Profiles in equity

Better practices for women, children and AIDS

In everything we do, the most disadvantaged children and the countries in greatest need have priority.

– adapted from the UNICEF Mission Statement
The original contributions from UNICEF staff are gratefully acknowledged:
Wing-Sie Cheng, Novia Condell, Khin Cho Win Htin, Aboubacar Kampo, Robert Gass, Shirley Mark Prabhu, Olena Sakovych, Annie Sampa-Kamwendo, Ye Yu Shwe, Alireza Tajlili, Alemach Teklehaimanot, Lori Thorell, Sonia Trikha, and Najin Yasrebi

Editors:
Ken Legins, Rekha Viswanathan and Carole Leach-Lemens

Technical Reviewers:
Mita Gupta & Rinko Kinoshita

Our sincere thanks to all of those noted here, and to the partners that have made the programme practices described in this publication a reality alongside UNICEF. They are part of a collective effort by national governments, non-governmental organizations, international partners, communities and individuals who are working to make the world a more equitable place for boys and girls, young men and young women, and their families.

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Introduction

Reaching the most disadvantaged and vulnerable children is central to UNICEF’s mission and lies at the heart of the “Children and AIDS” response. At the onset of the epidemic, children were the missing face of AIDS; but today, we can say children are front and centre because of UNICEF and our partners’ efforts to implement a more equitable global AIDS response.

However, significant challenges remain in narrowing the gap between beneficiaries and those still missing from the AIDS response. We know children receive life-saving HIV drugs at lower rates than adults; adolescents are less likely to know their HIV status than adults; young people who practice high risk behaviours are less likely than adults to have access to evidence-informed HIV prevention interventions; many pregnant women still lack access to quality maternal, HIV and reproductive health services to prevent vertical transmission of HIV and prolong their own lives; and girls, especially in high burden countries, are more likely to become infected with HIV at an earlier age than boys.

Ensuring an equitable children and AIDS response will require UNICEF and our partners to answer ‘who is missing out?’ and ‘which evidence-informed actions can be implemented to achieve HIV outcomes with equity?’ We have learned over the last 30 years that geography, gender, wealth, age, ethnicity, and social norms that blame and banish individuals who practice high risk behaviours lead to inequities in the AIDS response. We have also gained knowledge of ‘what works’ to prevent new infections, care for those living with HIV and mitigate the impact of the epidemic on families and communities.

Gender and poverty are the themes that underpin many of the determinants of inequity within the AIDS response – and are some of the most reliable determinants of inequity across many measures of health and development. This publication aims to detail a few good practices which address gender and other drivers of inequity, leading to improved results for women and children.
This map offers a snapshot of UNICEF and our partners’ interventions which impact on the lives of women, girls, men and boys. They range in discipline from policy development, data collection, programme implementation, advocacy to evaluation. It is our hope these examples will support our efforts to focus UNICEF and our partners’ work on defining under-served populations and scaling-up evidence-informed interventions to promote equitable access and coverage of quality interventions.

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Profiles in equity

Zambia

“I feel protected and cared for,” notes Samantha [her name has been changed for this article], a young woman of 15 who is just remembering those feelings again. She is a client of a One Stop Center for survivors of sexual abuse, where she receives emotional and medical support to cope with and overcome her experiences. “I am happy to have come here because the staff members at the centre have taught me how to protect myself from further abuse and from contracting HIV and AIDS.”

After Samantha’s mother reported her daughter’s case to the Victim Support Unit, she was referred to the local One Stop Center at the University Training Hospital in Lusaka, the capital of Zambia, where Samantha received medical and counselling services. Samantha, who says she could not forgive herself because she felt that it was her fault, narrates, “the counsellors know how to talk to children and help them understand the issues they are facing.”

“I am really happy with the service and would wish to recommend that the Government open more of these centres as survivors will benefit a lot,” adds Samantha’s mother.

Samantha is one of about 8,500 people that have made use of OSC services in 2008 and 2009.
Support, treatment and justice for survivors of relationship violence

Good Practice: At A Glance

Issue:
More than half of Zambian women and girls (53%) report having experienced beatings or physical mistreatment since the age of 15. Evidence suggests that physical, sexual, economic or psychological harm to women and girls, within the context of intimate partner relationships, is prevalent.

Action:
10 ‘One Stop Centers’ (OSCs) that offer a coordinated response for HIV post-exposure prophylaxis (PEP), care, psychosocial and legal support to survivors of violence were established in 2008 in seven districts, home to approximately four million people. 300 Child Rights Clubs (CRCs) situated in all 9 provinces of Zambia raised awareness about gender-based violence and the presence of the One-Stop Centers through drama and community outreach.

Costs:
Approximately USD 178,000 are spent to run one OSC each year. Volunteers are deployed in the field as well as for counselling and legal support.

Partners:
UNICEF; A Safer Zambia Consortium of organizations (ASAZA): Care Zambia, World Vision, International Justice Mission, Young Women’s Christian Association (YWCA) and the Ministry of Home Affairs; the Ministry of Community Development and Social Services, Gender in Development Division; UNFPA; and the Population Council.

Results:
About 8,500 survivors received services from the OSCs between 2008 and 2009, of which 60% were children. 100% of victims of sexual violence were tested for HIV. For those testing positive, they were either referred to care and/or put on antiretroviral medications. Those testing negative were given PEP. In the districts of Ndola, Mazabuka, Livingstone, Mansa and Kasama, approximately 9,750 students in twenty five schools, and about 16,000 community members were reached by community outreach and awareness-raising activities conducted by the Child Rights Clubs.

Lessons Learned:
Political leadership was key to the implementation and spread of One Stop Centers from one site to multiple sites. Building on existing services and infrastructure proved to reduce costs. Demand creation must be accompanied by adequate supply of facilities and services: too few shelters for survivors of violence were available to women and their families. Continued efforts are needed to better monitor and evaluate the impact of OSC on changing perpetrators behaviors, so the OSC is not only addressing the symptoms of the problem, but the causes.

Next Steps:
OSCs will be opened in five more districts, and will be accompanied by increased advocacy for the passage of anti-domestic violence legislation.
Good Practice

Issue:
More than half of Zambian women and girls (53%) report having experienced beatings or physical mistreatment since the age of 15, according to the Zambia Demographic and Health Survey 2001-2002. Physical, sexual, economic or psychological harm are inflicted within places that are otherwise considered sanctuaries— the home, community, school, work and within care and justice systems.

Early in his presidency, former Zambian President Levy Patrick Mwanawasa and First Lady Mrs. Maureen Mwanawasa spearheaded a campaign to raise the profile of gender-based violence and sexual violence in particular. The penal code was amended in 2005 to strengthen laws against sexual offenders. The minimum sentence for defilement (rape) is now 15 years and the maximum is life imprisonment.

A gender-based violence (GBV) partnership, under the helm of the Gender in Development Division has since emerged.

Action:
One Stop Centers (OSCs) were established following the Presidential Campaign. The OSCs deliver a coordinated response to the varied needs of women and children who experience abuse.

Zambia has now established ten OSCs in seven districts, including three in Lusaka. These districts are home to approximately four million people. Three OSCs are housed within health centres, while the remainder are community-based. With the support of UNICEF, training and sensitization of over 895 social workers, prosecutors, medical staff, Victim Support Unit officers, commanding officers, magistrates, and judges also took place between 2008 and 2009.

The model applies a multi-sectoral approach to service-delivery: The client is counseled upon arrival. A full medical examination is offered, including HIV, STI and pregnancy testing, depending on the age of the survivor. Upon receiving HIV-negative results, administration of post-exposure prophylaxis is recommended and sexually transmitted infection prevention measures are provided. Upon receiving HIV-positive results, immediate counseling is begun and a referral is made for long-term counseling to a non-governmental organization, faith-based organization, or community-based organization. Within the health facility-based centres, when treatment is required, a survivor is started on medication on-site, and initiated on a programme for monitoring adherence. Survivors who receive services from community-based centers are referred for treatment off-site.

Legal and criminal justice support are an integral part of the service package. The survivor is encouraged to meet with an on-site police officer from the Victim Support Unit who takes the survivor’s statement and follows up.

Referrals to organizations with ‘safe spaces’ are made through the social protection system.
The overall approach to addressing sexual violence also includes communications to lessen the social acceptability of gender-based violence. Under the aegis of the Gender in Development Division, a Gender-Based Violence (GBV) and Human Trafficking (HT) National Communication Strategy was developed in 2009, with HIV and AIDS as a cross cutting issue.

In September 2010, members of Child Rights Clubs mounted door-to-door campaigns in five districts to raise awareness on issues around GBV. The club members also informed the community about the presence and location of the One Stop Centers. Mobile video shows on gender-based violence and human trafficking were shown in the same communities, and musical concerts marked the culmination of the most recent communications initiative.

50 traditional chiefs and 50 of their chief stewards have been engaged through workshops to discuss and address defilement (rape), human trafficking and HIV and AIDS. The chiefs and their stewards have since pledged to fight gender-based violence in their chiefdoms, raise awareness amongst their people, and give respect to vulnerable girls, boys, women and men.

Cost:
Approximately USD 178,000 are spent in running one One Stop Center each year. Volunteers are integral to supporting the routine functioning of each Center.

Partners:
UNICEF, members of A Safer Zambia Consortium of organizations (ASAZA): Care Zambia, World Vision, International Justice Mission, Young Women’s Christian Association (YWCA) and the Ministry of Home Affairs, in collaboration with the Gender in Development Division, Ministry of Community Development and Social Services; UNFPA; and the Population Council.

Results:
About 8,500 survivors received services from One Stop Centers between 2008 and 2009; the highest figures were recorded in Mazabuka due to strong management and leadership practices.

The programme reports that all survivors of sexual violence are tested for HIV. Furthermore, they report that all clients who are eligible for treatment and care receive it within the health-facility based centres, or are referred to local health centres.

In the districts of Ndola, Mazabuka, Livingstone, Mansa and Kasama 9,750 students in twenty five schools, and about 16,000 community members were reached by community outreach and awareness-raising activities conducted by the Child Rights Clubs (CRCs).

Lessons Learned:
Scaling up services using existing structures- in this instance, the University Training Hospital established in 2005- has been critical for securing government buy-in and reducing capital costs.
Political leadership under the former president and First Lady Mwanawasa has been critical to strengthening political will among all line Ministries and commitments from several private partners.

There are far too few safe spaces for survivors of violence: in districts without shelters, survivors are referred for support to churches and NGOs. Demand exceeds supply, and existing shelters merit close attention and monitoring.

Continued efforts are needed to better monitor and evaluate the impact of OSCs on changing perpetrators behaviors, so the OSC is not only addressing the symptoms of the problem, but the causes.

**Next Steps:**
UNICEF is renovating a shelter in Mansa, with the support of the Dutch National Committee, and a new OSC is under development in Kasama.

The ASAZA consortium is supporting the replication of the OSC model in five more districts in Ndola, Mazabuka, Livingstone, Mansa and Kasama. Activities through the Child Rights Clubs (CRCs) will continue, with the aim of empowering children and engaging communities on issues of gender-based violence and human trafficking.

UNICEF continues to advocate for the passage of a proposed Anti–Gender Violence Bill, expected to be presented to parliament in the first sitting of 2011.

Annie Sampa-Kamwendo of UNICEF Zambia contributed this piece.

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**Essential Links**

Learn more about the One Stop Centers: [http://www.unicef.org/zambia/5108_5180.html](http://www.unicef.org/zambia/5108_5180.html)

Learn about the “Abuse, Just Stop it” Campaign supported by the Zambia government and UNICEF: [http://allafrica.com/stories/200910300876.html](http://allafrica.com/stories/200910300876.html)

Learn how Integration of Services for Victims of Child Sexual Abuse at the University Teaching Hospital One-Stop Centre took place: [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913632/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913632/)

On 26 May 2006 in Bangkok, the capital of Thailand, several children living with HIV performed a play about the stigma and discrimination faced by people living with HIV or AIDS. They wore masks as part of the drama, and also to disguise their identities. “We’re not living with a terrible illness, but we are living in a terrible world,” said one child.

“We are just like other children…We want to let you know we can do things, we have hopes, we have dreams just like other children do,” comments Nok Noi, a young man living with HIV, and an artist who participates in activities convened by the NGO “We understand.” The group promotes understanding and solidarity among young people living with HIV and the community, and is supported by UNICEF.

“The plays and other activities made me dare to think and speak out,” says 18 year old Dab, a Thai man living with HIV. “I used to think that I would die soon, but today I have friends and I have the courage to live. I feel that I have to rush in creating new plays, especially for children who are really ill, because I don’t know if I will see them again next week.”

Dab is a budding playwright. He first learned of the curative power of art and drama through the holistic care model employed by Srinagarind Hospital, with support from UNICEF.
Leveraging the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) for children made vulnerable by HIV and AIDS

Lessons Learned:

At A Glance

**Issue:**
Although most of the 8,000 – 11,000 children in Thailand who need treatment receive it, the most marginalized children living with HIV in high prevalence areas get lost between the cracks.

**Action:**
Through a process of consultation, evidence-building and strategic planning, UNICEF supported the Thai government to prepare a proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria to secure funds for the care, protection and support of vulnerable children. The proposal was approved in the amount of 42 million USD over 5 years.

**Partners:**
Thai Government, including the Ministry of Public Health and the Ministry of Social Development and Human Security; the Global Fund to Fight AIDS, Tuberculosis and Malaria; civil society; local NGOs; and UNICEF Thailand.

**Cost:**
USD 155,487 for activities related to proposal development.

**Results:**
The amount of funds now available for ethnic minorities, including children affected by HIV and AIDS that are not recognized by the Thai government has increased exponentially.

**Lessons Learned:**
Critical partnerships with the government, stakeholders and the Global Fund, and strategically conducted research were key to developing an exemplary and unique proposal for funding.

**Next Steps:**
The leveraged funds will be used to strengthen the capacities of Ministries that support vulnerable children, strategic information systems, and increased access to treatment for 113,000 vulnerable children in 29 provinces and 1,860 sub-districts, where approximately 61,000 of these vulnerable children are affected by AIDS.
Issue:
Treatment and care for the majority of Thai children in need of it is free and easily accessible. However, marginalized and vulnerable children, including ethnic minorities without Thai citizenship, are unable to routinely access services.

Action:
UNICEF Thailand, with support from the East Asia Pacific Regional Office and New York Headquarters, took the lead role in supporting Thailand’s successful application for funding from GFATM Round 10. The full amount requested (USD 42 million over 5 years) was approved. USD 15 million has been approved for the first two years.

The title and focus of the proposal is “Comprehensive HIV/AIDS Care, Support and Social Protection for Affected and Vulnerable Children Living in High Prevalence Areas to Achieve Full Potential in Health and Development: CHILDLIFE”.

Specific beneficiaries of Global Fund resources will be children affected by HIV or AIDS (CABA), other marginalized and vulnerable children living in communities of high HIV prevalence, and ethnic minority children who do not have Thai citizenship and are less able to access routine services.

The four objectives of the proposal were: (1) strengthened and coordinated policies and systems integrating child-sensitive, HIV-related health care, community involvement, and social protection, (2) equal and universal access to high quality, gender-responsive essential health and social services, (3) increased social acceptance and inclusion, and (4) strengthened national, provincial, district, and sub-district (including community) strategic information systems for improvement of services to vulnerable children. Expected outputs from this proposal include increased access to services for 113,000 vulnerable children in 29 provinces and 1,860 sub-districts, of whom approximately 61,000 of these vulnerable children are children affected by HIV or AIDS.

Partners:
Thai Government, including the Ministry of Public Health and the Ministry of Social Development and Human Security; the Global Fund to Fight AIDS, Tuberculosis and Malaria; civil society; local NGOs; and UNICEF Thailand.

Cost: USD 155,487 for activities related to proposal development.

Results:
The amount of funds now available for ethnic minorities not recognized by the Thai government has increased exponentially. There was an extensive return on investments in technical assistance, in the form of a 5 year grant for USD 42 million.
Lessons Learned:
Factors contributing to the development of a successful proposal can be split between content and process.

Key content elements included a focus on: children; data/evidence-based planning; showing how the funds would add value by benefiting a broader population of vulnerable and marginalized children; a sustainability plan; strengthening policies and systems and building ministerial capacity; gender equity, equality and most-at-risk populations. Consistency, coherence and clear logic linking the strategic and national priorities were essential to lay the case for funding.

Key process elements included: advocacy in collaboration with national organizations; ownership and leadership by the government; broad stakeholder engagement; consensus and definition of clear objectives; strong technical support; support from UNICEF for specific expertise and costs of proposal development; peer review; use of AIDSPAN guidance documents; and the strong commitment of proposal development team members.

Next steps:
UNICEF Thailand will continue to remain involved until final signature between Thai representatives and the Global Fund has been obtained, and then beyond in associated implementation activities.

Training of partners on the topic of social protection for children affected by HIV or AIDS, further gathering of strategic information in 2 select provinces, and developing a joint workplan are envisioned. Support will be provided to strengthen the Ministry of Social Development and Human Security in the effort to promote strengthened national responses to all marginalized and vulnerable children.

The provision of technical assistance and support for the implementation of the proposed national evaluation of the impact of social protection measures on children affected by HIV and AIDS will continue.

This piece was contributed by Robert Gass of UNICEF Thailand.


Profiles in equity

India

“Information is power. People still lack right information on HIV, its management and we do face a lot of stigma,” observes Sadhna Jadon, mother of two and recent widow.

Sadhna, living with HIV, lost her husband to AIDS in 2003. She lives in Ujjain in Madhya Pradesh, India. At the time of this interview, the state had no state or district-level networks for people living with HIV.

“The more we get to know and talk about it and spread knowledge on the issue, [the] more service we would do [for] the women and families living with HIV,” she adds.

Sadhna is one of 6 women who were recently elected ‘leaders of the positive networks’ from 20 districts throughout the State. The six leaders are now in the process of establishing a state-level positive network for women – a first for the State.

The idea for the creation of a state network body – one that could formally cohere disparate informal networks and advance the advocacy agenda for women living with HIV – was a spark that ignited during a ‘capacity building’ workshop with HIV-positive women’s groups that was convened by the Madhya Pradesh positive network in partnership with UNICEF and the Madhya Pradesh State AIDS Control Society in December of 2010.
Empowering women living with HIV to participate in state and national policy dialogs

Innovation: At A Glance

**Issue:**
Women living with HIV in India can face a multitude of obstacles when caring for themselves and their families. While people living with HIV or AIDS have been at the forefront of national responses to HIV, Positive Women’s Networks (PWN+) have not yet fully realized their potential to advocate for improved policies and programmes for women because of challenges in organization, leadership and communication within political spaces.

**Action:**
A series of consultations with women’s networks informed the development of a toolkit for advocacy. This was piloted with 30 state and district-level network members from Madhya Pradesh, Uttar Pradesh and Delhi; each is now a certified trainer.

**Partners:**
Positive Women’s Networks throughout India; UNICEF; State AIDS Control Societies (SACS); District AIDS Prevention and Control Units (DAPCUs); and state and district level government departments.

**Cost:**
USD 10,937 for conducting the assessment; USD 15,291 to develop the toolkit.

**Results:**
A network has emerged at the state level in Madhya Pradesh, and networks are emerging in other states which are engaged in state and policy level dialogs on HIV and AIDS issues.

**Next Steps:**
At the request of local networks, the 30 ‘master trainers’ are rolling out the capacity building sessions in 25 districts throughout the country. Proposals for national scale-up of this intervention are being formalized by the women’s networks. Supportive supervision is planned for all trainers trained through the use of the toolkit.
**Issue:**
In India, Positive Women’s Networks (PWN+) claim membership of more than 17,000 women in 13 states and 55 districts. Coupled with the Indian Network of Positive People (INP+), which reports membership of more than 60,000 women across the country, there are tens of thousands of women hooked into a network with the potential to advocate for their rights.

That potential is not yet fully realized.

**Action:**
In 2009, in consideration of potential gaps in the ability of PWN+s to advocate within political spaces, UNICEF supported an assessment - “Review of Capacity Building Needs of Members and Office Bearers of Positive Women Network with a view to increase their participation and ability to advocate for the rights of PLHAs”.

Adopting a qualitative approach, district-level network members, government officials and representatives of civil society organizations were interviewed or engaged through focus groups in the states of Manipur, Rajasthan and Tamil Nadu for their opinions related to the functioning of the PWN+ organizations and their capacities to network and engage with partners and officials toward a common goal. PWN+s were also assessed for their technical knowledge on HIV and PMTCT.

**Findings**
Lacking a common vision, a sense of role and responsibilities and an awareness of personal rights, property rights, many PWN+ members are not motivated to advocate through the networks.

Lacking knowledge on the basics of HIV, reproductive health, and mother-to-child transmission of HIV and methods to prevent it, PWN+’s role in community outreach and awareness raising is hampered. Those who possess sound technical knowledge are typically engaged by NGOs and have insufficient time to conduct outreach.

Efforts to sensitize government officials, women’s organizations and other organizations are lacking in part due to insufficient exposure of network members to political forums, government offices and hospitals. Additionally, office bearers are not always effective leaders or speakers. Most surveyed department officials at the district level were ignorant of the goals and activities of local networks.

Findings were shared with the positive women at district, state and national level, the National AIDS Control Agency, UNAIDS, UNIFEM, UNDP and other organizations working with and for people living with HIV. A consensus on steps to address the gaps was subsequently developed by all stakeholders and the development of a capacity-building toolkit was prioritized.

The toolkit was developed following consultations with positive women’s networks from 13 districts, and an exhaustive review of toolkits with the same objectives. Topics include, but are not limited
to: advocacy for the rights of women and children; fundraising; how to avail benefits of National and State government schemes available for women; violence and mechanisms for redress; gender-responsive budgeting; livelihood options for women, technical knowledge on HIV, including accurate information on what it means to be HIV positive; how to stay healthy and eat well; information on antiretroviral treatment, and sexual and reproductive health; care of HIV positive children; and positive prevention.

The Madhya Pradesh PWN reviewed the draft toolkit and identified the 30 women from the district level networks of MP, UP and Delhi who would be trained to roll-out the toolkit to more districts in more states.

Though still in its initial phase, one lesson is emerging: supervision and monitoring of trainers will become a vital element of programming if this roll-out is to be successful.

**Partners:**
Positive women's networks throughout India; UNICEF; State AIDS Control Societies (SACS); District AIDS Prevention and Control Units (DAPCUs); and state and district level government departments.

**Costs:** USD 10,937 for conducting the assessment; USD 15,291 to develop the toolkit

**Results:**
In Madhya Pradesh, a state level network of women living with HIV was formed immediately after the roll-out of the toolkit; membership is continually expanding, and concrete areas of advocacy have been defined which are relevant to women living with HIV and AIDS.

**Next Steps:**
The women's network has established contact and begun advocacy with state government departments, as well as reached out to positive women about national and state schemes that they can benefit from.

Proposals to conduct capacity building sessions with all members of all states' district level networks are fully developed, and plans are underway for the 30 ‘master trainers’ to initially roll-out the capacity building sessions in 25 districts throughout the country.

This piece was contributed by Sonia Trikha, UNICEF India.

Visit the UNICEF India website: [http://www.unicef.org/india/hiv_aids.html](http://www.unicef.org/india/hiv_aids.html)

Visit the Knowledge Community on Children in India: [http://kcci.org.in/](http://kcci.org.in/)
Katja, 17 years
[name changed to protect identity]

“The first time I tried to dope was with my father. He proposed it himself. It was a methamphetamine powder, cocaine. Roughly speaking - stimulants. Then I met a bunch of people like me. Now I wonder what bound us together back then? Only drugs and talks about money or rather where to earn it. ...and I was 14 when I went to the street.

One day I stood at our gathering place and police took me. There were these long procedures and I was put on the record as a result. I ran away and hid. During one of my visits to police I met social workers from the UNITUS fund (a UNICEF partner). They started asking me how I ended up there. They also suggested that I go to a doctor to go through medical examination. At that time I was almost 16 years and in my entire life I never went to the doctor. I was scared. Several times I agreed to come and did not show up because I did not trust them. And they called me back patiently, waiting for me to come. And eventually I thought why not? It was for free while generally, to visit a doctor cost quite some money. Finally I came and doctors examined me and I began healing. I visit a psychologist, and social workers.

Now I'm looking for a normal job and started studying in a college… My groupmates do not know my story and I do not tell about it. I would keep on living the way I used to if I did not come to the project.”

[Adapted from an interview contributed by Sergiy Prokhorov]
Mobile outreach for young women most-at-risk of HIV infection

Good Practice: At A Glance

Issue:
Young women who sell sex or live on the street in Ukraine do not benefit from state health or social services, despite alarmingly high rates of HIV. Their situation is especially precarious, but how do they relate to a system that rejects and blames them?

Action:
International and national partners researched the plight of these young people, brought this data to planning councils, and subsequently pilot-tested a combined drop-in center/outreach model to bring reproductive health, HIV prevention, social welfare, and harm reduction services to them. They also advocated for a more protective legal and policy environment for this population.

Partners:
UNITUS; City Centre for Social Services for Families, Children and Youth; International HIV/AIDS Alliance, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); and UNICEF.

Cost:
USD 50,000 for provision of basic services in one site for one year.

Results:
117 adolescent females who had never benefited from HIV prevention services before received services between February and December of 2009. The National AIDS Programme and the State Social Services now recognize female adolescents who sell sex as an essential constituency for services. The national AIDS law for age of consent for testing has been lowered to 14.

Lessons Learned:
Trust and good communication between caseworkers and young people were critical in dispelling young peoples’ mistrust of the health and social services system. Formal cooperation agreements guaranteed access to the various government health and social welfare services.

Next Steps:
The programme will be replicated in two more sites. Funds leveraged through the GFATM will support training of case-workers who interact with young people who sell sex. Advocacy for a less punitive legislative and policy environment for young people who inject drugs, sell sex and/or live on the streets will continue.
Good Practice

Issue:
According to 2006 data from Ukraine, about one fifth of female sex workers (19%) were living with HIV, with many barely into their teens (20% were between the ages of 15 and 24).1 Research suggests that adolescent who sell sex face police harassment, place a low premium on health and are loathe to seek health services from a system that rejects them and in which they have no trust. Precise data on their situation is limited.

Action:
Research to understand the HIV-risks and realities of street-based adolescents was conducted in four regions in Ukraine, with stark findings: 15% reported selling sex before the age of 15; only 25% reported using condoms at the last sexual intercourse; and 19% reported ever having injected drugs.

UNICEF and partners followed this with a review of the policy and legislation environment for adolescents who inject drugs, sell sex, or who otherwise live on the fringes of society. The ability of local service providers to provide relevant services to young men and women who are wary of the system was also assessed. With these findings in hand, a series of planning consultations with national and local partners and young females who sell sex were convened. This led to the decision to pilot-test a drop-in center model for the provision of reproductive health, HIV prevention, testing and social services for young women who sell sex in four districts known for extremely high rates of incidence of new infections among this population. No similar services were available in the districts, and a strong monitoring framework was put in place to ensure the pilot programme was closely watched for its effects on its clients.

About the model
Clients are recruited by a locally known non-governmental organization, UNITUS, on the streets and through mobile outreach clinics, a local AIDS centre, the Women’s Consultation Centre, an STI clinic and the Criminal Police for Minors.

Outreach or drop-in centers allow project implementers to offer prevention, harm reduction and social services, as well as refer clients to government health and social services for more specialized services. Use of a common coding system across referral points assures confidentiality is not compromised. Client phone numbers are only maintained by one point of contact within the project; no common contact databases are maintained.

Partners:
UNITUS, a local non-governmental organization; City Centre for Social Services for Families, Children and Youth; International HIV/AIDS Alliance, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria; and UNICEF.

Cost:
USD 50,000 for provision of basic services in Mykolayiv for one year.

Results:
117 adolescent females who had never been reached by HIV services before were served by UNITUS and its partners between
February and December of 2009. Over 90% of all clients interviewed (62 of 69) through a client satisfaction survey used the services more than once.

Close to 100% (67 of 69) have already recommended the project services to their peers; and (68 of 69) reported overall satisfaction, including improved HIV knowledge and skills for prevention, and better access to health care.

The legislative review commissioned by UNICEF, and subsequent advocacy work by national and NGO partners resulted in revisions to the national AIDS Law on age of consent for testing: 14-18 year olds can now receive HIV tests without parental consent. Adolescent females who sell sex are also now included in the National AIDS Programme and the work of State Social Services.

Monitoring and evaluation are integral to the process. At this stage it is too early to measure the programme’s impact on averting new infections or improving health of clients living with HIV.

**Lessons Learned:**
Findings indicate that the personal relationship maintained by case-workers with clients and the use of personal mobile phones for communication was instrumental in stimulating demand for services and in retaining clients.

Clients often mentioned confidentiality and trust as reasons for continued contact with the service. Clients considered non HIV-related services a key part of the package.

In Ukraine’s environment of highly vertical systems, provision of all essential services under one roof was impossible; formal cooperation agreements were found to improve linkages between systems, and access to multiple services by clients.

**Next Steps:**
The programme is being replicated in two other regions in Ukraine. Funds have been leveraged through the GFATM to train shelter staff to deliver HIV prevention services, and to advocate for adolescents who face heightened risk of HIV or AIDS. Partners in Ukraine will continue to raise the call on behalf of young women whose voices are not yet heard.

Olena Sakovych of UNICEF Ukraine contributed this piece.

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Read four Case Study Reports on interventions for at-risk youth that were piloted in Mikolayiv and three other cities in Ukraine: [http://www.unicef.org/ukraine/Case_Study_EN_FINAL_block.pdf](http://www.unicef.org/ukraine/Case_Study_EN_FINAL_block.pdf)

Learn about findings from the baseline assessment of HIV-risks faced by street-based adolescents in Ukraine: [http://jech.bmj.com/content/early/2010/09/23/jech.2009.097469.full](http://jech.bmj.com/content/early/2010/09/23/jech.2009.097469.full)


Visit the UNICEF Ukraine website to view photoessays on the state of young people in the region: [http://www.unicef.org/ukraine/media_10515.html](http://www.unicef.org/ukraine/media_10515.html)
Eleven-year-old Kamran sells sex in a poor neighbourhood of the city of Karachi.

At the time of this photo, in October 2008 in Pakistan, unknown numbers of children were victims of sexual exploitation. Hundreds of thousands of other children and young people around the world also face situations which put them at high risk of HIV infection, though reliable statistics have been difficult to find.

The Asia-Pacific Evidence to Action HIV and AIDS Data Hub, developed in 2008, was a response to this gap in data on the situation of boys, girls, young men and young women affected by or at risk of HIV or AIDS.
Asia-Pacific regional HIV data hub reveals facts on the most marginalized

Improving Evidence for Programmes:
At A Glance

**Issue:**
Within the Asia-Pacific region, where HIV and AIDS often remain hidden among marginalized sub-populations, data that reveals differences by age or gender are largely missing or not publicly accessible. Policies and programmes may therefore not reach those that need services the most.

**Action:**
The Evidence to Action HIV & AIDS Data Hub was launched in 2008 to provide better access to comprehensive national and sub-national data on HIV and AIDS from the Asia-Pacific Region.

**Partners:**
UNICEF, WHO, UNAIDS and the Asian Development Bank, with the support of the Science and Technical Advisory Group (STAG), comprising 15 regional experts with a broad range of expertise.

**Cost:**
USD 400,000 annually

**Results:**
National policies and programmes for women, girls, men and boys are being influenced by the inclusion of analysis and data from the Hub in large-scale funding proposals, policy meetings - including key 2010 regional meetings- and national websites in several countries.

**Lessons Learned:**
Government confidence in the Hub is critical if data is to inform decision-making. Building and sustaining stronger networks at country level, notably with national AIDS programme managers, country data focal points, UN co-sponsors as well as civil society organizations can facilitate systematic HIV data collection, analysis and use.

**Next Steps:**
Gender-based data analysis is underway in collaboration with the UNAIDS Asia Pacific Regional Support Team. The range of available content will be expanded. A mechanism for more frequently updating data is being developed in collaboration with national data managers, national AIDS councils and civil society organizations, and the Data Hub is supporting the creation of the official website of the Asia-Pacific Prevention of Parent to Child Transmission (PPTCT) Task Force for the Elimination of Pediatric HIV and Congenital Syphilis by 2015.
Improving Evidence for Programmes

Issue:
In 2008, the Evidence to Action HIV & AIDS Data Hub opened its online website to collect all available HIV and AIDS data from 27 countries in the region; at that time, only two of the countries had either a national website or a central database of their own.

Even with the current increase in websites and available data, interpretation and analysis remains a critical weakness. “What often happens in countries,” explains UNAIDS Regional Programme Advisor for Strategic Information, Amala Reddy, “is that there are three to four agencies collecting different data but no one is synthesizing it and coming out with messages. No one puts it together into one picture and explains what it means for policy makers or in terms of priorities.”

Two years since its launch, the Data Hub is playing that critical role.

Action:
The Data Hub, co-funded and managed by UNICEF, offers strategic information on HIV prevalence and epidemiological status, vulnerability and HIV knowledge, risk behaviours, the economics of AIDS and the national responses in the 27 countries in the region (including Hong Kong Special Administrative Region).

The hub collates 60,000 data points for 1,300 indicators and sub-indicators from over 900 unique sources.

Data that might otherwise be lost is pieced together and analyzed by the Data Hub and the respective national data keepers. This includes data on adolescents and children and gaps in AIDS spending.

The Hub captures data at national and sub-national levels comprising almost 4,000 geographic points. The information is organized by subgroups – including populations at higher risk – and disaggregated as finely as possible by age, gender and sub-national level administrative region. For instance, despite various classifications and definitions for sex workers across the region, the Data Hub has pulled existing data together and refined it to facilitate meaningful analysis. This is just one demonstration of the Hub’s commitment to “knowing your epidemic.”

Examples of facts uncovered:
A startling 82% of surveyed sex workers in Lao are below the age of 25.
63% of surveyed men who have sex with men in Viet Nam are below the age of 25.

Charts and presentations on the status of the epidemic among key affected populations is one feature of the website

![HIV and AIDS Data Hub for Asia-Pacific](chart.png)

Source: [www.evidenceaction.org](http://www.evidenceaction.org) - Based on data from national Behavioral Surveillance Surveys.
The Hub collates and provides access to all indicators (country specific and global) in one place, distinguishing it from many other websites. The Hub also provides trend data and an analysis of the changing pattern of HIV incidence and prevalence.

The website also serves as a repository of reference materials. Currently over 2,000 publications are available online. The website includes links to National AIDS Programmes and Ministries of Health, international non-governmental organizations, other civil society organizations and partners in the region.

**Partners:**
The Secretariat, composed of UNICEF, WHO, UNAIDS and the Asian Development Bank, is supported by a regional collection of experts, known collectively as the Scientific Technical Advisory Group (STAG).

**Cost:**
An annual budget of USD 400,000 allocated by UNICEF, the Asian Development Bank and UNAIDS supports operations costs.

**Results:**
National programmes in Indonesia, Maldives, Nepal, Pakistan, Philippines, Sri Lanka and Viet Nam extensively use its products for policy development, GFATM and other funding proposal development and for public consumption on government websites. When the health minister in Nepal inaugurated the country’s national AIDS e-library on HIV strategic information, he highlighted the importance of working with the Data Hub.

The Hub’s extensive involvement in regional consultations and strategic national meetings is further evidence of its relevance and usefulness. [See http://aidsdatahub.org/en/regional-profile/regional-review for information used]

**Lessons Learned:**
Access to the latest comprehensive data is proving difficult. The Data Hub can only work with publicly available information. Ms. Reddy notes “there’s a lag between the latest data and government approval.” This hurdle can be overcome as governments, especially policy makers, benefit increasingly from the analyses offered on the Data Hub.

The Hub’s comprehensive repository of age- and gender-disaggregated data as well as sub-national data has brought greater clarity on risk profiles, behaviours, coverage of services and programmes in the region. “The Hub’s users are now able to access multiple sources of data on HIV and AIDS from the website, at one click when in the past, they would have had to contact different countries and offices for these information” says Wing-Sie Cheng, Regional HIV Adviser, UNICEF EAPRO.

“The Data Hub is created largely in response to the concentrated nature of the epidemic in Asia-Pacific, which calls for targeted rather than generic actions,” she adds.
Next steps:
The Data Hub has supported the creation of the official website of the Asia-Pacific Prevention of Parent to Child Transmission (PPTCT) Task Force for the Elimination of Pediatric HIV and Congenital Syphilis by 2015. The Hub will launch a PPTCT Task Force webpage providing country fact sheets, data products and interactive mapping capabilities. In addition, the Hub will support analyses providing a regional overview of the barriers to eliminating paediatric HIV infections, supplemented with national case studies and best practices. And the Hub will promote the use of its Network, Forum and Project Management tools as powerful mechanisms for collaboration.

The Data Hub will expand its range of services, and increase access to quality strategic information. “Innovative tools, and free and open source software will be the driving mechanisms behind greater usage of data and health system strengthening,” says Wing-Sie. “Ultimately, strategic information must drive better health outcomes and service delivery.”

The Data Hub is also working closely with the UNAIDS Asia Pacific Regional Support Team to provide a series of gender-based data analysis.

Khin Cho Win Htin and Ye Yu Shwe of the Data Hub, and Lori Thorell and Shirley Mark Prabhu of UNICEF EAPRO contributed this piece. This is adapted from a news story produced by Karen Emmons of UNICEF EAPRO.

Visit the HIV and AIDS Data Hub for the Asia-Pacific region: http://aidsdatahub.org/

Learn how Cambodia assesses the situation of young people who are at high risk of HIV: http://www.youtube.com/user/unicefcambodia

Visit the UNICEF East Asia and Pacific Region website for full access to regional data and publications: http://www.unicef.org/eapro/activities_3606.html
The role of caring for the health and welfare of children has traditionally been left to mothers. The UNICEF Male Champions programme however advocates for a shift in this traditional female role and encourages male involvement in the birth, delivery and care of the baby.

Male Champions act as role models in their community, and are supported to persuade and influence other men to be involved in the prevention of HIV to the unborn child.

Involvement of males in PMTCT services can help boost the number of women willing to undergo HIV testing during their pregnancy, as male partners and family members can have a strong influence over what medical treatment, care and support the family receives.
Engaging men in prevention of mother-to-child transmission of HIV

**Good Practice: At A Glance**

**Issue:**
Less than half (46%) of all pregnant women were tested for HIV in Zimbabwe in 2009; just over half (56%) of pregnant women in need of antiretrovirals for the prevention of HIV transmission to the child received them. Low levels of community involvement and male engagement may be impeding progress.

**Action:**
In 2009, the Male Plus PMTCT Champions (M+PC) initiative was launched and linked to health-care facilities in four catchment areas. The initiative uses a peer support, outreach and referral model to improve PMTCT utilization among pregnant women and testing among their male partners.

**Partners:**
The Ministry of Health and Child Welfare; PACT–Zimbabwe: Ruveheneko Programme; and UNICEF.

**Costs:**
Approximately USD 22,200 for one site.

**Results:**
Close to 90% of women seeking care in antenatal and postnatal care sites were tested for HIV by June 2010 – an improvement of 30 percentage points in comparison to the baseline rate in 2007. Similarly, there was a four-fold increase in the proportion of pregnant women accompanied by their spouses or partner to antenatal care visits (from 11% in 2007 to 40% in 2010).

**Lessons Learned:**
Where possible, existing community programmes should be the starting point for community-based interventions. Four M+PC champions per target area may be insufficient, and can challenge the reach and coverage of the intervention; and more Male Champions are needed to support the programme’s peer-to-peer element. The visibility and credibility of Champions must be a consideration; the use of uniforms may foster both. While male engagement was necessary for improved uptake of services, it is not sufficient to reach the goals of virtual elimination.

**Next Steps:**
Based on findings from the programme evaluation, plans are underway for replicating the programme in seven districts across Zambia, while also analysing other barriers to the uptake of PMTCT services.
Issue:
While still unacceptably high, new HIV infections among women of childbearing age in Zimbabwe have declined from 23.1% in 2004 to 16.1% in 2009. However, there is little evidence to suggest comparable success in preventing new infections among children.

In many communities, men are the key decision-makers in most household matters, including health care. There is evidence that a lack of male engagement in PMTCT interventions may hinder the demand for, and access to these services.

The current approach to male involvement is inadequate. Males are reached through their partners – and beliefs about women as vectors of infection and disease are perpetuated.

Action:
UNICEF conducted baseline assessments in 16 sites in Mberengwa and Wedza districts in 2007 and Nyanga district in May 2009. The results informed strategic plans for implementation, monitoring and the development of a male-involvement package in PMTCT.

Subsequent consultations with government and non-governmental organization partners guided the development of the M+PC model.

Four sites with community-based programmes run by PACT Zimbabwe were chosen based on feasibility: Seke clinic, Musume, Mt. St Mary’s and Reginal Coiel rural hospitals.

72 Champions – in this instance, both males and females - were recruited through home-based care programmes or local HIV and AIDS support groups. All Champions were trained to offer psycho-social support to couples going through PMTCT, and to provide HIV education during community gatherings and home visits. They were also trained to counsel families on related topics including infant feeding in the context of HIV.

The tasks of the champions are
- To mobilize and sensitize communities and families about PMTCT
- To attend antenatal care sites
- To make home visits follow ups to PMTCT clients
- To assess and assist pregnant women who need transport and advise accordingly
- To refer clients to health centers
- To act as link between community and health center
- To encourage men to participate in health programmes.
- To assist communities and families to maternal and child health care services including PMTCT
- To provide information on HIV/AIDS, testing and counseling and feeding options
- To undertake data collection and record keeping
- To document all PMTCT activities in the communities
Empowered with Champion Utility kits (T-shirts, stationary bag, a reference manual, reporting books, a cap, and bicycle) small mixed sex groups of Champions worked with communities and villages adjoining a health centre (collectively known as an intervention site) to provide information and support, notably to pregnant women in maternity waiting homes.

Male Champions conduct health talks once a week at farmers gathering, church meeting and funeral ceremonies. They document the number of people gathered at the discussion, and the number of people agreeing to be tested. In select sites, champions have established young people’s clubs to sensitize the community through drama and songs.

Champions also visited households of PMTCT clients. Pregnant women, their partners, and young people of childbearing age who were either untested or in an HIV-positive couple could then be supported and counseled. Various avenues to locate and connect HIV-positive persons to health services were created. A specific analysis of the impact of the referrals on increased service utilization is pending.

Partners:
The Ministry of Health and Child Welfare; PACT-Zimbabwe; Ruveheneko Programme; and UNICEF.

Cost:
On average, USD 22,200 was needed to support one intervention site with a team of four PMTCT champions for one year.

Results:
Close to 90% of women seeking care in antenatal and postnatal care sites had been tested, according to results from a comparison of pre- and post-data in June 2010, representing an improvement of 30 percentage points. Similarly, there was a four-fold increase in the proportion of pregnant women accompanied by their spouse or partner to antenatal care visits (from 11% in 2007 to 40% in 2010).

1,324 couples were referred for testing and counselling, and over 1,680 males reportedly accompanied their pregnant spouses to the ANC. Evaluation findings suggest that community mobilization and targeted household visits by male Champions may have influenced this increased demand for services by males. Over 90% (74,721 people) of the population in the four pilot sites was reached with messaging around PMTCT.

72 Male +PMTCT Champions demonstrably improved their knowledge about HIV and AIDS; mother-to-child transmission of HIV and how to prevent it; the advantages of knowing one’s status; breast-feeding methods and feeding options in the context of HIV; and the roles of males, the family, the community and health facilities in reducing MTCT. All champions were voluntarily tested for HIV.
Lessons Learned:
Male peer support was perceived by programme participants as essential to male involvement in PMTCT.

Information, education and communication materials should be produced in all local languages. Otherwise, opportunities for learning are lost.

Champions should be easily recognizable. Uniforms are proposed.

Four Champions for each intervention site is inadequate to achieve the outreach and communications aims of the programme. Improved modes of transportation also need to be considered so Champions have greater reach.

An initial training and subsequent monthly meetings may be inadequate to keep Champions fully aware of PMTCT. Refresher trainings should be considered.

Demand creation without adequate supplies is a threat. Maintaining a consistent supply of testing kits, prophylaxis and medications is essential for the programme to meet its goals.

While the engagement of men is necessary for improving the uptake of PMTCT services, it is not sufficient.

Next Steps:
There are plans to establish 126 male peer support groups in the seven districts supported by UNICEF to deliver PMTCT/ Paediatric HIV services within the maternal, newborn and child health system.

Strengthening the participation of men in PMTCT services is one of the priority strategies for PMTCT in the Zimbabwe National HIV/AIDS Strategic plan 2011-2015; UNICEF will continue to support this priority area.

Continued efforts are needed to identify and address barriers to the uptake of PMTCT services.

Aboubacar Kampo and Alemach Teklehaimanot of UNICEF Zimbabwe contributed this piece.

Visit the UNICEF Zimbabwe website: http://www.unicef.org/india/hiv_aids.html


Profiles in equity
Islamic Republic of Iran

“I had just started senior high school and was 15 when a counsellor came to our school and introduced the Adolescent Friendly Services (AFS) centre in our neighbourhood,” says Mahshid, a boisterous 16 year old girl living in the Islamic Republic of Iran.

Mahshid had dropped out of school a year earlier, and had just been reintroduced on the condition that she would behave well.

“We would run out of school and not return home until late. I would argue with everyone at school and most teachers. I didn’t know the wrong or right.” Following her parent’s divorce when she was 13, she says “that was the worst age for me. I was so confused at school and I was surrounded by many friends whom I trusted so soon.”

Mahshid visited the AFS centre and felt an immediate pull toward it. “I felt I liked the environment and people there. It was safe and fun.”

The AFS centre is an initiative supported by UNICEF Iran and run by the Islamic Republic of Iran Ministry of Health and Medical Education. Through peer outreach, counselling, infotainment and referrals, the programme not only reaches young people with information and services on HIV and AIDS, it trains the next generation of leaders.

“There were lots of things that I didn’t know and I learnt through the life-skills training course” Mahshid says. Since her experience dropping out of school, Mahshid has gone on to emerge as a peer leader, and an effective peer educator. “You might not take it seriously when your mother or father tells you something, but when it comes from a friend, it’s certainly very effective.”

Mahshid has just one thing to add at the close of the interview. “I don’t want to turn 25,” she laughs as she says, “because then I cannot come to AFS centre anymore.”

[This interview was contributed by Bahareh Yeganehfar of UNICEF Iran]
Local strategies to increase coverage and access to HIV prevention services for marginalized young people, especially girls

Lessons Learned:

At A Glance

**Issue:**
Over half of all females (51%) testing positive for HIV in the Islamic Republic of Iran are aged 15-34, with strong implications for adolescents. Young people are at increased risk of HIV-exposure through injecting drug use or unprotected sex with a person who injects drugs. Despite this evidence, programmes for adolescents in general and girls in particular are lacking.

**Action:**
Adolescent-friendly HIV prevention services (AFS), based on a model of peer education, information dissemination and referrals, were rolled out in six cities, with a mandate to focus on marginalized young people – especially young women. The model incorporated a gender-sensitive approach with defined indicators and targets. Strategies included outreach to places where young women gathered, and holding information sessions for their parents and community leaders (including religious leaders).

**Partners:**
The Ministry of Health and Medical Education and UNICEF

**Results:**
Over eight thousand people used the adolescent friendly centers in 2007 and nearly three quarters (73%) of these service recipients were considered ‘most at risk’. In the same year, mobile education sessions reached 61,831 people, of whom 23% (14,430) were ‘at risk’. Most at risk was defined as individuals with high risk sexual behavior, such as drug use, and/or being in an environment that encourages drug use.

**Lessons Learned:**
Incorporating a gender lens at the planning stage is essential to ensure sex-disaggregated quantitative results are available for analysis. Holding information sharing sessions with parents and community leaders (including religious leaders), and delivering some service components in community non-health centres (such as mosques and charity centres) can facilitate the process of access to girls and women. Development of a Code of Conduct can govern male and female peer educators’ official exchanges, ensuring parents’, communities’ and high level officials’ ongoing trust.

**Next Steps:**
Based on the results of the evaluations, including impact on HIV incidence, the programme, currently limited to health centres, will be expanded to more sites. The focus on most-at-risk young people will become sharper. UNICEF is working with United Nations (UN) partners and the Ministry of Health and Medical Education to address the issues of prevention among young people and accelerated implementation of sexual health interventions within the National Strategic Plan (2010-2014), which is in the process of finalization.
Issue:
According to recent estimates (Ministry of Health and Medical Education/UNAIDS), close to 86,000 people are living with HIV in the Islamic Republic of Iran, which has a national HIV prevalence of 0.12%. Nearly one in five (18%) injecting drug users in the country are living with HIV, and 25-34 year olds account for 40% of all infections. This suggests that young people are engaging in behaviours that put them at risk for HIV, including unprotected sex and injecting drug use. Appropriate support and services for this population is lacking.

Data shows that young people are having sex at an early age; one study showed 15% of boys aged 15-18 had had sex before age 15. This percentage rises to 28% when asked if they had had sex before 18. For unmarried female students the percentages were 1% and 7%, respectively. These statistics are a particular cause for concern in light of no condom awareness among many sexually active 15-18 year old males (at 28%).

Opportunity
The government in the Islamic Republic of Iran has a policy and programme environment that takes into account the needs of young people at increased risk for HIV. Interventions to reduce risk and vulnerability, including harm reduction and methadone maintenance therapy services, are available free of charge at drop-in centres, mobile clinics and in prisons. HIV testing and antiretroviral therapy is also provided free of charge. While it is illegal to use drugs, the Law Enforcement Force does not arrest injecting drug users who are participating in a harm reduction programme.

Legislation requires health service providers to provide all available services to all clients without discrimination or age restriction. This policy lies at the core of this innovative UNICEF-supported programme that mobilizes young people to transform the lives of other young people, most at risk children, youth and women who were not accessing available services for fear of being stigmatized.

Action:
Recognizing gaps in the response for young people, the Government of the Islamic Republic of Iran and UNICEF Iran developed a pilot project to improve service coverage and empower at least 60% of programme participants to protect themselves from HIV. The primary beneficiaries were at-risk children, youth and women. A programmatic approach was coupled with the development of policies to integrate model services into health and social centres.

The Adolescent Friendly Services (AFS) Projects were first piloted in Tehran and Bam in 2005; they expanded to include the cities of Zahedan, Bandar Abbas, Mashhad in 2006, and Khoramabbad in 2007.

Participatory planning and design
Existing programmes and funding were identified and mapped, and various approaches were costed. Gaps in services and funding became evident.
UNICEF then coordinated consultations with a wide range of stakeholders in 2005, including government partners and young people. From decisions on how to define a “high risk area” (with implications on AFS site placement) to decisions on how to assess the capacity of sites to deliver counseling and peer education services, most-at-risk stakeholders were involved. Peer educators were also recruited from among most-at-risk groups.

Based on the consultations and a mapping of the core services, “adolescent-friendly health services” (AFS) were developed for people between the ages of 10 and 19 initially, and then expanded to include people up to the age of 24 subsequently. These steps were followed by sessions to build the capacity of the cadre of AFS service providers.

Following the roll-out of the programme to multiple cities, UNICEF and the Ministry of Health and Medical Education supported a review of the different locally adapted approaches to identify the core components needed to deliver AFS at scale.

How the model works:
Male and female peer educators hold group and individual education sessions in locations where their peers are known to gather, such as parks, hairdressers, barber shops and bus stops. The peer educators use drama, information, education, communications materials and participatory activities, such as football, to break the ice and draw a crowd before going on to provide skills-based HIV and AIDS education. All materials are developed using a participatory approach and focus groups. Peers are referred to select services as needed.

AFS staff and educators provide separate group education and life skills sessions for girls and boys each week in the AFS Centre. Parents are encouraged to attend separate workshops. Peer educators and service recipients report these sessions as important for building faith in AFS among community members and strengthening family relationships.

Trained counsellors provide regular services to most-at-risk children, youth and women in the stationary AFS centres. Male condom provision is routine in Iranian Health Centers.

Referrals, as noted above, are an essential part of the overall package of services. Clients receive a unique confidential code, not tied to personal identification. This enables tracking and follow-up. A new monitoring system has recently been developed to assess how effective the referral system is, and to measure if it is adolescent-friendly. Initial results are promising, but tentative.

In the cities of Bandar Abbas, Mashhad and Bam, a service referral form bearing the logos of the AFS and Ministry of Health and Medical Education is given to AFS clients who require additional services. All service providers that are listed have signed a joint memorandum of understanding (MOU) with AFS to deliver services.
Results:
Over eight thousand male and female young people aged 10-24 used the stationary AFS in 2007 and nearly three quarters (73%) of these were defined as most at risk. In the same year, mobile education sessions reached 61,831 people, of which 23% (14,430) were at risk. There is no monitoring data for 2008 due to a break in the project, but data collection has since resumed.

Data from two sites covering the first six months of 2009 show that 3,515 male and female young people aged 10-24 were seen in stationary AFS sites. Nearly 40% of these clients and almost a quarter (23%) of the 3,798 clients reached through outreach services were most at risk children, youth and women.

Data from 2009 and 2010 indicates that five females and 24 males between the ages of 10 and 14; 57 females and 90 males between the ages of 15 and 19; and 161 females and 225 males between the ages of 20 and 24 were referred to midwives, physicians, voluntary counseling and testing sites, drop-in centers for people who use drugs, psychiatrists, sports centers or specialized support services. Of the total of 562 referrals, 156 reported uptake.

Lessons learned:
The MOUs among service providers have been critical to improving access to multiple services.

Data from a few sites shows that male peers can facilitate the project’s access to both at-risk young men and other most-at-risk groups, despite assumptions that young women would be more effective in recruiting other young women.

Applying a gender lens at the planning level is essential to ensure the collection of sex-disaggregated data. This has helped the project to refine its approach and improve the inclusion of girls/young women throughout the project’s activities and improve service coverage among them. However, intensified efforts are needed to improve utilization of referral services.

Holding information sharing sessions with parents and community leaders (including religious leaders) and also delivering some components of services in non-health community centers (such as mosques, charity centers, and other points of service delivery) can facilitate the process of access to girls and women; this is especially so in communities where access to services among young women is challenged by family norms.

Development of a code of conduct can govern official exchanges between male and female peer educators, guaranteeing the project’s credibility with parents, communities and high level officials.
Next steps:
UNICEF is now working with the Ministry of Health and Medical Education to develop a roadmap for scale-up and identify mechanisms to hand over the coordination of AFS to authorities at the local level.

UNICEF is working with United Nations (UN) partners and the Ministry of Health and Medical Education to address the issue of prevention among young people, and promotion of sexual health more rigorously within the new National Strategic Plan (2010-2014), which is being finalized.

Najin Yasrebi and Alireza Tajjili of UNICEF Iran contributed this piece.

Learn more about HIV and adolescent-friendly services in the Islamic Republic of Iran by visiting the UNICEF website: http://www.unicef.org/iran/hiv_aids.html
Profiles in equity

Jamaica

“I’ve been through a lot of crime and violence in my life,” says Andre, a soft-spoken young man of 20. His father, uncle and best friend were killed, and his former home was burned down.

Andre comes from one of the poorest and most violent areas of Jamaica.

Immersed from a young age in the culture of guns, Andre struggled to find his way. “The Bashy Bus saved my life,” Andre said. “It got me thinking the way a young man ought to think.”

‘Bashy’ is a Jamaican term for ‘party’, and the Bashy Bus programme, run by the local government, NGO partners and UNICEF, uses drama and song to talk directly to young people about critical issues. The bus travels across the country, dramatizing the challenges children and young people face in dealing with HIV and AIDS, violence and the enormous social pressure to have sex at a young age.

Inspired by the message of the Bashy Bus, Andre received counselling and took an HIV test.

“I was actually fretting because I could have got HIV, because I was very vulnerable and at risk,” he recalled. The test was negative, and it gave Andre the impetus to change his life. He is planning to attend college and hopes to become an entertainer.

“I feel very, very good, and I tell myself I’ll never engage in unprotected sex again,” he said.

*Andre is no longer with the Bashy Bus Programme

[Adapted from an article written by Chris Niles.]
Peer education to improve HIV and health services for poor youth

Good Practice: At A Glance

Issue:
Young women and young men living in rural, poor or violence-prone areas are facing a disproportionately high risk of HIV compared to the country at large, where the overall prevalence rate stands at 1.8%. These same communities show low levels of knowledge about HIV, low age at sexual initiation, low rates of condom use at last sex and the prevalence of forced sex among young women and men who have sex with men. In addition, health and HIV prevention services tend not to be available, and when available, not used.

Action:
In 2006, a programme was launched in the high prevalence communities of St. Catherine, St. Ann, St. Ann rural and St. James. The programme linked peer education and community mobilization activities to a mobile reproductive health service called the Bashy Bus, which delivered gender-sensitive programmes and referrals for local health services to young men and women.

Costs:
Peer educators were paid. The cost to run the service for a year amounted to approximately USD 50,000.

Partners:
Children First (a non-governmental organization); the National HIV/AIDS Programme (Ministry of Health); and UNICEF.

Results:
A comparison of baseline data gathered in 2006 and data gathered following the intervention, in 2008, showed forced sexual encounters had decreased; and the age of sexual debut in both males (from 11.8 to 13.9 years) and females (14.9 to 17.1 years) increased. Condom-use with non-primary partners increased for both males (77.3% to 88%) and females (54.1% to 74%).

Lessons Learned:
Buy-in from adults for the provision of services to young people is key for increased use, and buy-in from sub-regional health structures for the provision of mobile health services is key for the programme’s longevity. In a programme which fostered mass mobilization and one-to-one peer interactions, young clients viewed small peer interactions as most effective, and networking by peer educators with local young people was critical. The non-judgmental nature of the mobile services makes them an ideal point of service-delivery for young men who have sex with men and young women who have experienced relationship violence.

Next Steps:
The Northeast Region (with a total estimated population according to the Statistical Institute of Jamaica of 370,860 in 2009) Health Services is absorbing the Bashy Bus programme into its payroll and services; the facilitators of the programme are considering how to move forward to meet the needs of young men who have sex with men and young women who are affected by gender-based violence.
Good Practice

Issue:
The parishes St. Catherine, St. Ann, St. Ann rural and St. James, located in March Pen, Ocho Rios and Montego Bay, are areas of high HIV prevalence. Prevailing norms suggest young women are more likely to become pregnant. Rates of transactional sex are thought to be significant. A baseline survey initiated by UNICEF and Children First in 2006 in six communities, including the three noted above, with similar rates of HIV-risk, showed that one in every 10 (50 of 471) respondents had a forced sex encounter in the past year and did not seek help. Of those who reported a forced sex encounter, 32 (65%) hoped for family planning services, but did not seek or receive these services; and 36 (72%) wanted to get HIV-tested, but did not seek or receive these services. Discrimination and a sense of ‘being disrespected’ were voiced as common reasons for non-utilization of the few existing services.

Action:
Following the baseline assessment, UNICEF and Children First launched the Bashy Bus programme with the Ministry of Health in the parishes of St. Catherine, St. Ann, St. Ann rural and St. James. Envisioned as a mobile health service, it was intended to bring services to young people, not vice versa. While operating as a central component of the programme, the Bashy Bus was a part of a larger approach.

About the programme
Peer educators recruited from similar communities experiencing violence or deprivation are trained by Children First to understand HIV, the value of HIV services, and how to mobilize young people through dance, drama and music.

The peer educators then select communities based on sexually transmitted infections (STI) and pregnancy data that suggest high levels of risky behaviours. They are trained to learn what the needs of the community are through informal conversations with youngsters, community organizations and leaders in local industry. A key strategy employed by the peer educators, also known as the Bashy Bus kru, is to engage in ‘risk conversations’ with groups of no more than three young people at a time, in a non-school environment.

The kru are versed in building skills among peers to use condoms properly, negotiate condom use, make decisions around sex, among other topics; they apply these skills through workshops that work in tandem with large parties or ‘hype sessions’ thrown by the crew to raise awareness about HIV and provide HIV counselling, testing and health-related services.

The Bashy Bus, working closely with local health services, then goes into the township, and offers HIV testing and pap smear services with same day results. A core team of professional counsellors also counsel young men and women, and referrals are offered to those that test HIV-positive or have STIs. These results are returned to the local health service, which ensures complementarity of services. All services are confidential.

The Bashy bus also offers referrals to auxiliary services such as vocational training.
**Cost:**
The cost to run the service for a year amounted to approximately USD 50,000.

**Partners:**
UNICEF, Children First and the Ministry of Health.

**Results:**
Results were obtained following a comparison of 2006 baseline and 2008 post-intervention data, and an analysis of the intervention and comparison communities.

For those adolescents primarily dependent on their sexual partners for money, the level of forced sex declined over the two-year period, from 60% in 2006 to 38% in 2008.

Female adolescents with partners who were five or more years older had more forced sex encounters than those with younger partners. In 2006, 41% of female adolescents with older partners had forced sex encounters, compared to 28% of female adolescents with younger partners. In the 2008, the corresponding figures were 36% and 19%, respectively.

Overall, results indicate that levels of forced sex encounters have declined over the last two years.

Since 2006, there has been an increase in the age of initiation for sex in both males (from 11.8 to 13.9 years) and females (14.9 to 17.1 years).

Condom use with non-primary partners has increased for both males (77.3% to 88%) and females (54.1% to 74%).

While direct attribution of behaviour change results to the Bashy Bus Service cannot be made, there was minimal to no penetration of other HIV prevention services during the period of the interventions, suggesting a strong role for the Service.

**Lessons Learned:**
Effective engagement of young people required a community approach. This has two practical aspects: a) increased engagement with parents in the form of parent workshops was a necessary step to build trust and legitimacy for the programmes and improve utilization among young people; b) reaching out to young people outside of the school setting was vital for engaging all youngsters. Young people in school and out-of-school showed similar risk behaviours, and school attendance was not regular or predictable.

Strong emphasis on small group interaction and peer-to-peer interactions was critical to maximizing the intervention’s impact.

There was greater than anticipated utilization of counselling services by young MSM and young women.
Drama and music are an important mobilizing force for young people; it was leveraged effectively to convene groups of young people who could receive HIV prevention services and referrals.

Recruiting peer educators from similar backgrounds is essential if trust is to be built and networks are to be maximized. This lesson is underscored by the connections peer educators made with local young people who would warn them to stay away when violence flared up in the community.

Focusing services solely around HIV can be viewed as a deterrent for uptake by young people, as it is thought to increase stigma. Referrals for vocational services and workshops on improving self-efficacy appeared to improve the capacity of young women to reduce acts of transactional sex.

**Next Steps:**
In April of 2011, the Northeast Region assumed administration of the Bashy Bus programme, with the aid of a bus provided by UNICEF and the technical assistance of Children First.

Programmes specifically for young men who have sex with men and young women will be further developed following substantive qualitative research. Plans are underway with local child protection agencies to strengthen data collection on the issues of gender-based violence and child exploitation.

Assessments are underway to understand which communities could sustain the programme and benefit from its services.

Novia Condell of UNICEF Jamaica contributed this piece.

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Learn more about the Bashy Bus and other programmes to prevent HIV infections in young people: [http://www.unicef.org/jamaica/hiv_aids_17316.htm](http://www.unicef.org/jamaica/hiv_aids_17316.htm)
Profiles in equity

Malaysia

Parameswary Nadarajan, 18, learns about HIV and AIDS from Kogilavani Gunasegar, 19, in the town of Sungai Petani, in the northern state of Kedah. Ms. Gunasegar is part of a women’s peer-to-peer pilot programme. UNICEF is working with the Kedah State Health Department to raise HIV and AIDS awareness among lower-income girls and women, incorporating information about the disease into cooking and crafts classes, grooming lessons, and health-services hotlines.

Both young women and young men are a part of the global response to HIV prevention. The comprehensive report on the status of women and HIV in Malaysia, spearheaded by UNICEF, ensures that the situation of girls and women is not only better understood by local and national policy-makers, but that they are an essential constituency for services.
National reporting on the status of women and children in the context of HIV

Improving evidence for programmes:

At A Glance

**Issue:**
Clear data on the effects of HIV and AIDS on the lives of girls and women in Malaysia was not available to inform the 2006-2010 National Strategic Plan for HIV/AIDS, though they were noted as a target population for HIV interventions. In the absence of that data, relevant policies and programmes for girls and women were largely missing, and the population was underserved.

**Action:**
In 2006, UNICEF undertook an extensive review to understand the needs of women and girls living with or affected by HIV and AIDS. Data pertaining to HIV and women and girls, published and un-published, was compiled from all available sources, including the government, non-governmental organizations as well as academia, and analyzed.

**Partners:**
The Ministry of Health-AIDS/STI Sector; All Women’s Action Society; Protect; Save The Children; and UNICEF.

**Results:**
The first comprehensive report on women and girls within the context of HIV in Malaysia was completed within three months. Topics include: sexual violence, sexual and reproductive health and injecting drug use.

**Next steps:**
More detailed analyses of the effect of HIV on women and children are expected by the end of 2011.

**Issue:**
In Malaysia, women and girls remained largely an unknown quantity within the context of HIV. While the National Strategic Plan on HIV/AIDS 2006 – 2010 included women and girls as a target population for HIV interventions, the lack of clarity on the impact of HIV on women and girls impeded an effective response to their needs.

**Action:**
In 2006, UNICEF undertook an extensive review to define the needs of women and girls living or affected by HIV and AIDS. Data pertaining to HIV and women and girls, published and un-published, was compiled from all available sources and analyzed. This included HIV surveillance.
data, official reports from the Ministry of Health, Ministry of Home Affairs, Ministry of Women, Family and Community Development, Royal Malaysian Police, several other government agencies, together with data from surveys and studies from non-governmental organizations and academic institutions.

The first comprehensive report on women and girls within the context of the HIV epidemic in Malaysia was completed within three months and formally launched in 2008 by the Ministry of Health and UNICEF. The report includes data on sexual violence, sexual reproductive health and injecting drug use.

Partners:
The Ministry of Health-AIDS/STI Sector; All Women's Action Society; Protect; Save The Children; and UNICEF, which provided the technical support, and advocated for buy-in from the primary stakeholder, the Government of Malaysia.

Results:
The report is an official reference tool for the Ministry of Health’s State AIDS Officers. The Ministry of Women, Family and Community Development is advocating for local language translation to promote greater access to the report among social welfare officers. Many women's NGOs have adopted the document as they work toward a better understanding of HIV and its impact on women and girls.

The report informed the 2008 UNGASS Country Progress Report for Malaysia. The gender analyses have been used extensively throughout 2008 and 2009 in official documentation by government and civil society representatives, including the annual State of the Malaysian HIV Epidemic roundtable stakeholder consultation, contributing to improved coverage of quality services for women and girls affected by HIV and AIDS.

In 2008 the national World AIDS Day message drew directly from the Report, at which time the Minister of Health announced the formation of the multi-ministerial Taskforce on Women, Girls and HIV. The Task Force’s mandate is to provide guidance and recommendations to address the situation of women and girls through a multi-sectoral approach with the direct involvement of the Ministry of Women, Family and Community Development, and to put specific recommendations into practice. The Taskforce continues to be an active force, and will be instrumental in the implementation of the National Strategy on HIV and AIDS 2011 – 2015.

Next Steps:
More detailed analyses of the epidemic’s effects on women and girls and of the quality and uptake of HIV services by women and girls are expected by the end of 2011.


Visit the UNICEF Malaysia website: [http://www.unicef.org/malaysia/aids.html](http://www.unicef.org/malaysia/aids.html)
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