



What Works for Children in South Asia
HIV/AIDS PREVENTION AMONG
YOUNG PEOPLE

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

What Works for Children in South Asia
HIV/AIDS PREVENTION AMONG
YOUNG PEOPLE

© The United Nations Children's Fund (UNICEF)
Regional Office for South Asia, 2004

For further information, please contact:

Regional Planning Officer
Planning, Monitoring and Evaluation Section
UNICEF Regional Office for South Asia
P.O. Box 5815, Lekhnath Marg
Kathmandu, Nepal
Tel: (+) 977 1 4417082
E-mail: rosa@unicef.org

Cover Photo: UNICEF
Design and Layout: Format Printing Press, Kathmandu, Nepal

Contents

Background	1
The Situation	2
What Works: Rationales, Principles and Approaches	6

Background

The prevalence of HIV/AIDS among young people in South Asia¹ continues to rise, despite an increasing awareness of the virus, knowledge of its prevention, care and support, and availability of resources. While this unfortunate state can be explained by the lag between the growth of the epidemic and the response to it, it is also due, in part, to the failure to act decisively and effectively with the knowledge and resources that are available.

The HIV/AIDS *body of knowledge* shows that the best prevention strategy is an *expanded response*: one that simultaneously reduces vulnerability, risk behaviour, and the impact of infection. Yet, despite its self-evident and logical nature, this response remains difficult to successfully implement. The UNICEF Regional Office for South Asia's (UNICEF ROSA) report, *Learning, Sharing to Action: HIV/AIDS prevention among young people in South Asia*, has attempted to understand and synthesize the challenges and lessons learned from the delivery of an *expanded response* in South Asia.²

Working with other UNAIDS co-sponsors, UNICEF identified a series of HIV/AIDS prevention projects for young people, which built awareness, developed life skills, provided services, and/or created a supportive environment, as well as promoted the rights of young people, confronted gender (and other forms of) inequality, and ensured the participation of young people, including those living with HIV/AIDS. Twenty-six projects were identified, of which eight, which met the above criteria most closely, and for which sufficient information was available, were developed into full case studies, and became the basis of *Learning, Sharing to Action*.

Ten-Step Strategy for the Way Forward

1. End the silence, stigma and shame
2. Provide young people with knowledge and information
3. Equip young people with life skills to put knowledge into practice
4. Ensure access to youth-friendly health services
5. Promote access to voluntary and confidential HIV counseling and testing
6. Promote the participation of young people
7. Engage young people who are living with HIV
8. Create safe and supportive environments
9. Reach out to young people most at risk
10. Strengthen partnerships, monitor progress

The Situation

Over the past decade, the prevalence of HIV/AIDS has grown in South Asia³ from negligible numbers up to an estimated 5 million people living with HIV/AIDS. Globally, South Asia is now home to 10% of all people living with HIV/AIDS⁴. Throughout the region, the disease is marked by concentrated epidemics among vulnerable groups, with a low prevalence in the wider population. If left unchecked, these could become generalised pandemics in parts of the region.

International experience has demonstrated that HIV/AIDS prevention can work, by delaying the onset of sexual activity, reducing risk behaviours, and promoting safer sex. Most importantly, it has shown that new infections can be prevented.

The challenges to developing an effective response in South Asia are many:

South Asian political, societal and religious leaders should become more engaged in providing the *leadership* needed to confront the pandemic.

South Asian civil society should develop the confidence to **mobilize and challenge** the leadership, public indifference, and socio-economic contributing factors to act.

The removal of *social and economic exclusion* of people marginalised by gender, age, ethnicity, language, sexuality and caste, fuels the pandemic, through discrimination, exploitation, migration, and conflict.

Selected Data on HIV/AIDS in South Asia

- Globally, India has the second highest number of people living with HIV/AIDS, after South Africa. In 2002, it was estimated to be between 3.82 and 4.58 million. Although the national prevalence remains low, five states now have generalised epidemics of over 1%.
- Only 65% of young people in Bangladesh have heard of HIV/AIDS. 90% of sex workers in central Bangladesh do not use condoms.
- 68% of injecting drug users and 17% of sex workers in Kathmandu, Nepal are living with HIV/AIDS. One in five Nepalis is sexually active before the age of fifteen.

A willingness to hold a *public and open dialogue* on the socio-economic roots of the epidemic. Failure to do so contributes to its spread, as does a reluctance to acknowledge adolescent sexuality, sex outside of marriage, addictions, HIV infection and sex between men. In South Asia “...sex is a theme that cannot be discussed publicly, individual choice for young adults in fundamental matters is strictly limited, and women’s ability to assert their rights and preferences, particularly when sexual issues are concerned, is illusory.”⁵ The dominant discourse that traditional South Asian cultures are a protection against HIV/AIDS has been proven tragically wrong.

Ensuring widespread correct knowledge of prevention and consistent practice of *safer behaviour*.

Increased *national capacity and means* for governments to be able to develop and manage effective and efficient HIV/AIDS programming.

Synopsis of Case Studies

School-Based Family Life Education and HIV/AIDS Prevention,

Maharashtra, India

Targeting secondary school students, teachers and teacher trainees, in Maharashtra State, this UNICEF-funded project was delivered by the *Sevadham Trust*. Using peer educators and teachers, *Family Life Education* and HIV/AIDS prevention was delivered in 1,754 secondary schools in 14 municipalities, as well as 96 teacher training colleges. An emphasis was placed on advocacy and social mobilisation to develop support for the project among communities and officials of the state Ministry of Education, particularly high-level decision makers.

“Chatting With My Best Friend”, Kathmandu, Nepal

Targeting young people between 12 and 19 years, this UNICEF-funded and managed project, delivered life skills-based education through a weekly “entertainment education” radio show to approximately 3,000,000 young listeners. *Chatting* supported a range of Information, Education and Communication (IEC) materials, over 500 listeners’ clubs, and a television drama, “*Catmandu*”, focused at urban young people. Efforts were invested in developing the young broadcasting professionals, as well as generating and supporting a dialogue between the show and its listeners, throughout Nepal.

Adolescent Peer Organised Network (APON), Dhaka, Bangladesh

Developed by the Bangladesh Rural Advancement Committee (BRAC), and funded by several donors, APON grew out of a larger effort to provide basic education to underprivileged children, mainly girls. APON strove to empower and develop the skills of girls, change traditional perceptions, develop peer support, and support continued education. Involving close to 200,000 girls in 58 regions, the project delivered life skills-based education on a range of issues, developed IEC materials, trained 5,000 peer educators, and through their *Delayed Marriage Scheme*, helped girls to complete their education by providing a grant. Other activities included livelihood training and micro-credit, as well as a small initiative to develop the life skills of boys. Social mobilisation was undertaken to convince parents of the value of girls participating in the project.

Mahila Samakhya, Bihar, India

Targeting women and girls, especially from scheduled castes and tribes, and other disadvantaged groups in rural areas, the project sought to educate and empower them. Operating in over 2,000 villages in eight districts, it assisted women’s groups to discuss issues, seek collective solutions and mobilise support; started saving and credit schemes and girls’ clubs; and, offered basic education and life skills to girls (9-15 years), early childhood education, and full-time residential higher-level education. A consortium of UNICEF, the World Bank, and the Governments of India and Bihar funded this project.

Working with Young People On Sexual & Reproductive Health, Kathmandu, Nepal

Working with young people, aged 13 to 24 years, in five districts, this European Union and UNFPA-supported project sought to increase young people's knowledge of sexual and reproductive health (SRH) and the utilisation of SRH services. The *Family Planning Association of Nepal (FPAN)* implemented this project through advocacy efforts at the community, district and national levels, as well as community mobilisation. It also invested in the creation of IEC materials, dealing with a range of life skills issues and the development of peer educators and teachers in the use of the IEC materials. In order to assist, the peer educators, 15 Youth Information Centres (YIC) were created, to allow young people to have a "safe" place to socialise and discuss issues. Health and counseling services were offered.

Young Star Club, Solukhumbu, Nepal

Targeting children and young people, this youth-led club, sought to promote their participation in the process of development, through community service. The Club engaged in a range of leadership training, non-formal education, community development, awareness ranging, health care, income generating, and recreation activities. A range of donors supported them. As a youth-led club with a commitment to participatory decision-making processes, members determine the priorities and activities of the Club, including HIV/AIDS.

Humsafar Trust, Mumbai, Maharashtra, India

Targeting Men having Sex with Men (MSM), including transgendered *hijiras*, the Humsafar Trust sought to motivate safer sex practices, provide STI services, provide a safe meeting place for MSMS, and develop a *continuum of care* model. This was achieved by advocating at state, municipal and local levels, to gain support for the Trust's work, despite MSMS' tenuous legal status. Efforts were also invested in ensuring that MSMS had access to services. Other activities included street outreach, a drop-in center, access to health and counseling services including VCT, STI treatment and referrals, and, on-going research into the target population. This work was supported through a range of donors and income generating activities.

Girl Child Shield Project, Islamabad, Pakistan

Working across Pakistan, through the *Pakistan Girl Guides Association (PGGA)*, this UNICEF and SDC-funded project, sought to improve the status of girls, through awareness raising, and building self-esteem, confidence, communication skills, and the ability to engage in community service. The project took a rights-based approach, and worked in over 800 schools. This was undertaken through gender-based awareness raising in the Facts of Life, Interpersonal Communication Skills, Child Rights, Education, Girl Child Issues, and Team Building. Efforts were invested in advocating for an increased role for girls in their families and communities, and also in the capacity and skills of Guides and adult staff.

What Works: Rationales, Principles and Approaches

In South Asia, a variety of HIV/AIDS prevention for young people programming rationales, principles and approaches have been used. This analysis of the eight case studies in *Learning, Sharing to Action*, reinforces an ongoing need to re-learn the value of principles like participation and advocacy, and specific approaches like peer education. It should be recognised that awareness, life skills, and health services, do not automatically lead to safer behaviour or fewer infections. Each rationale, principle and approach has limits, and what works well in one situation, will not necessarily work well in another. Sound programming depends upon accepting and adopting these lessons.

Programming Rationales and Principles:

The rationales for HIV/AIDS prevention projects that were reviewed varied considerably. While some were intended to increase general awareness and life skills, others targeted specific. Several projects focused on sexual health and HIV/AIDS prevention without ever specifically mentioning these as rationales or objectives. One reason for this was a concern that an explicit focus on “difficult” topics could create resistance. As such, the Humsafar Trust, accepting the tenuous legal status of Indian men who have sex with men, ensured that its documentation was suitably discreet. Similarly, the Sevadham Trust obeyed Indian laws forbidding in-school promotion of condoms. Another, more encouraging reason was that many projects took a holistic approach, accepting that sexuality was only a part of the development of young people. Unfortunately, few projects sought the views of young people prior to project design.

Project rationales generally recognised that young people lacked the awareness and life skills needed to make healthy life choices. This was attributed to the conservative nature of regional societies, lack of access to education, and low socio-economic status, all of which increase vulnerability to HIV/AIDS. What was less clearly articulated was how awareness, life skills, and youth-friendly health services, could overcome these basic inequities in the wider environment, to support safer behaviour.

This analysis has highlighted the importance of programming principles like positive social change, and evidence-based and results-focused programming, as well as advocacy, mobilisation and participation.

Positive Social Change: As the risk of HIV/AIDS is linked to vulnerability, the ability to confront social practices, which marginalise young people, and to promote *positive social change*, is critical. This change, however, threatens economic and social privilege like patriarchy and the caste system, and is difficult to achieve, given the pervasive nature of such negative social practices as prejudice and exclusion. In this context, the survival of the Humsafar Trust, which challenges the myth that homosexuality does not exist in South Asia, is a success, as are the existence of projects which promote the abilities of young people to take control of their own lives.

Many of the projects confronted social norms and broke down barriers. Projects like the Adolescent Peer Organised Network (APON), *Mahila Samakhya*, and the *Girl Child Shield Programme* reported that the girls and young women, who had received training, were more ambitious and confident. APON believes that it is possible to empower girls even in a conservative rural society. Young people, who had been involved with projects, were reported as better able to demand an increased share of resources, and to organise for both their own and their community's betterment. Given the social contexts of many young people in South Asia, especially young women, the act of developing them as leaders is revolutionary.

Despite these successes, positive social change remains a challenge for prevention programming. As discussed in a recent Panos Institute report: *"...there appears to be a growing consensus that focusing on risky behaviours of individuals is insufficient when not taking into account the social determinants and deep-seated inequalities driving epidemics."*⁶

The need to recognise the role of inequity in spreading HIV/AIDS, and to work for its end, does not mean that prevention work should cease until all inequities are addressed. However, projects often proceed without a *vulnerability analysis* of who is vulnerable to HIV/AIDS and why, and what aspects of the wider environment obstruct prevention efforts. For example, most school- and club-based delivery models for life skills-based education automatically excluded *young people who are not attending school, and are married, parents, working, or migrants*. A challenge for projects like the Family Planning Association of Nepal (FPAN), the Young Star Club, and the *Girl Child Shield Programme* is to move beyond educated, unmarried, sexually non-active, and relatively privileged young people, to those who are more vulnerable.

Social change for HIV/AIDS prevention must occur at both the macro and micro levels. At the macro level, civil society must be prepared to politicise the epidemic and promote an open and public dialogue on the factors underlying the

spread of the disease, like women's subservient status, criminalisation of MSM, and restrictions on services for young people. This raises an ethical challenge for programming, as a singular focus on awareness building and skills development, risks placing the entire responsibility for HIV/AIDS prevention on those most vulnerable and least empowered. At the micro level, projects should be vehicles for social change, by challenging cultural beliefs and practices through their work. APON and the Young Star Club do this for girls, by creating leadership opportunities, promoting education, combating child marriages, and elevating the status of girls within their communities.

Evidence-Based and Results-Focused: Successful HIV/AIDS prevention programming must be *evidence-based* and *results-focused*: understanding the target, their current and desired states, as well as expected results which are SMART⁷. Unfortunately, few projects undertake the *operational research* needed to develop *baseline data* or articulate *expected results*, against which progress can be measured. Without an understanding of the target, projects can come to realise, as FPAN did, that the young people whom were the intended target, were not those who were reached. The outcome is an inability to *monitor and evaluate* programming impacts, specifically safer behaviour, or to study the effectiveness of different approaches. However, it is also important to accept that this requires capacity and resources, which may not exist. Some projects, such as *Chatting*, were able to use existing research, such as UNICEF's *Knowledge, Attitude, Practices and Skills (KAPS)* studies. Humsafar innovatively used a community newspaper to gain insight into MSMs, and then with limited technical support, had their staff conduct a baseline study two years into the project. This survey was then repeated two years later.

The challenge is to create the discipline that operational research, baseline data, and monitoring and evaluation frameworks bring, in order to plan for and demonstrate meaningful results. Given that all South Asian countries have committed themselves to the UNGASS Declaration, including reporting against agreed indicators, there is an opportunity for all prevention work to measure progress using *UNGASS indicators*⁸.

Advocacy and Social Mobilisation: Given the sensitivities surrounding HIV/AIDS programming, there is an accepted need to consciously and continuously build stakeholder support. To this end, most projects supported *advocacy* and *social mobilisation* activities, customising them to various stakeholders. To overcome parental opposition, APON went door-to-door, from the project's beginning, explaining the benefits of their work (i.e. literacy, livelihood skills), as well as committing to monthly parent meetings. Likewise, FPAN engaged in a large initial advocacy and mobilisation effort to win the support of parents,

communities, and local and district officials. In the case of the school-based *Family Life Education and HIV/AIDS Prevention Programme*, Sevadham worked discreetly with communities, school officials, and government decision-makers, in order to dispel misconceptions, diffuse tensions, and create ownership. Humsafar built support for MSM services with city and state officials, including the police. Many projects planned for ongoing advocacy and mobilisation, acknowledging that stakeholders change.

Parents were often the focus of mobilisation efforts, particularly when projects involved their daughters. Community-level mobilisation was a form of awareness raising, convincing parents of the importance of HIV/AIDS prevention for themselves and their children. Humsafar developed advocacy efforts for community police and business owners, to allow their outreach workers to work unobstructed in MSM *cruising areas*. They also worked to reduce the prejudices of Mumbai hospital staff, to improve the access of MSM to health services. Sevadham and FPAN built ownership for their activities among local and state authorities. The result for Sevadham was the Ministry of Education integrated the *Family Life Education* curriculum into teacher training and took over management of the entire programme. The result for FPAN was that local Village Development Committees agreed to operate nine of the project's thirteen Youth Information Centres.

Different interventions were needed for different stakeholders, ranging from community awareness campaigns to personal lobbying of high-level officials. Such advocacy and mobilisation had one goal: to identify those stakeholders who could hinder and/or help the project, and develop their support. As both the Sevadham and Humsafar Trusts realised, such support did not need to be

Some Youth-Relevant UNGASS Indicators

Indicators of Commitment and Action:

- National Policy Composite Index (partial relevance)

Indicators of Programming and Behaviour:

- % of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who have taught it during the last academic year.
- % of young people (15-24 years) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- % of young people (15-24 years) reporting the use of a condom during sexual intercourse with a non-regular sexual partner

Indicators of Impact:

- % of young people (15-24 years) who are HIV-infected.

formal. In the case of Sevadham, the Maharashtra Ministry of Education permitted the school-based *Family Life Skills and HIV/AIDS Prevention Programme* to operate without formal approval. Sevadham was able to do this because of the support it had built at the community, school, and Ministry levels; and because it adhered to the ban on the promotion of condoms within schools. In the case of Humsafar, they were able to work with government officials, including the police, despite the uncertain legal status of MSMs. They achieved this by educating officials on the public health need for their services, and by maintaining a high professional standard.

Although advocacy and mobilisation are critical for programming success, and something, which was generally done well, the need to promote positive social change, creates new challenges. If socio-economic practices create the vulnerabilities, which drive the epidemic, there is a corresponding need for prevention projects to advocate and mobilise for social change. This means raising issues, which are difficult for public discourse, such as sex outside marriage, pre-marital sex, addictions, and sex between men, as well as promoting action to confront inequities.

Participation: The *participation* of young people and *youth ownership* were explicit programming approaches in many projects, though practices varied greatly, ranging from total youth control, to more limited roles. Most projects involved young people in the design and delivery of specific activities, but not in management. The absence of monitoring and evaluation frameworks, limited the opportunities for participatory assessments. Only the Young Star Club could claim *accountability to youth* for programming decisions and results achievement.

Chatting with My Best Friend is an example of an innovative approach to overcoming the participatory limitations of a radio show. Through the use of listener feedback, a commitment to personalised responses to all letter writers, and the development of listeners' clubs, *Chatting* has remained responsive to its listeners. It has also worked hard to overcome the one-way format of broadcasting, entering into a genuine dialogue with its listeners. In 2001, there were over 500 self-initiated listeners' clubs in 61 of Nepal's 75 districts. Participation in these clubs is an important step in supporting healthy behaviour through interpersonal discussions and positive peer influence.

As a youth-owned community group, the Young Star Club promotes young people as community development champions, a role enhanced through *partnerships* with other community groups, national and international non-governmental organisations, and government agencies. All Club priorities,

including HIV/AIDS, were determined by the members, and not by external groups or agendas. Of particular note, is the Club's commitment to the capacity building of all members, including girls, through training and leadership opportunities. The Club's principled tolerance for failure, allows young people to assume leadership roles and learn from the process. The Club also recognises that participatory action is time-consuming, and must be learned. It has chosen to remain a voluntary organisation, without paid staff.

Like the Young Star Club, Humsafar is deeply rooted in its community, with all staff and volunteers being MSMs or *hijira* (transgendered). Strong ethical and moral standards, high quality training for all volunteers and staff, and, a commitment to self-analysis, self-criticism, and participation, support community ownership.

As with donor-funded programming in other sectors, there is a tension between participatory approaches and accountability for funding. This tension will remain unavoidable, so long as prevention programming is externally resourced. There is also tension between participatory methods, which are time-consuming, and the urgent need to respond decisively to HIV/AIDS.

It can also be problematic, if donors and their implementing partners view youth groups as *instruments* for project implementation, and not "member-owned". Some thought should also be given to the ethics of establishing local groups of young people for the purpose of implementing an externally driven agenda. The Young Star Club is a model of sustainable youth involvement and ownership for the Solokhumbu, even if its organic and local nature, youth-ownership, and commitment to volunteerism is a challenge to the implementation preferences and replication/expansion desires of external agencies. There is no guarantee that this programming model would work elsewhere, and the preferred strategy, where possible, should be to build awareness and mainstream HIV/AIDS prevention into existing and viable youth groups.

Programming Approaches:

This analysis has highlighted the role and importance of several programming interventions, including life skills-based education, peer education, and youth-friendly health services. Many interventions achieved significant gains in developing awareness of HIV/AIDS, its transmission, and the means to prevention, as well as building the skills needed by young people to make informed choices. Many provided impressive coverage with a low *per person*

cost. Sevadham covered 1764 schools in Maharashtra and offered teacher training at IR12 per student teacher. *Chatting* reaches an estimated weekly audience of 3,000,000, at US\$0.025 per listener. APON has trained 200,000 girls, while the *Mahila Samakhya Programme* believes that it has contributed to rising female literacy in Bihar. In addition to these delivery successes, there were also important lessons on the design and delivery of interventions.

Life Skills-Based Education: Many of projects referred to the blend of awareness building and skills development, required to prevent HIV/AIDS, as *Life Skills-Based Education*. This describes a set of personal and interpersonal skills, which help people, make informed decisions, solve problems, and communicate effectively. This comes from recognition that preventing HIV/AIDS requires more than building awareness of the virus and the means to avoid it.

Life skills-based education has been adapted to a variety of environments, including in-school and out-of-school activities, and where necessary, made *age-appropriate*, as young people need to be taught about HIV/AIDS prior to puberty. This is a challenge for both the Sevadham and Humsafar Trusts, which are forbidden from providing sexual health information to young people. Potential parental and community opposition to children receiving HIV/AIDS prevention messages, is another challenge, and is usually managed through advocacy, stressing that knowledge does not encourage sexual activity.

The successful implementation of life skills-based education is often attributed, in part, to advocacy, social mobilisation, and ownership, which developed stakeholder support. It also depended upon building implementation capacity, whether for peer educators or teachers, young people or adults, volunteers or paid staff. It also required high quality, accurate, and comprehensive *Education, Information and Communication (IEC)* tools. Other lessons were that sexual health should only be a component of the overall curricula, and that the emphasis should be on general life skills; for out-of-school programmes: literacy. There were also perceived benefits to separating the sexes (FPAN), and girls from women (*Mahila Samakhya*).

Mahila Samakhya found that it needed a range of education options for girls and young women, both married and unmarried. Literacy classes for girls and women had to be separated, as the girls tended to learn quicker and discourage the older women. There was also a need for a residential programme, which combined literacy, basic education, and life skills, with leadership training. *Mahila Samakhya*, like APON and the Young Star Club, stressed the importance of girls' literacy, as a means to develop life skills.

With mass media efforts like *Chatting with My Best Friend*, there appear to be opportunities to better link radio to existing local life skills-based education. This is an issue of coordination, and should be considered by donors and governments.

Life skills-based education remains the current model for building awareness and developing the skills needed to make informed and healthy decisions. As previously mentioned, its efficacy is limited by the degree of inequity in the wider environment. Clearly, many South Asian societies value neither sexual knowledge, nor independence of spirit, among girls and young women. So long as social norms dictate that it is preferable to be both sexually ignorant and subservient, girls and women will continue to be vulnerable to HIV/AIDS. As such, the delivery of life skills-based education should be placed in the context of a wider social struggle to confront inequities, and develop specific activities to promote positive social change, at the level of the project. Again, APON provides examples of local interventions, which confronted the socially proscribed role of women.

A final thought on life skills-based education is that most projects treated sex as primarily a public health issue – unavoidable, unpleasant and possibly risky. Only FPAN discussed sex in terms of human development and pleasure. While this issue is sensitive and needs to be age-appropriate, an inability to talk honestly and openly about sexuality, reduces the effectiveness of life skills-based education.

Peer Education: A popular programming approach is *peer education* because of its cost-effective and efficient nature, and its ability to engage young people in difficult issues, such as HIV/AIDS. It is also a commitment to participation, through the use of young people in project delivery. Girls involved in APON spoke of the effectiveness of peer education for sensitive topics. With Sevadham, peer educators were expected to deliver *Family Life Education*, including HIV/AIDS, both within the class and on an informal one-on-one basis. In the cases of APON, FPAN and *Mahila Samakhya* in Bihar, peer educators worked outside of school. In these three interventions, it appeared important for the programme to develop both *formal groups* and “*safe places*” for young people, specifically girls and young women, to meet and discuss issues. *Chatting* promoted listeners’ clubs as a place to listen to, and discuss the show’s “embarrassing issues”, away from their families.

Most projects placed a heavy emphasis on the selection, training, support and supervision of peer educators, and noted with satisfaction that they were a concrete project legacy, capable of supporting communities for years to come. It

was also important for some projects to develop peer educators, particularly girls, as leaders. Several of the projects invested heavily in *training adults and older young people to provide support and supervision* to the peer educators. Sevadham was able to get the *Family Life Education* curriculum integrated into Maharashtra's teacher training, ensuring in-school support for peer educators. *Mahila Samakhya* mothers' clubs were unique in that they chose a group member to be trained as their leader and peer educator. A critical part of implementing peer education was the development of IEC tools, for use by peer educators.

Various projects adopted different positions on the issue of compensation for peer educators. In the case of the Sevadham Trust, FPAN, and the *Girl Child Shield Programme*, volunteers were used. With APON and Humsafar, honorariums were paid. These payments were justified as necessary to recognise contributions and create loyalty. In the case of APON, the honorarium gave female peer educators status within their families and communities. APON also noted that it was important for the organisation to formally introduce peer educators to the community, in order to ensure their acceptance and respect.

Peer educators, properly trained, supported and supervised, are an excellent way to deliver life skills-based education. Assessments reiterate that young people would rather discuss sensitive issues with a peer than an adult, such as a teacher or counselor. However, given the privileged backgrounds of many peer educators, there is a need to confirm the ability of peer educators to meet with more vulnerable and less-privileged young people as equals. There also appears to be a lack of self-reflection in the training of most peer educators and their adult leaders. Peer education will only be successful if delivered in a non-judgmental manner, by young people aware of their own biases and preferences. Some projects have identified a high turnover of peer educators as an ongoing challenge, and one that can only be managed by continuous development of new peer educators. A final concern is the tendency of many projects to view their peer educators as the goal of their project, as opposed to the means through which awareness and skills are disseminated to a wider audience. Peer education is a tool and not a measure of programming success.

Youth-Friendly Health Services: If young people are to avoid HIV/AIDS, awareness and skills are not enough: they must also consistently practice safer behaviour. For those who are sexually active, there is a need for *youth-friendly health services*, including access to condoms, voluntary and confidential counseling and testing (VCT), and care for sexually transmitted infections (STI). Experience indicates that if such services are to be successful, they must focus on general health, not just sexual health, and provide accessible, affordable and discrete care.

Two examples of health service delivery were FPAN and Humsafar. FPAN distributed condoms, and offered counseling, clinical services, and laboratory testing for HIV/STIs. Humsafar established an integrated outreach, in-house clinical/counseling and referral system, providing a *continuum of care*. FPAN's services were generally underutilised, though the anonymous condom provision was successful. This underutilisation was attributed to the targeting of non-sexually active youth, as well as the challenge of trying to encourage young people to access sexual health services in smaller communities. With Humsafar, the general openness of MSM culture, towards matters of sexuality, may have facilitated more care seeking behaviours, as did its deep knowledge of its clientele and its anonymous urban setting. Both FPAN and Humsafar believed that services had to be delivered in a discrete, accessible and "safe" manner.

The provision of health services can be difficult, as the restrictions placed upon Sevadham and Humsafar showed. South Asia, like much of the world, remains trapped by cultural myths concerning sexuality; primarily, that sex does not occur before or outside of marriage. As stated in the UNAIDS 2002 annual report *"While it is difficult for many adults to admit, large numbers of young people begin sexual activity at a relatively early age, are sexually active before marriage, are not monogamous, and do not use condoms regularly enough to ensure protection."*⁹

To be fair, there may be sound programming reasons to not provide some services to young people, including community and official opposition, and a lack of capacity and resources. What is striking, however, is that most of the projects that did not offer services, also did not offer information or referrals to existing services.

Future challenges to service provision include a limited supply and a growing demand for services, fueled by a growing awareness of HIV/AIDS. Meeting this demand will require considerable investment, and prevention projects can no longer assume that someone else will provide the services, for which their programming is creating a demand. Increasing requests for condoms, VCT, and the STI treatment by young people is a logical and desirable programming outcome, for which projects should be prepared. If services are to be developed, there is also a need for operational research on why young people seek health services, the services they need, and the delivery models they prefer.

Finally, service delivery presents two ethical challenges. The first is how to provide health and counseling services to young people who may be legally forbidden from receiving them because of their age. This limitation has

potentially lethal consequences for sexually active young people and must be confronted. The second ethical challenge is the issue of *partner notification*. One of the expanding areas of new HIV/AIDS cases in South Asia is of wives infected by their husbands, who are having sex outside of marriage, often as MSM or as clients of sex workers. This is a particularly large risk for the wives of migrant males. Given the overall low status of women and their subservient status within marriage, as well as the stigma that comes with HIV infection, it has been difficult for wives to protect themselves and for husbands who are living with HIV/AIDS, to inform their wives of their sero-status, as well as to take preventative measures.

Income Generation and Skills Training: Given that the socio-economic vulnerability of young people; particularly those marginalised by gender, ethnicity, language, sexuality or caste, is recognised as a cause of the conditions that put young people at risk of HIV/AIDS, surprisingly few projects focused on *income generating activities* and *livelihood skills training*. Both APON and the Young Star Club had attempted such activities. In the case of the Young Star Club, it was decided that the benefits of such activities did not justify their costs, and they were discontinued. With APON, the case study indicated that young women were being trained for employment that did not exist. Since then, APON has committed itself to market studies and developing training accordingly. *Mahila Samakhya* has assisted its mothers' clubs to start saving and credit facilities.

These activities should be a concern for projects seeking to improve the status of vulnerable young people; however, they are not strictly HIV/AIDS prevention approaches. Rather, they traditionally fall within the sphere of community development. It would be preferable to mainstream HIV/AIDS into existing or future community development activities, rather than the reverse. One option, open to groups like APON, is to draw on the income generating activities and livelihood skills training experience of parent or partner organisations. In their case: BRAC.

Other Innovations: Beyond these generic, and for the most part, known approaches, there were also several interesting innovations. *Chatting with My Best Friend* developed a TV serial named "Catmandu", focusing on the challenges facing urban youth, including drug and alcohol use. APON started an initiative for boys, to build their awareness of HIV/AIDS and gender issues. APON also developed the *Delayed Marriage Scheme*, which gave girls a small grant to complete secondary school, in return for a promise to not marry before their 18th birthday. *Sevatham* and the *Girl Child Shield Project* encouraged their peer educators to take their skills beyond schools, and into the wider community.

Moving Forward:

This analysis has reinforced several “truths” about HIV/AIDS prevention programming in South Asia. The first is that prevention is irrelevant without concomitant efforts to effect the broader *positive social changes* necessary to make young people less vulnerable to HIV/AIDS. The second is that programming must move beyond developing *awareness* and *life skills*, to providing access to *youth-friendly health services* and then, to promoting *safer behaviours*, accepting that there is no simple linear relationship between awareness, skills, service provision and behaviour. If *prevention* programming is to *prevent* the spread of HIV/AIDS, it is into these difficult areas of societal and individual behaviour change that programming must go.

Other conclusions, which could be drawn from UNICEF ROSA's *Learning, Sharing to Action*, were that programming needs to be *evidence-based* (including *vulnerability analysis*) and *results-focused*, if they are to know where they began, where they are going, and if they ever arrived. If well integrated, *advocacy*, *social mobilisation*, and *participation*, can be sound programming principles. *Age appropriate life skills-based education* and *peer education* are the primary means by which HIV/AIDS prevention programming can be undertaken. In the future, more effort is required to cover *vulnerable young people*, including working, migrant and out-of-school young people, those who are already married or are parents, and those marginalised by gender, ethnicity, language, sexuality or caste.

However, reaching less vulnerable (and possibly more privileged) young people should not necessarily be viewed as a programming failure. Indeed, given the socio-economic constraints that restrict access to many young people, and the success of peer education, there could be an expanded role for these peer educators, reaching beyond their schools and groups, to those who are more vulnerable. Such an expansion would require a parallel growth of supervision and support. Sevadham, Young Star Club, and the *Girl Child Shield Programme* have each expressed a desire to use peer educators in the wider community.

When the vulnerability of girls and women is discussed, it is usually related to particular vulnerabilities and rarely to gender relations, specifically, the behaviour of men towards women. This further strengthens the argument that awareness, life skills and health services are not enough, if broader social and economic factors afford women no power over their sexual relations: “*In the vast hinterland of AIDS-awareness the relationship between men and women, boys and girls, is often overlooked, and yet in the end only equality will defeat the virus.*”¹⁰

The reality is that women, outside of particular high-risk groups, are most at risk of HIV infection from their husbands. If prevention programming is to be successful in this area, awareness and skills must be augmented with broader efforts to empower girls and women in their choices, and to change gender relations. APON has already started to work with boys. Many other programmes, included boys in their life skills-building activities. The *Girl Child Shield Project* has proposed specific skills building for boys as a possible future programming area. Additionally, as already mentioned, *young married people should be a special focus of prevention programming*, particularly those where the men are migrant labourers.

Any *expanded response* to HIV/AIDS prevention must involve *young people who are living with HIV/AIDS*. The ending of stigma and discrimination against those with HIV/AIDS is recognised as a prevention activity, as people who can live openly with HIV/AIDS are more likely to seek medical help and to practice safer sex. Likewise, youth-friendly health services must offer a *continuum of care* for those young people who are infected, including access to *prevention of mother to child transmission* interventions, to reduce the possibility of young mothers infecting newborn children.

Though many projects discussed their *replication* and *expansion* (“*scaling-up*”) potential, few have moved forward with this. One example of a systematic “*scaling-up*” is Sevadham, which moved quickly from a pilot to state wide coverage of Maharashtra. This was planned from the beginning of the project, indicating considerable faith and/or experience on the part of Sevadham, and the funder, UNICEF, in the strength of Sevadham and the implementation model. *Mahila Samakhya* also successfully expanded its existing activities to increase the breadth of their coverage, while *Chatting* created new activities, in order to increase the depth of their coverage.

There are limits, to which any project can be expected to expand or replicate itself. In the case of the Young Star Club, there are limits to what a voluntary organisation, with a general community development mandate, can do to prevent the spread of HIV/AIDS. There are also questions about whether a community-driven response to HIV/AIDS is replicable, given that what works well in one community, will not necessarily work well in another: there is no one way to mobilise a community. Implementing and funding agencies should be careful about extracting principles and operating methods from one successful project for application elsewhere. There is also an ethical dimension: funders should not weaken the legitimacy or effectiveness of community groups for an externally driven purpose.

Earlier in this analysis, the danger of awareness building and skills development programming creating increased demands for health services that did not yet exist was discussed. Growing demands for services such as condoms and VCT, which are not met, could mean wasted prevention efforts. Every awareness building and skill activity (with the exception of mass media) should give careful consideration to the expansion of youth-friendly health services, before moving elsewhere to replicate more awareness and skills, resulting in more unmet demands for services.

An analysis of programming *sustainability* quickly reveals that no intervention funded by a donor is sustainable unless (1) it involves a community-based organisation with deep roots in that community, a base of volunteers, and a range of funding sources, such as Humsafar and the Young Star Club; (2) a government or local body is willing to assume responsibility for the programming, as the Maharashtra Ministry of Education did with Sevadham's *Family Life Education and HIV Prevention Programme*; or, (3) there is commercial potential, as with the radio show, *Chatting with My Best Friend*, with its 3,000,000 listeners. If sustainability is defined as adaptability, flexibility and responsiveness, organisations like the Young Star Club and Humsafar, given their service-orientation, funding diversity, large pools of volunteer labour, and freedom from the controls imposed by large donor funds, can respond effectively to emerging needs. Given their local and autonomous nature, they can also initiate programming with minimal external processes and limited funding.

A final thought is that the official bodies responsible for planning and coordinating the national responses to HIV/AIDS were notable in their absence from the descriptions of many prevention programmes. There may be a need to better *communicate and coordinate with National HIV/AIDS Control Programmes*, in order to ensure the effective and efficient use of resources, and the sustainability of programming.

Endnote

- ¹ The effort to better understand this challenge culminated in 2003, with the South Asia High Level Conference: *Accelerating the Momentum in the Fight Against HIV/AIDS in South Asia*, and the release of *Learning, Sharing to Action*. See also, *Accelerating the Momentum in the Fight Against HIV/AIDS in South Asia: Overview Paper*, UNICEF ROSA and UNAIDS: Kathmandu, 2003, Pp. 2-3.
- ² *Learning, Sharing to Action*, UNICEF(ROSA):Kathmandu, 2003, Pp.20.
- ³ South Asia refers to Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.
- ⁴ All figures in this section are from the 2002 and 2003 editions of the UNAIDS and WHO's *AIDS Epidemic Update* (UNAIDS and WHO: Geneva). Pakistan data is from UNAIDS/WHO,
- ⁵ Gupta, P., *States of Denial: AIDS and South Asia, Himal South Asia*: Kathmandu, Vol 16, No 3, March 2003, Pp. iii.
- ⁶ *Missing the Message? 20 years of learning from HIV/AIDS*, The Panos Institute, London, 2003, Pp.19.
- ⁷ SMART = Specific, Measurable, Achievable, Relevant, and Time-Bound
- ⁸ *United Nations General Assembly Special Session: Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators*, UNAIDS: Geneva, 2002.
- ⁹ *Report on the Global HIV/AIDS Epidemic 2002*, UNAIDS: Geneva, 2003, Pp.70-71.
- ¹⁰ Revill, J., *Aids prevention is about attitude not prophylactics*, *Guardian Weekly*: London, Vol 170, No 11, March 4-10, 2004, Pp. 18.

United Nations Children's Fund
Regional Office for South Asia
P. O. Box 5815
Lekhnath Marg
Kathmandu, Nepal

Telephone: 977-1-4417082
Facsimile 977-1-4418466 / 4419479
www.unicef.org