and illicit drugs have increased throughout the region (heroin, opium, pharmaceuticals, ATS)
- Increase in injecting drug use
- Sharing of injecting equipment is dangerously high among people injecting drugs in the region
- Asian women and young people are increasingly using drugs
- Cross-generational use in families
- Female (and male) People Injecting Drugs are increasingly involved in commercial sex work
- Drug injecting is a behavior that bridges across many marginalized segment of society

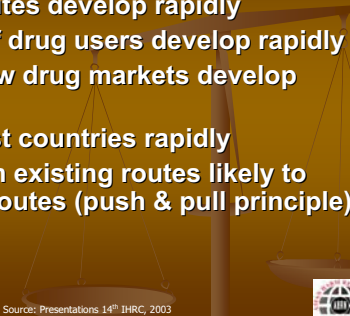


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Drug Trafficking & HIV/AIDS

- Trafficking routes develop rapidly
- Populations of drug users develop rapidly
- Creation of new drug markets develop rapidly
- HIV enters host countries rapidly
- Crack down on existing routes likely to result in new routes (push & pull principle)

Source: Presentations 14th IHRC, 2003



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Epidemiology of HIV/AIDS in Asia

- Drug injecting is an increasingly important feature of the HIV epidemics in Asia
- High HIV prevalence among IDUs throughout the region
- Among People Injecting Drugs in Asia HIV has diffused more rapid than among other populations at risk:

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Epidemiology of HIV/AIDS in Asia (12-2003)

- Estimated 7.4 million PLWHA in Asia/Pacific;
- >1 million new infections in 2003;
- 500,000 people AIDS Deaths;
- HIV epidemic largely concentrated on Indian subcontinent—3.8 to 4.6 million infected people in India alone, end of 2002 (UNAIDS 2003).
- In the Asia Pacific EVERY DAY:
 - 2685 new Infections (111 per hour);
 - 1192 recorded AIDS deaths.
- In 2003 around 50 % of all new infections are among women
- Around 50% were young adults in the 15–24 years age group
- Less than 1% of PLWHA has access to ART

Sources: WHO, UNAIDS, UNESCO

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HIV in South and South East Asia Present and Future...

- Adults and children living with HIV/AIDS in South and South East Asia in 2003: 5.3-9.4 Million
- In the absence of scaling up of evidence based interventions it is estimated that by 2010 in South and South East Asia 18,5-25 million additional persons will get infected with HIV

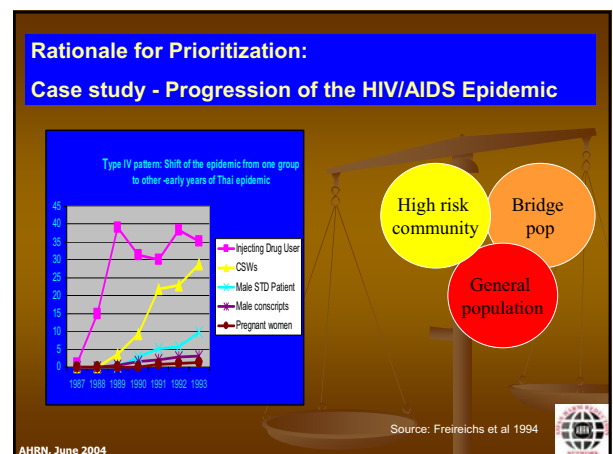
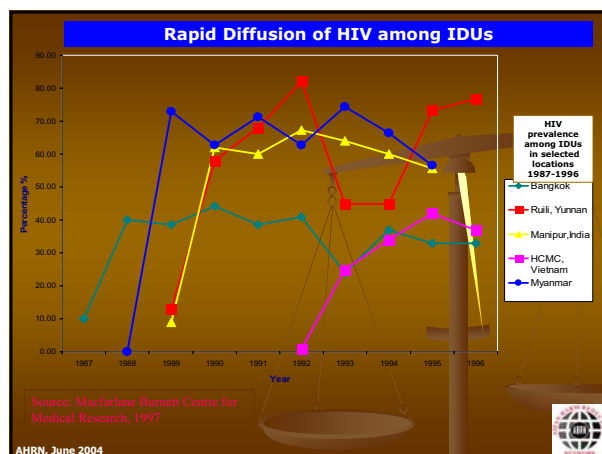
Sources: WHO, AHRN

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Asia's future...?

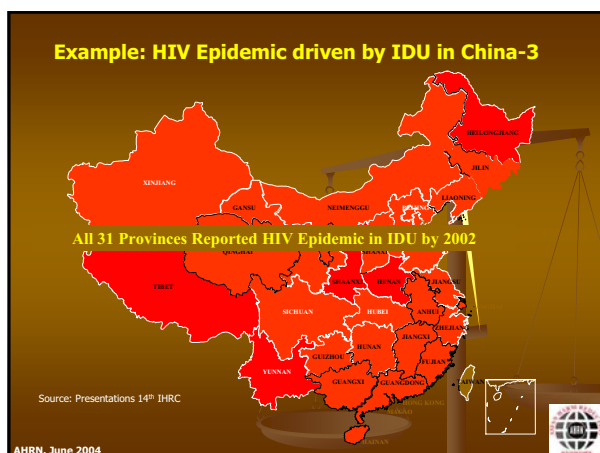
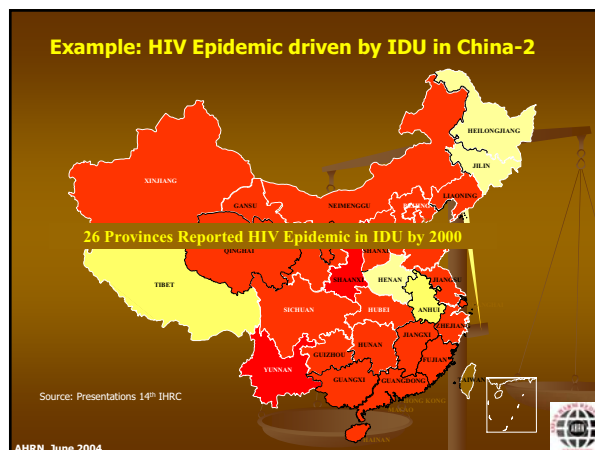
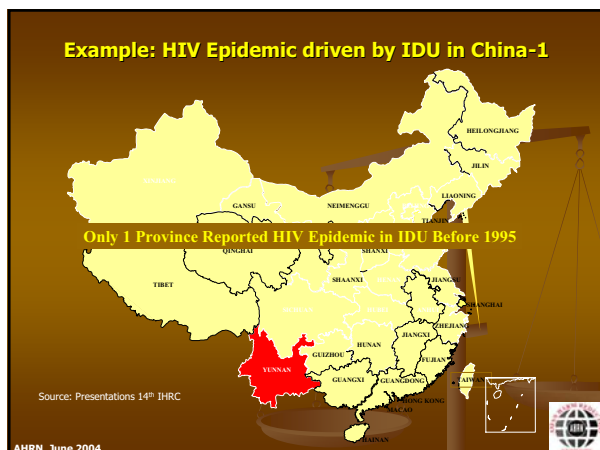
- Current global figure of PLWHA is 35/40 million
- By 2010 the Asia Pacific Region could be home to HALF OF ALL anticipated 70/80 million PLWHA!!

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Beyond HIV, Other Health Threats

- STIs increase the probability of HIV transmission and often co-exist in people using drugs and overlapping sub-populations.
- The resurgence of TB and/or the development of resistant TB strains have been associated with drug injecting.
- Overdose

Source: Various documents, V

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Beyond HIV, Other Health Threats: Hep B, Hep C

- Very little systematic data is available at the national level
- Local project data and research studies with small sample size indicate:
 - 15 – 60 % HbsAg among IDUs
 - 40-90 % anti HCV among IDUs

In certain parts of Asia, Hep B is very high in general population

Sources: UNAIDS, 14th IHRC

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Beyond HIV: Infectious Diseases Cluster in Underdeveloped Communities

- Disease Clustering is more than just a biological occurrence:
 - Social and economic factors codetermine the risk of exposure
 - Primarily found among disenfranchised populations without adequate access to health information and care (the poor, women, refugee populations, homeless young people, prisoners, people who inject drug and sex workers)
 - The legal context of drug use (criminalization, police repression), stigma and discrimination (e.g. by medical providers) are strong disincentives to seeking timely medical help for infectious (and other) diseases
- In order to design effective interventions, careful consideration must be given to non-medical factors and the development context.

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Drugs and Development

- Drugs are intricately intertwined in the geo-ethnic politics in many parts of the Asian region
- Fuel for enduring and bloody conflicts
- Associated with displacement, poverty (drug use as coping mechanism)
- Impoverished communities rely on drug (opium) economies
- Drugs and drug policies complicate wider development objectives and encroach on human rights
 - Contribute to soaring imprisonment rates,
 - Leads to corruption, decrease in popular trust of government
- Upcoming implementation of opium bans may result in humanitarian disaster, including severe food shortages, educational drop out and forced migration.

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Drugs and Development (cont'd)

- In developing countries people involved in drug production or trafficking are often paid in drugs
- By nature of addiction, drug dependent persons give everything they have or what they can obtain, for drugs and pauperisation is the inevitable consequence under the dominant circumstances of poverty in such countries
- Not only the drug dependent person is affected by increased poverty, but also people living with him/her. Food security, shelter, education and all other aspects of well-being are diminished for the whole family
- Drugs can also affect cognitive capacity/operation and further diminish opportunities for a way out of the cycle of drug use and poverty

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Models and lessons learnt within the region:

- Sharan; India *
- LALS; Nepal *
- Nai Zindagi; Pakistan
- Pakistan Society; Pakistan
- Hong Kong Methadone Clinic; Hong Kong
- Mitsamlanh Friends; Cambodia
- Mea Chan Project; Thailand*
- Prison Program; Iran
- Triangular Clinic; Iran
- Care Bangladesh

* Projects established a feasibility of best practice interventions in their communities in India, Nepal and northern Thailand, respectively. They demonstrated effective harm reduction practices however these interventions are significantly scaled-back while the HIV/AIDS epidemics among Injecting Drug Users are on the rise.

Sources: UNAIDS, AHRN Clearing house

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2. The Epidemic in Asia - Implications for Young People

- Dr. Scott Bamber, HIV/AIDS Project Officer, UNICEF Office for Thailand

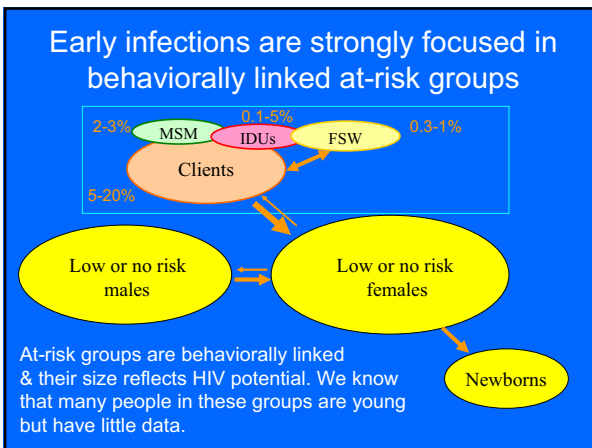
The Epidemic in Asia – Implications for Young People

Dr. Scott Bamber, UNICEF Thailand
 Based on presentations by: Dr. Tim Brown
 East West Centre / UNAIDS / Thai Red Cross AIDS Research Centre
 and Gregory Carl, UNICEF EAPRO

For every child
 Health, Education, Equality, Protection
 ADVANCE HUMANITY



Asian epidemic dynamics –
 What do Asian epidemics look like in terms of vulnerability of young people?



But if early epidemics all basically look like this, why do they differ so much in severity and rate of growth?

Explaining the differences 1

- HIV is a “behaviorally transmitted” disease, and....
- The level and intensity of HIV risk behaviors vary around the region

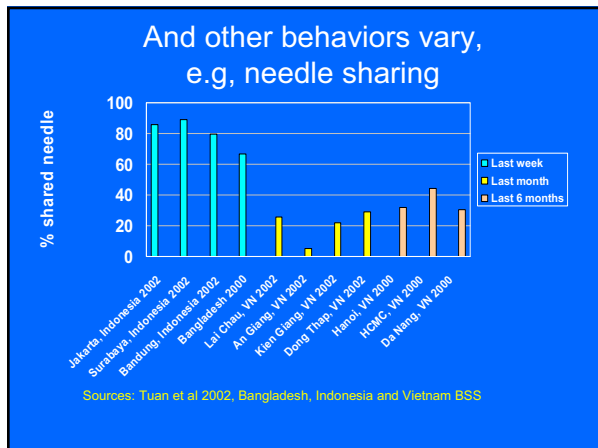
The number at risk varies...
 Percent adult male clients in various Asian countries

Country	% clients	Number	Year
Thailand	22% / 10%	4 / 1.8 million	1990/1997
Cambodia	13%	0.5 million	2000
Japan	11%	3.2 million	1999
China	9%	34.0 million	2000
Philippines	7%	1.6 million	2000
Hong Kong/ Singapore	5%	0.1 million	Early 1990s

•5 to 20% of adult males visit sex workers
 •Fall in % clients in Thailand doesn't necessarily mean less vulnerability owing to increase in casual sex with “clean” partners

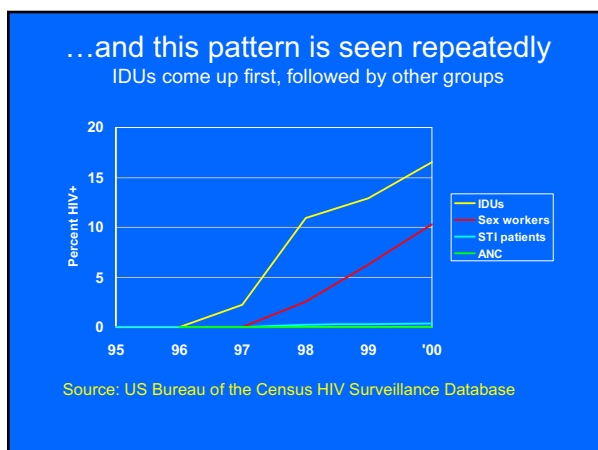
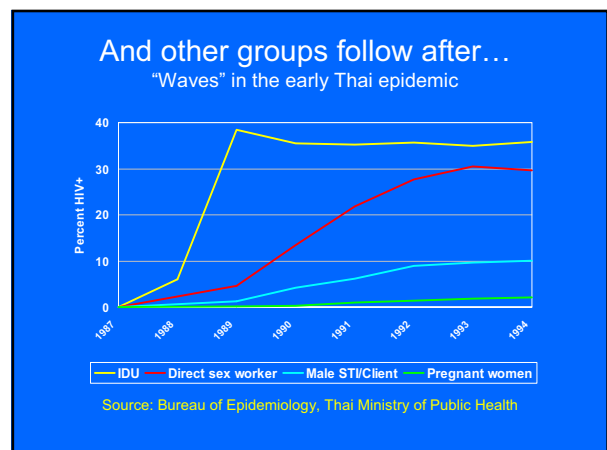
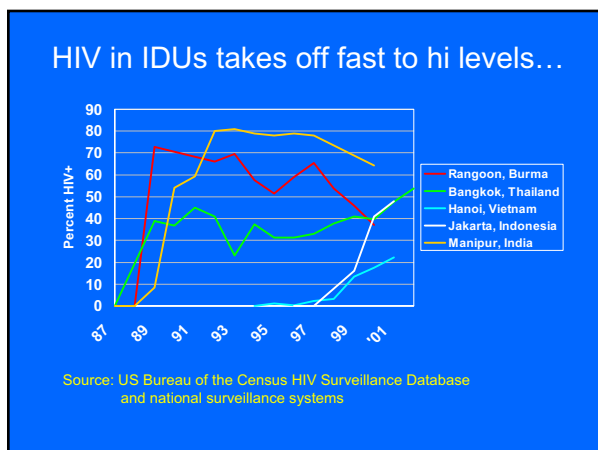
2. The Epidemic in Asia - Implications for Young People

- Dr. Scott Bamber, HIV/AIDS Project Officer, UNICEF Office for Thailand



Explaining the differences 2

- Epidemics grow at different rates and to different levels in different sub-groups
 - Some transmission modes are more efficient
 - The contribution of different sub-populations varies from place to place



Explaining the differences 3

- The links between the different sub-epidemics vary in strength around the region:
 - Some sex workers inject drugs
 - Some male sex workers visit female sex workers
 - Many high risk men and women have lower risk partners

2. The Epidemic in Asia - Implications for Young People

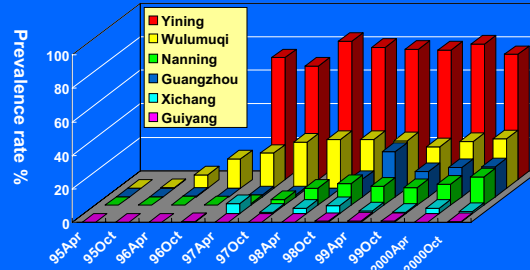
- Dr. Scott Bamber, HIV/AIDS Project Officer, UNICEF Office for Thailand

Explaining the differences 4

- Epidemics don't take off until HIV is introduced....
- And HIV is introduced at different times, even within the same country

HIV "introductions" at different times

HIV among IDUs in different Chinese provinces



Source: Zheng Xiwen MAP Meeting Melbourne 2002

Explaining the differences 5

- Behaviors are changing in the region

In some places condom use climbs...

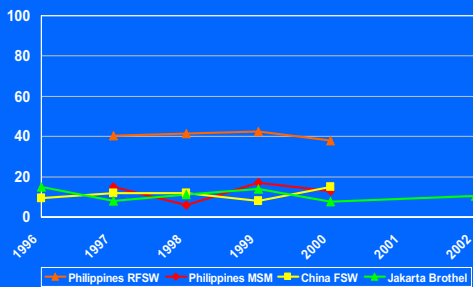
Consistent condom use in Cambodia over time



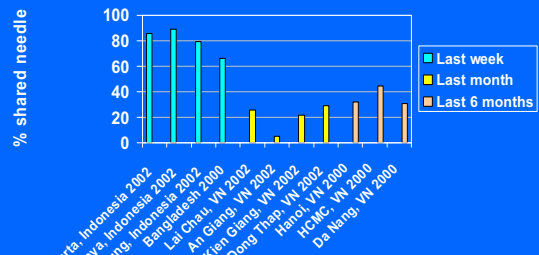
Source: Cambodian Behavioral Surveillance System

But in others it remains low...

Consistent condom use in various populations



Needle sharing remains high...



Sources: Tuan et al 2002, Bangladesh, Indonesia and Vietnam BSS

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- Dr. Scott Bamber, HIV/AIDS Project Officer, UNICEF Office for Thailand

Explaining the differences 6

- Other biological factors vary
 - Prevalence of STIs varies around the region and we know this can increase HIV transmission
 - Knowledge of STIs around the region is very low
 - At-risk population probably not primarily young people in school however little data is available

Clearly all Asian epidemics are NOT alike

- Substantial diversity from country to country
 - Level of risk & rate of growth (determined by vulnerability)
 - Relative contribution of different at-risk pops
 - Linkages among the sub-epidemics (young people and high-risk groups, and between high-risk groups)
 - Time of HIV entry into populations
 - Evolution of risks and vulnerability over time and effectiveness of responses
 - Other biological factors (STIs)
- Country-specific assessments among young people are needed, but current knowledge is limited

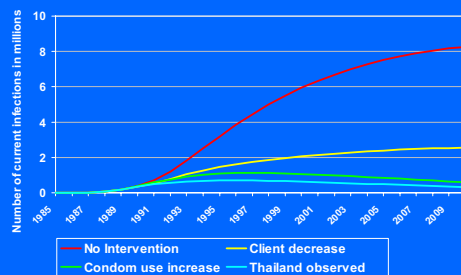
However,
Epidemiological evidence shows
many lower risk Asian countries
are today entering the faster
growth period...

...and in most places the IDU
epidemics that may seed sex work
epidemics are well underway

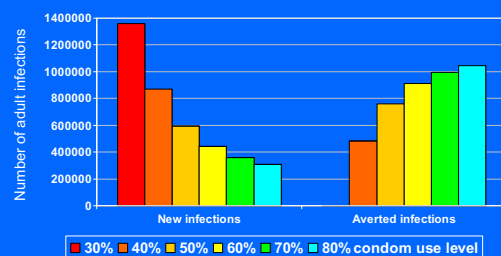
But HIV growth is not inevitable...

We know how to interrupt the
chain of transmission in Asia...

Thailand shows that the course of Asian epidemics can be changed



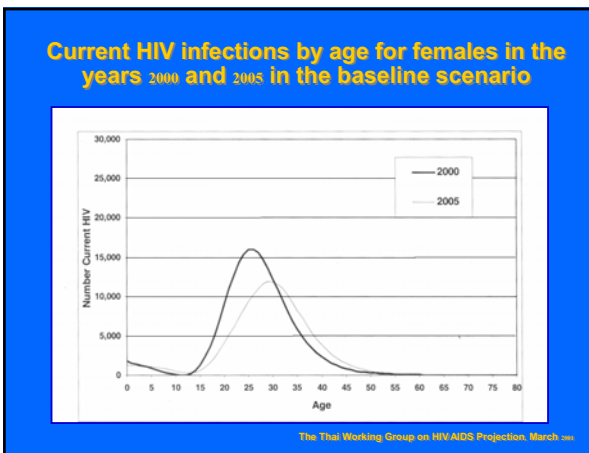
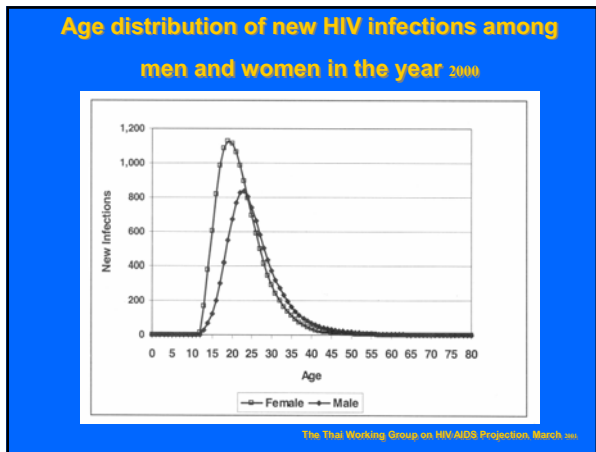
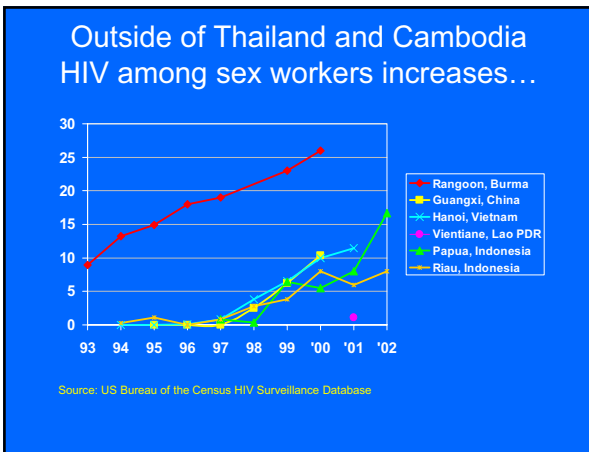
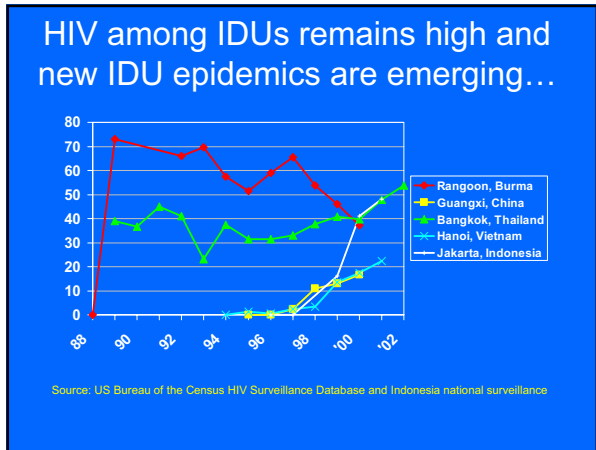
Impact of increasing condom use in infections averted by 2015



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- Dr. Scott Bamber, HIV/AIDS Project Officer, UNICEF Office for Thailand

But, despite these notable successes, the response to HIV in Asia today is flatlined...
the epidemic is alive and well...



Studies of Young People's Behaviour - what do they tell us?

- Few rigorous studies have been carried out of young people's vulnerability
- Those that have been done include:
 - Savy study, Vietnam
 - Pinoy study, Philippines
 - Phraya study, Thailand

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**PHRAYA Study, Chiang Rai Province
November-December 1999**

- 1725 adolescents and young adults participated in the study
- Self-administered survey

Characteristic	Male N=893	Female N=832
Sexual Intercourse	48.3	43.1
Consistent condom use with steady sexual partner	15.6	10.5
Consistent condom use with casual sexual partner	32.7	47.8
Ever been coerced into sex	6.5	21.0

EC and CDC

Contraceptive characteristics by sex

Characteristic	Male N=893	Female N=832
Any Contraceptive method	39.5	31.1
Oral Pill	68.0	62.5
Condom	59.8	41.3
Withdrawal	47.4	35.9
Morning After Pill	34.9	15.8
Injectables	11.2	13.0
Ever had a genital sore or ulcer	13.	10.5

EC and CDC

Contraceptive characteristics by sex II

Among those with a history of sexual intercourse

Characteristic	Male N=893	Female N=832
Ever pregnant (subject or partner) (%)	16.9	27.3
Total number of pregnancies (n)	100	131
Last pregnancy outcome: Abortion (%)	84.8	83.0
Delivery (%)	7.6	4.0
Other, e.g. miscarriage (%)	7.5	13.0

EC and CDC

Prevalence of Chlamydia and HIV by sexual history and sex

Among those with a history of sexual intercourse

Sexual His	Male, N=893		Female, N=832	
	C. Trach. n %	HIV n %	C. Trach. n %	HIV n %
Intercourse	16 (3.7)	1 (0.2)	22 (6.1)	3 (0.8)

Prevalence of methamphetamine in urine by Audio-CASI and sex

Urine Test	Male, N=893		Female, N=832	
	Ever Used n %	Never Used n %	Ever Used n %	Never Used n %
Positive	108 (85.0)	19 (15.0)	38 (82.6)	8 (17.4)

EC and CDC

Summary

- Data from studies shows the potential links between risk groups and vulnerability of young people
- Lack of rigorous studies of young people such as those which been done for high-risk groups
- But the few studies which have been done give cause for concern

- Results of studies show that assumptions about behaviour of young people are frequently off-target
- Important for programming to be evidence-based in order to be on target and to show results

2. The Epidemic in Asia - Implications for Young People

- Dr. Scott Bamber, HIV/AIDS Project Officer, UNICEF Office for Thailand

Source Presentations


- Tim Brown, Why Are Asian HIV Epidemics Different? Exploring Program & Policy Implications of HIV Diversity, March 2004
- Tim Brown, Why Do HIV Epidemics in the Countries of Asia Differ? Possibilities and alternatives, March 2004
- Tim Brown, What Drives Asian Epidemics? The Asian Epidemic Model – a tool for exploring national epidemics, March 2004
- Tim Brown, What Really Matters? Exploring the dynamics of Asian HIV epidemics, March 2004
- Tim Brown, I Heard That It's Over! Where are Asian epidemics going in the future? March 2004
- Tim Brown, Flatlined...The Asian Response to HIV, February 2004
- Gregory Carl, Situation of Young People in Thailand, Thailand Project Launch and Joint Regional Teams Workshop, June 2002

3. Lifeskills for Behavior Development and Change Among Young People

- Gregory Carl, Regional HIV/AIDS Project Officer, BDCC/Lifeskills, UNICEF East Asia and Pacific Regional Office

Lifeskills for Behavior Development and Change Among Young People

Greg Carl
Regional HIV/AIDS Project Officer- BDCC/Lifeskills
UNICEF East Asia and Pacific Regional Office



What is Lifeskills-based Education?


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Lifeskills-Based Education

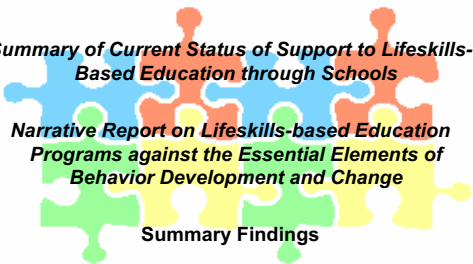
“Lifeskills-based education is designed to facilitate the practice and reinforcement of psychosocial skills in a culturally and developmentally appropriate way: it contributes to the promotion of personal and social development, the prevention of health and social problems, and the protection of human rights.”

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Framework for Lifeskills-based Education
Essential Elements of Behavior Development and Change



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Summary of Current Status of Support to Lifeskills-Based Education through Schools

Narrative Report on Lifeskills-based Education Programs against the Essential Elements of Behavior Development and Change

Summary Findings

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Evidence Base

There has been/is a profound lack of behavioral and vulnerability data among young people in-school [and out of school].

Where data is available, it is often not linked to programming.

However, many countries in the Region are stepping up to the challenge.

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3. Lifeskills for Behavior Development and Change Among Young People


- Gregory Carl, Regional HIV/AIDS Project Officer, BDCC/Lifeskills, UNICEF East Asia and Pacific Regional Office

Are We Looking at Both?

Risk
The level at which an individual or population engages in activities which place them at risk

Vulnerability
A person's ability or lack of ability to act on the decisions they make

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Appropriate Messages

Behavioral and vulnerability often not applied to advocacy efforts or the development of materials.

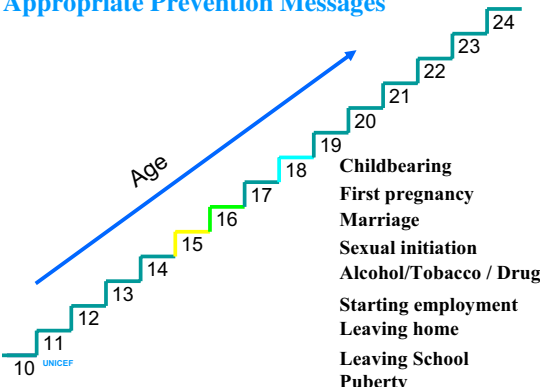
Young people are not involved in the analysis of the data and the development of messages

Lack of experiences and guidelines on how to develop appropriate messages.

There is an opportunity to learn from the experiences of countries in the Region.

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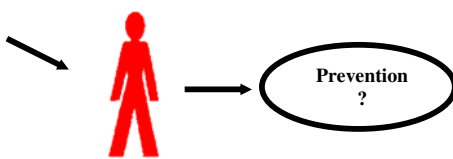
Appropriate Prevention Messages



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Prevention I

Information on HIV/AIDS/STD, Drug and Substance Use, Unplanned Pregnancy, Etc.



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Prevention II

Information on HIV/AIDS/STD, Drug Use, Reproductive Health

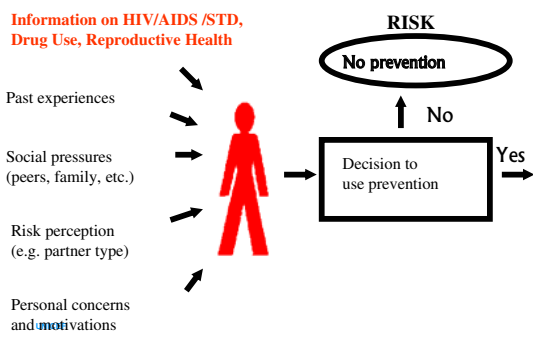
Past experiences

Social pressures (peers, family, etc.)

Risk perception (e.g. partner type)

Personal concerns and motivations

Life Skills Focus I



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Prevention III

RISK

No prevention

Yes No

Access to services

Skills to use Prevention

Social pressures

Use prevention

Barriers: Legal, Social, Economic, Time of day

Barriers: Education, Training, Culture, Religion

Barriers: Gender roles, Norms, Education

Life Skills Focus II


Protective Factors

VULNERABILITY

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3. Lifeskills for Behavior Development and Change Among Young People

- Gregory Carl, Regional HIV/AIDS Project Officer, BDCC/Lifeskills, UNICEF East Asia and Pacific Regional Office



Lifeskills Development

3 questions for Lifeskills development:
 “What Lifeskills?”
 “Lifeskills for what?”
 “How will Lifeskills be developed?”

Competency-based curricula now being developed

Lifeskills applied to specific content areas

Interactive teaching and learning methods used. But, Lifeskills-based education is not synonymous with these methods

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Life Skills Areas in Asia Determined by an Evidence Base?


General Lifeskills	Mental Health
HIV/AIDS and STD	Sexual and Reproductive Health
Drug and Substance Use, including Alcohol and Tobacco	
Communicable Diseases: Tuberculosis and Malaria, other	
Relationships with Family & Friends	Gender Roles
Physical Growth and Development / Nutrition	
Hygiene and Sanitation	Population Education
Agriculture/Pesticide Safety	Environmental Protection
Child Rights	Peace Education
Personal Safety	Road Safety
Job Search	Landmine Safety

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Life Skills should be thought of as an Approach not a Methodology

People Generally Remember		Level of Abstraction
10%	Read	Verbal Receiving
20%	Hear Words	
30%	Watch Still Picture	Visual Receiving
50%	Watch Demonstration	
70%	Do a Site Visit	Hearing, Saying, Seeing, Doing
90%	Do a Dramatic Presentation	
	Do the Real Thing	

UNICEF Wiman and Mierhenry, Educational Media, Charles Merrill, 1969.



Linkages to Services & Supplies


The majority of BDC/LSBE programs in the Region do not provide services and supplies

When services are available, they are linked to programming.

However, some country programs have incorporated the availability or unavailability of services into the decision-making, problem solving process.

Young people want to develop skills on how to access services – Youth consultations, BKK 2004

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Supportive Environment


Many national AIDS policies/strategies support skills-based HIV prevention education in light of the UNGASS Declaration of Commitments

A few education directives are in place but there is still a lack of policy.

Many countries in the Region are taking up the challenge of policy development.

Community involvement and ownership in programming is still weak in the Region.

UNICEF **Nevertheless, there are some good examples**



Sustained Action

The majority of LSBE programs in the Region are co-/extra-curricular

There is dependency on in-service teacher training through cascade training models

A number of countries are moving toward compulsory Lifeskills-based education (as a separate subject or incorporation into core subject areas) and building Teacher capacity through the institutionalization of LSBE in pre-service teacher training.

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3. Lifeskills for Behavior Development and Change Among Young People

- Gregory Carl, Regional HIV/AIDS Project Officer, BDCC/Lifeskills, UNICEF East Asia and Pacific Regional Office


Behavior Development / Behavior Change Programming Needs to Be Sustained

Co-Curricula / Extra Curricula
vs
Core / Compulsory Curricula

3 main options:
Integration/Infusion alone
Single/Multiple "Carrier" Subject (s)
Separate Subject

Teacher Training Pre- & In-Service


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Collaboration & Networking

- Reduced duplication of efforts
- Contribute to the pooling of technical and financial resources
- Can facilitate the scaling up of programming.
- Can facilitate linkages to needed services and supplies
- Mechanism to collect important data needed to report on global commitments.

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Monitoring & Evaluation

- Weak or Non-existent or only process oriented
- Do not examine Lifeskills development
- Behaviors and behavior change related to sensitive topics cannot be assessed in the classroom, other than by "intention"
- Need to link LSBE programming to institutionalized behavior and vulnerability assessments among young people

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Monitoring & Evaluation

Short Term ↔ Long Term

Personal Level

- Skills developed and their application
- Choices examined (Prevention/ Harm Reduction)
- Plans and capacity for putting choices into action

↕

- Health seeking and harm reduction behavior (individual/group)
- Increased of service usage
- Rates of HIV/STD, drug use, unplanned pregnancies among youth

Social Level

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Monitoring & Evaluation

Short Term ↔ Long Term

Baselines ↔ Situational/Behavioral Changes

National Level

- Behavioral Surveillance Surveys
- Health Surveillance Surveys
- Situation Analyses

↕

Program/Project Level

- Behavioral Assessments
- Local Health Surveillance, Situation Analyses
- Services Accessed

↕

Activity Level

- Lifeskills Development
- Changes in Knowledge, Attitudes, Behavior

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UNICEF Priorities in Prevention Education

- ❖Effective School Health Programs
- ❖Placement in Curriculum
- ❖Promotion of Behavioral Change
- ❖High Quality Teaching and Learning Materials
- ❖Training and Support to Teachers
- ❖Expansion to National Scale

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3. Lifeskills for Behavior Development and Change Among Young People

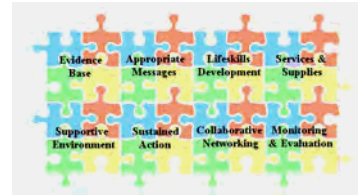
- Gregory Carl, Regional HIV/AIDS Project Officer, BDCC/Lifeskills, UNICEF East Asia and Pacific Regional Office

The Regional Forum

- To focus on what is possible
- To discuss and develop a country level framework / strategy for LSBE
- To determine what technical inputs are required to move forward (the how to...)
- To develop a human resource network

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Thank You



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4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration



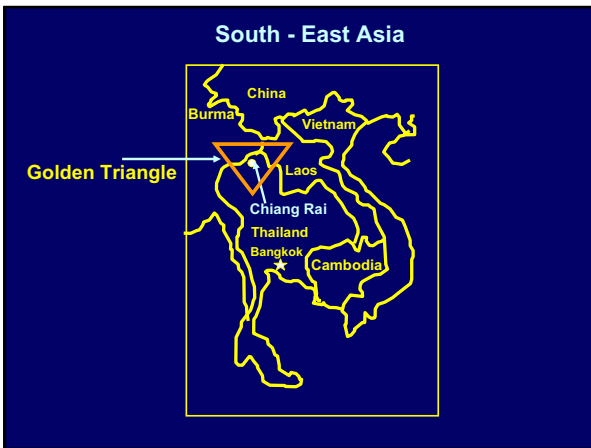
Automated, Computer- Assisted Data Collection

Can eliminate

- Social desirability
- Interviewer bias
- Between and within interviewer variation in questioning
- Coding errors
- Data entry errors
- Inconsistent and missing data

Disadvantage

- Quantitative
- Investigator driven data



Audio - Computer - Assisted Self - Interview (ACASI) PHRAYA Study, 1999



ACASI summary 1999

Pros:

- Evaluate a large number of subjects in short time
- High enrollment rate
- High response rates to sensitive questions
- Virtual absence of missing data
- Method feasible and acceptable

Cons:

- High costs
- Not mobile

Palm™ - Assisted Self - Interview (PASI) PalmPhraya Study, 2002



4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration

Palm™ - Assisted Self - Interview

Objectives:

- Evaluate feasibility of PASI for collection of sensitive behavioral data
- Test whether PASI and ACASI give similar response rates to sensitive questions
- Test whether PASI gives higher response rates to sensitive questions than written questionnaire and face-to-face interview
- Assess completeness of self-reports by looking at biological markers of sensitive behaviors, e.g., smoking, drug use

Methods

Setting, subjects and time period:

- 1,283 15 to 21 year students attending vocational schools in Chiang Rai province were enrolled from November 4 to 15, 2002

Study design:

- Randomized cross-sectional and simultaneous administration of PASI, ACASI, self-administered questionnaire (SAQ) and face-to-face interview (INT)

Sensitive questions asked

- Drug use
- Sexual experience
- Contraceptive use
- Dietary behavior
- Suicide attempt and ideation

Table – Randomization of study subjects (N=1,283)

	Method				p <
	PASI %	ACASI %	SAQ %	INT %	
Male	50.3	49.5	51.3	48.6	NS
16-19 years	59.1	58.8	59.5	58.7	NS
Live with parents	66.2	68.9	67.5	65.6	NS
Parents married	77.7	77.5	78.1	74.8	NS
Income ≤7,000 B	63.1	55.4	57.2	59.7	NS

Table – Answers to sensitive questions

	Method			
	PASI ¹ %	ACASI %	SAQ %	INT ² %
Past 3 months:				
Drink and drive	63.7**	64.0	59.9	54.3**
Smoke	65.6*	62.8	61.2	74.3
Ever use methamphetamine	19.2*	24.0	20.5	21.1

¹Comparing PASI vs ACASI

²Comparing PASI vs INT

* p < .05
** p < .01
*** p < .001

Table - Answers to sensitive questions

	Method			
	PASI %	ACASI %	SAQ %	INT %
Ever sex contact	43.3	53.8	43.6	64.7***
Oral sex	37.3	42.9	35.9	13.2***
Sex intercourse Yesterday	58.5*	56.3	52.0	57.0
	11.3*	12.3	9.9	3.5***

4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration

Table - Answers to sensitive questions

	Method			
	PASI %	ACASI %	SAQ %	INT %
Sell sex	6.7***	5.5	7.7	0.9***
Buy sex	8.2***	7.1	3.5	2.5***
Ever sore or ulcer	6.7***	8.0	6.0	2.5**
Ever pregnant	11.0***	11.7	10.3	7.6

Results

Table – Laboratory results

	Method				Total n %
	PASI n %	ACASI n %	SAQ n %	INT n %	
ATS*	10 (3)	10 (3)	7 (2)	4 (1)	31 (2)
Cotinine	32 (10)	42 (13)	34 (11)	41 (13)	149 (12)

*ATS, amphetamine type substance

Prevalence of amphetamine type substance in urine and self-report of use in past 7 days

Selfreport	Urine		Total n (%)
	Yes n (%)	No n (%)	
Yes	17 (54.8)	38 (3.0)	55 (4.3)
No	14 (45.2)	1214 (97.0)	1228 (95.7)
Total	31 (2.4)	1252 (97.6)	1283 (100)

Disagreement between self-reports and lab results

Agreement Kappa .38

Kappa for self-report of amphetamine type substance use in past 7 days and urine test

Self-report	Urine		Total n	Kappa
	Yes n	No n		
PASI yes	6	12	18	.41
PASI no	4	306	310	
ACASI yes	6	19	25	.31
ACASI no	4	296	300	
SAQ yes	2	5	7	.27
SAQ no	5	301	306	
INT yes	3	2	5	--
INT no	1	311	312	

$\chi^2=3.3$; $p<0.34$

Prevalence of cotinine in urine and self-report of smoking today

Selfreport	Urine		Total n (%)
	Yes n (%)	No n (%)	
Yes	81 (54.4)	43 (3.8)	124 (4.3)
No	68 (45.6)	1091 (96.2)	1159 (95.7)
Total	149 (11.6)	1134 (88.4)	1283 (100)

Disagreement between self-reports and lab results

Agreement Kappa .55

Agreement between self-report of smoking (today) and cotinine urine test

Self-report	Urine test		Total n	Agreement Coefficient (Kappa)
	Yes n	No n		
Palm Yes	21	12	33	.61
Palm No	11	284	295	
ACASI Yes	28	8	36	.68
ACASI No	14	275	289	
Quest. Yes	20	19	39	.49
Quest. No	14	260	274	
Interview Yes	12	4	15	.38
Interview No	29	272	301	

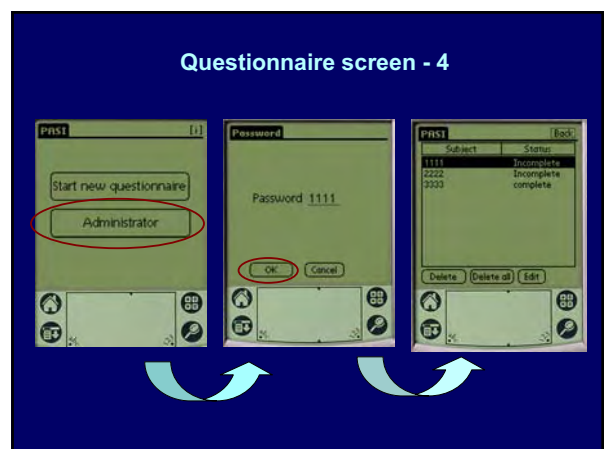
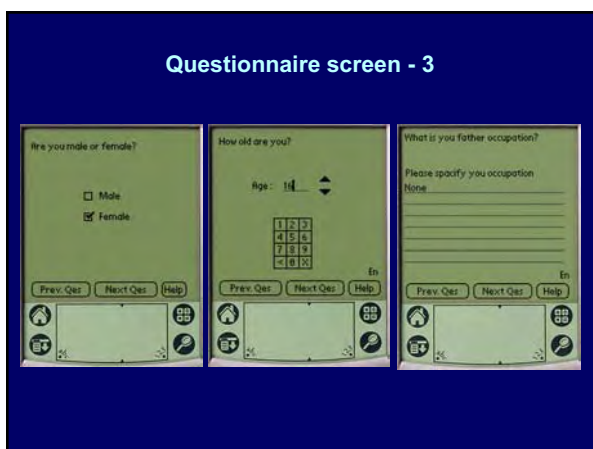
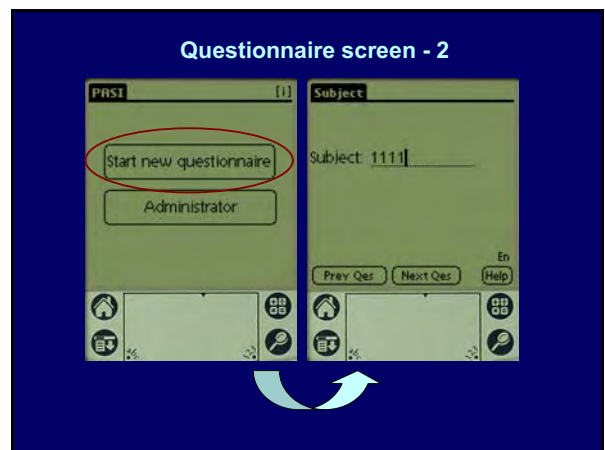
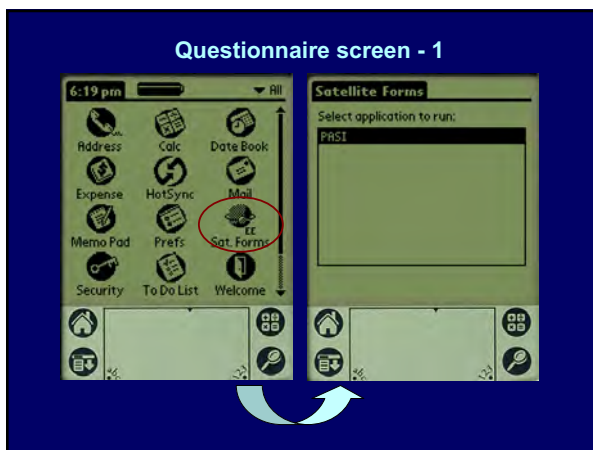
$\chi^2=9.7$; $p<0.02$

4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration

Palm™ - Assisted Self - Interview

- Palm™ M500, running PalmOS 4.0
- Thai language support via Thai Hack Software
- Data collection program developed with Satellite Forms
- IBM laptop with Access 2000 upload application using Palm™ Hotsync
- SPSS 11.0 for Windows for daily data monitoring



4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration

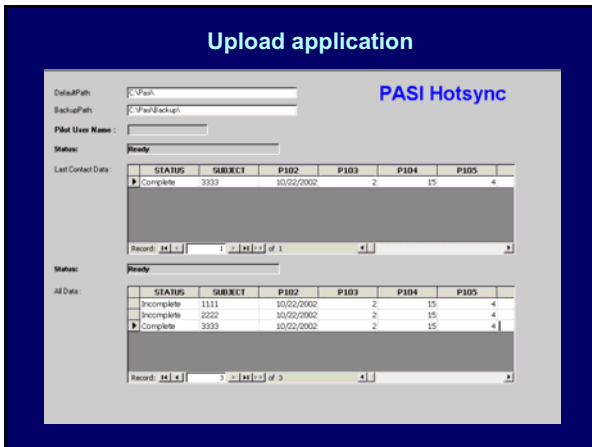


Table – Data quality (at least one instance)

	Method			
	PASI %	ACASI %	SAQ %	INT %
Incomplete or missing data (Data should be there, but not there)	0	0	64.5	9.8
Inconsistent data (Data should not be there, but there)	0	0.3	58.5	5.7
Either	0	0.3	79.9	13.6

Hardware costs: PASI vs. ACASI

PASI:

- \$100 per unit by 40
- \$1,500 for IBM Laptop

Total:\$5,500

ACASI:

- \$1,000 per unit by 40
- \$4,000 for Server
- \$500 other costs

Total:\$44,500

Conclusion - 1

Feasibility

- PASI can be applied for the collection of sensitive behavioral data

Answers to sensitive questions

- Response rates in PASI are not lower than in ACASI
- Response rates in PASI are higher than in interview

Data quality

- Completeness and consistency rates in PASI/ACASI are highest, SAQ is lowest

Conclusion - 2

PASI compared to ACASI:

- PASI is cheaper
- PASI is highly mobile

PASI compared to SAQ:

- PASI data are of higher quality
- PASI has no need for data entry
- PASI allows instant data collection monitoring

Other applications

- Men who have sex with men HIV prevalence survey in Bangkok
- Behavioral surveillance in youth by Thailand's Ministry of Public Health

4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration

Acknowledgements

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National Risk Behavioral Surveillance Among Youth

Using

“Palm™ Assisted Self-Interviewing (PASI)”

Thailand

National Risk Behavioral Surveillance (BSS) in Thailand, 1995-2003

- National BSS was first implemented in 1995 among 4 populations in 20 provinces
- In 1996, risk behavior surveys of grade 11 male and female students (age 15-19 years) were added
- Cross-sectional survey among 300-500 youth has been conducted annually
- Self administered questionnaire (SAQ) was used for data collection

Key Issues on National BSS among Youth in Thailand

- There has been growing concern among public health community about risk of HIV infection, other sexually transmitted diseases and pregnancy among youth in many provinces
- Increase monitoring of behavioral risk among youth to assess the impact of intervention programs
- More reliable data collection tool for BSS is needed

Program Goals

To strengthen behavioral surveillance among youth in order to obtain more reliable, consistent and sufficient information on risk behaviors by implementing PASI as a tool for data collection and extend the population to cover youth age 15-19 years in vocational school students

Program Objectives

1. To implement a national risk behavioral surveillance among vocational school students, age 15-19 years old, using PASI in 24 of 76 provinces of Thailand
2. To analyze and disseminate the results obtained from the system to public health authorities for program planning and improvement.
3. To assess barriers and find solutions related to the implementation of PASI in target provinces, and consider program revision and expansion in the future

4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration

Target Populations

- Second year vocational school students, age 15-19 years, selected by two stage clustered sampling
 - 24 provinces were randomly selected from 12 regions, 2 provinces each
 - Classrooms were randomly selected from all schools in all selected provinces
 - All students in selected classrooms will be interviewed
- Sample size was calculated based on previous data regarding percentage with sexual experiences

Site of Surveillance 24 provinces



Major Activities

Activity 1: Identify working Group

- Thailand Ministry of Public Health
 - Bureau of Epidemiology (BoE)
 - Bureau of Mental Health Development
 - Representative from Provincial Health Offices
- Ministry of Education
 - Bureau of Vocational Education
- Thailand MOPH-US CDC Collaboration (TUC)

Activity 2: Develop Surveillance Guideline and Data Collection Tools

Via several workshops, indicators and standard operational procedures for BSS among vocational school students using PASI were developed.



Activity 3: Develop Computer Software

PASI software was written using Satellite Forms (Pumatech Inc., California, USA) for application development.



4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/ US CDC Collaboration

Activity 4: Capacity Building on Implementation of the National BSS among Youth Using PASI



Training course on national BSS was provided to 150 responsible staff from all provinces on March 15-17, 2004

Introductory course on PASI-BSS implementation was provided to 50 responsible staff from 24 provinces on Mar 18-19, 2004



Training-of-trainer workshop on equipment operation was provided to 5 BoE staff who are responsible in training for local staff on May 3-4, 2004.



Training on SOP for PASI-BSS implementation was provided to responsible staff in 24 provinces in May, 2004



Activity 5: Data Collection

Data collection will be done in June - July 2004

Activity 6: Utilize BSS Data for Program Planning Intervention

1. Analyze and utilize the results obtained from the system by linking the high risk behaviors with the existing intervention programs and HIV prevalence reported from the existing serosurveillance
2. Disseminate and discuss the results from this survey with local health authorities and Director General of related Departments of MOPH for further intervention plans

4. Computer Assisted Self Interviewing

- Dr. Frits van Griensven, Chief, Behavioral Science Section, and team Ministry of Public Health/

Activity 6: Program Revision and Expansion

1. Develop M&E work plan to assess barriers and to find solutions of all steps of program implementation
2. By using M&E information, revise the 'PASI' guidelines and tools, and consider the implementation of the revised system for national BSS in other populations

Strengths and Program Expectation of PASI

Implementing PASI as a tool for data collection is expected to strengthen the national behavioral surveillance system among youth. strengths of PASI include:

- Specifically designed for BSS data collection
- Feasible to integrate into the existing system
- Reliable and consistent BSS results
- User-friendly database management system
- Quick feedback for program monitoring

Acknowledgement

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- Peerapon Ratana

Thank you for your attention...