



# HIV prevention with especially vulnerable young people

CASE STUDIES OF SUCCESS AND INNOVATION

## SAFE PASSAGES TO ADULTHOOD

In 1999, the UK Department for International Development (DfID) funded a major programme of research into young people's sexual and reproductive health in poorer country settings.

Coordinated jointly by the Centre for Sexual Health Research at the University of Southampton, the Thomas Coram Research Unit at the Institute of Education, University of London, and the Centre for Population Studies at the London School of Hygiene and Tropical Medicine, the principal objectives of the Safe Passages to Adulthood programme are to:

- fill key knowledge gaps relating to the nature, magnitude and consequences of reproductive and sexual health problems amongst young people;
- identify situation-specific key determinants of young people's sexual behaviour;
- identify culturally-appropriate means by which barriers to good sexual and reproductive health can be overcome;
- identify new opportunities to introduce and evaluate innovative programme interventions;
- develop concepts and methods appropriate to the investigation of young people's sexual and reproductive health.

The programme does not define young people through the use of rigid age boundaries. Rather, it adopts a life course perspective in which the focus of interest is on individuals in the period prior to the transition to first sex, and up to the point of entry into marriage or a regular partnership. This spans the key transitional events of 'adolescence' and captures a period of high sexual health risk and distinctive service needs.

Sexual and reproductive health includes physical and physiological processes and functions in addition to psychological and emotional aspects. It encompasses young people's capacity to decide if and when to have children; the ability to remain free from disease and unplanned pregnancies; freedom to express one's own sexual identity and feelings in the absence of repression, coercion and sexual violence; and the presence of mutuality and fulfilment in relationships.

Beyond young people themselves, the Safe Passages to Adulthood programme focuses on policy makers and practitioners as 'gatekeepers' to the promotion of young people's sexual and reproductive health.

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### *Case studies of success and innovation*

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## INTRODUCTION

In the year 2004, it was estimated that up to 6,000 young people between the ages of 15 and 24 years were being infected by HIV every day, bringing to 10 million the total number of young people living with HIV/AIDS (UNFPA, 2005).

Young people's vulnerability to HIV/AIDS varies according to economic, political, social, cultural and religious context. While young people in general are often denied the knowledge and resources they need to protect themselves and their partners against infection, certain groups find themselves especially vulnerable by virtue of their gender, age, sexuality and socio-economic circumstances. These include young migrants and refugees, young homeless people, young people who inject drugs, young sex workers, young men who have sex with men, and young people living in particularly impoverished circumstances.

To reflect these variations in vulnerability, a coherent yet differentiated public health response is called for. In order to be effective, this needs to be sensitive to local specificities, and be operationalised together with other non-health sector work, while working from core principles central to what is globally recognised as good prevention practice.

In 2004, the World Health Organisation's Department of HIV/AIDS and the UK Department for International Development (DfID) supported the Safe Passages to Adulthood programme to develop a joint publication entitled *HIV/AIDS prevention and care for especially vulnerable young people: a framework for action*<sup>1</sup>. This offers a straightforward guide to priority setting, outlining five core principles underpinning effective HIV/AIDS prevention programming with young people.

<sup>1</sup> Available at: <http://www.safepassages.soton.ac.uk/pdfs/evypframework.pdf> (accessed 18<sup>th</sup> February 2006)

While of relevance to work with young people in general, these principles establish a framework within which to meet the needs of especially vulnerable young people. The five principles are:

- Putting the young person first;
- Promoting meaningful participation;
- A commitment to rights;
- Promoting gender equity; and
- Tackling risk and vulnerability.

This follow-up publication is intended to be read in conjunction with *HIV/AIDS prevention and care for especially vulnerable young people: a framework for action*. It describes programmes in Argentina, Nigeria, Iran, India and Kenya whose work with especially vulnerable young people illustrates some or all of these five principles in action.

## Five principles for success

### *Putting the young person first*

The words used to describe people have important implications for how their circumstances and needs are understood. Terms such as 'young people', 'adolescents' and 'children' have wide currency, and official definitions exist for each of them. From the point of view of HIV/AIDS prevention, the term young people implies three important things:

- concern for a relatively wide age range (10-24 years in WHO's definition) in which risk and vulnerability can occur;
- awareness of social variability (via the emphasis on diversity implied by the word 'people') in the transition from childhood to adult life; and
- concern for individual dignity and respect (through notions of 'personhood' and an emphasis on the individual as a bearer of rights).

Young people is an inclusive term. Yet within any context, needs and potential vary enormously. Careful analysis of these differences is necessary to provide a sound basis for the planning, provision and monitoring of appropriate services. While often valuable as a mean of raising general awareness, approaches targeting young people 'as a whole' run the risk of either ignoring those who are most marginalized and vulnerable, or of failing to recognise the culturally and socially differentiated nature of the stage of life referred to as youth.

One key to success lies in making the young person who is especially vulnerable, and their needs, central in the HIV prevention response, together with addressing health needs in a pragmatic and non-discriminatory way.

### *Promoting meaningful participation*

Numerous UN system documents, best practice reviews and other sources of information point to the importance of participation. With respect to HIV and other health issues, social participation is vitally important to health (Dairo and Aglobitse, 2004; Health Development Agency, 2004). This is no less true of work with young people than with other groups. Young people's participation in the identification of needs and in programme design and development

should lead to greater acceptability and appropriateness (Lansdown, 2001; Kirby et al., 2003; Senderowitz et al., 2003). It should also result in programming that is inclusive rather than stigmatising and discriminating. Through meaningful participation, young people become a potential resource in addressing the global HIV pandemic (Bellamy, 2002; Bond, 2004; Family Health International, 2005).

One of the clearest rationales for the participation and involvement of young people in HIV programming derives from the United Nations Convention on the Rights of the Child (CRC)<sup>2</sup>. This assigns to children and young people the right freely to express their views and opinions, and have them considered, in relation to many walks of life. This includes the manner in which they are treated by adults and society more generally, as well as the services that are provided, and to which they have access. Taking seriously the words of this convention should be the cornerstone of any coherent future public health response.

While efforts have been made to promote young people's participation in targeted HIV-related activities, fewer programmes have tried to promote young people's participation as part of a more encompassing strategy (Morrow, 1999). Research suggests that young people typically feel excluded from wider societal decision-making and perceive many efforts to increase their involvement in programme planning as tokenistic (Lansdown, 2001; Bellamy, 2002; Matthews, 2003). The challenge therefore lies in developing policy frameworks and participation opportunities that respect young people's interests and needs, and which are perceived as valuable by the young people concerned.

2 Available at: <http://www.unicef.org/crc/crc.htm> (accessed 18<sup>th</sup> February 2006)

## *A commitment to rights*

The links between health and human rights are increasingly well documented<sup>3</sup>. Promoting human rights within the context of HIV/AIDS is important not only as a means of tackling the structural factors that render some groups systematically more vulnerable than others, it is also important with respect to unleashing the power of individuals and of communities to make a difference to their own lives (e.g. Mann and Tarantola 1996).

The right of children to express their views and opinions, and have them considered, is one of a number of fundamental rights enshrined in the UN Convention on the Rights of the Child (CRC). Another article in this convention recognizes the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health (Article 24). Article 27 recognizes the right of every child to a standard of living adequate for physical, mental, spiritual, moral and social development. Articles 28 and 29 recognize the child's right to education directed towards the development of personality, talents and mental and physical abilities to their fullest potential. Two additional optional protocols seek to protect children against participation in armed conflict and recruitment to the armed forces; and against illegal adoption, child prostitution and involvement in pornography. These articles and the optional protocols offer a sound basis around which to develop a coherent and committed public health response<sup>4</sup>.

There are numerous other international human rights instruments of public health relevance to young people and HIV/AIDS. These include the Universal Declaration on Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic Social and Cultural Rights; the Convention on Elimination of All Forms of Discrimination Against Women; the Convention on the Elimination of All Forms of Racial Discrimination, regional charters, and specific rights in relation to living with or being affected by HIV/AIDS. Beyond these conventions, there are international agreements that offer a normative framework within which to couch a response. These include ICPD+5, the Beijing Declaration and Platform for

3 See, for example, [http://www.hsph.harvard.edu/fxbcenter/FXBC\\_WP10--Gruskin\\_and\\_Tarantola.pdf](http://www.hsph.harvard.edu/fxbcenter/FXBC_WP10--Gruskin_and_Tarantola.pdf) (accessed 18<sup>th</sup> February 2006) for a discussion of general issues and <http://www.ohchr.org/english/about/publications/docs/g6.pdf> (accessed 18<sup>th</sup> February 2006) for the application of these principles to HIV prevention and care

4 <http://www.who.int/child-adolescent-health/RIGHTS/crc.htm> (accessed 18<sup>th</sup> February 2006)

Action and its five-year follow up, and the Millennium Development Goals. Already, rights-based programming for prevention, care and impact alleviation is showing success<sup>5</sup>.

### ***Promoting gender equity***

Globally, young women are disproportionately affected by HIV/AIDS, and most markedly so in parts of Africa. Three-quarters of all HIV infections worldwide occur in women in Africa, and throughout sub-Saharan Africa HIV infection rates among teenage women are up to three times higher than rates for teenage men (UNFPA et al., 2004). The physical immaturity of younger women and women's status in society enhance vulnerability to HIV infection. Women's lower social status may prevent them from exerting control over their sexual relationships.

For many girls and young women, first sexual experience takes place within the context of marriage, which is often construed as a safe and moral context. Girls, more than young men, are encouraged to wait until marriage before having sex. Yet, marriage for young women is often at an early age, to older and more sexually experienced partners, and in contexts where marriage is not synonymous with monogamy for many men. The result is both risk of infection at an age when young women are biologically most vulnerable, coupled with ill-conceived notions of security and safety through marriage. All over the world, stereotypes of femininity mean that young women have to negotiate between being knowledgeable, and appearing innocent, in order to protect their sexual and social reputations (Rivers and Aggleton, 1998a; Rao Gupta et al., 2003).

But it is not only young women who are made vulnerable to HIV by existing gender norms. In the Americas, in East Asia and throughout much of Europe, greater numbers of young men than young women are infected, largely because HIV transmission is still concentrated among injecting drug users and men who have sex with men (UNAIDS, 2004). Dominant images of masculinity and 'manliness' can make it difficult for boys to seek sexual and reproductive health advice. Men are supposed to be knowledgeable and experienced about such issues, and to seek help is to risk being perceived as less of a man (Rivers and Aggleton, 1998b; Barker, 2005).

<sup>5</sup> See, for example, [http://www.undp.org/execbrd/pdf/04-10\\_final%5B1%5D.pdf](http://www.undp.org/execbrd/pdf/04-10_final%5B1%5D.pdf) (accessed 18th February 2006) for evidence submitted to the UNICEF Executive Board Annual Session, June 2004 and Aggleton et al. (2005); [http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf), [http://data.unaids.org/Publications/IRC-pub02/JC637-GlobalFramew\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/JC637-GlobalFramew_en.pdf) (accessed 18th February 2006).

Promoting sexual responsibility among men is central to the health of both men and women. Until recently, gender based approaches to sexual and reproductive health, including HIV and sexually transmitted infection (STI) prevention, have focused on empowering young women to assert themselves and redress the balance through their increased knowledge and ability to take control. This approach has a number of flaws, however, in that it tends to adopt a stereotypical notion of men, their desires, motivations and interests, and assumes that all aspire to the same expressions of masculinity.

It is important, therefore, that the public health response to HIV/AIDS and young people starts from the diverse needs and interests of both men and women. There is a pressing need to unpack the multiple ideologies of gender that exist, and the manner in which these are influenced by class, ethnicity and sexuality. While dominant forms of masculinity and femininity may be divisive and harmful, predisposing to greater vulnerability and risk, alternative and oppositional ways of living are possible. These should be made the starting point for future HIV prevention efforts in ways attuned to local specificities and needs (Mane and Aggleton, 2001).

Ultimately, and for lasting success, programmes need to address young people's gender vulnerability in a variety of ways, within both short- and longer-term time frames. In the short term, gender-sensitive programmes may offer some hope. But in the longer-term, gender-sensitive programming will not radically change the unequal gender relations that fuel the epidemic and make women and men differentially vulnerable. Socially transformative and empowering programmes must be implemented alongside gender-sensitive programmes in the hope of ultimately challenging the very foundations of the epidemic (Rao Gupta et al., 2003).

### ***Tackling risk and vulnerability***

#### ***Risk***

In the context of HIV, risk can be defined as the probability that a person may acquire infection. Certain behaviours create, enhance and perpetuate risk. They include unprotected sex with an infected partner, multiple unprotected sexual partnerships, and injecting drug use where injecting equipment and drug preparations are shared. Globally, early responses to HIV aimed mainly at reductions in risk-taking behaviour through the targeting of individuals and groups.

Examples of targeted interventions here include the provision of information and education about HIV and AIDS, life skills education, drug risk education, and programmes to enhance women's and young people's capacity to ask for, and negotiate, protection.

### ***Vulnerability and the importance of context***

Experience has shown, however, that in order to be successful HIV prevention should focus not only on risk-taking behaviours, but also on environmental, cultural and societal factors. Political, economic and social inequalities influence young people's sexual and reproductive health, as well as their opportunities for involvement in injecting drug use. Vulnerability to HIV is influenced by three sets of variables, and the interactions between them:

- (i) factors such as group or subculture membership;
- (ii) the quality and coverage of services and programmes; and
- (iii) broader societal and environmental influences.

The first set of factors includes the social networks of which an individual is a part. Some young people, for example, may find themselves at enhanced vulnerability for HIV infection by virtue of their membership of a group in which HIV infection is particularly prevalent (e.g. by being young injectors, by being young and homeless, or by being involved in sex work where levels of infection are high).

Service and programme factors on the other hand include the cultural appropriateness (or inappropriateness) of HIV prevention programmes; the accessibility (or inaccessibility) of services due to distance, cost and other factors, and the capacity of health systems to respond to growing demand. Many young people may be rendered especially vulnerable to HIV through a deficiency in young person friendly reproductive health service provision. Young injecting drug users not infrequently find it difficult to access services set up with the adult injector in mind.

Broader societal and environmental factors influencing vulnerability include political decisions, economic inequalities, laws and cultural norms that act as barriers or facilitators to prevention. Such influences may lead to the inclusion, neglect or social exclusion of individuals depending on their lifestyles and behaviours, as well as socio-cultural characteristics. Among the broader forces structuring young people's vulnerability are inequalities of age, gender, sexuality, poverty

and social exclusion. With respect to gender, for example, inequalities in access to education, in income distribution, in the ownership of property and in employment opportunities can enhance young women's vulnerability to HIV. With respect to poverty, economic disparities within a country are critical in determining vulnerability. Violations of rights, physical abuse and sexual exploitation can deepen the gap between those who benefit from economic growth and those who suffer its ill effects.

Vulnerability-reduction measures are, of course, necessary as part of broader moves towards enhanced social justice and overall development. But they are also central to effective HIV prevention among young people. Sometimes they can be applied within the context of broad-based programmes addressing young people as a whole - e.g. through specialist youth friendly service provision or through legal reform to enhance young people's access to condoms. On other occasions, they may be applied in a more focused way in contexts of special or complex vulnerability.



## Three priority fields of action

Two decades of global learning have identified three priority fields or areas of work, within each of which action must be taken if HIV prevention is to succeed:

- the reduction of risk;
- the reduction of vulnerability; and
- the reduction of impact<sup>6</sup>.

Each of these fields is inter-related, such that action within any one of them impacts upon the others. Simultaneous action across all three domains lays the foundations for a successful response.

### *Action to reduce risk*

Risk reduction among young people in general can be accomplished in a variety of ways. Overall objectives and approaches identified include the:

- promotion of safer sex (including abstinence, delayed sexual initiation and the consistent use of condoms);
- encouragement of risk reduction in drug use (including use of clean injecting equipment);
- detection and early treatment of other sexually transmitted infections;
- use of voluntary and confidential counselling and testing;
- prevention of HIV transmission from infected mothers to their infants;
- prevention of HIV transmission through infected blood and blood products; and
- prevention of HIV transmission within the health care setting.

Reductions in risk can be brought about by a variety of means. These include:

- information, education and communication (IEC) and behaviour change communication (BCC) strategies;
- schools-led education;
- skills building education;
- peer education; and
- outreach work with young people in difficult circumstances.

While some of these means will be suited to meeting the needs of young people in general, others are more attuned to the circumstances of those who, for different reasons, are especially vulnerable. These latter approaches include peer-led education and outreach approaches in sex work and drug use, as well as among homeless young people, street dwellers, migrants and refugees. The use of formal and informal networks to communicate safer sex and harm minimization messages among especially vulnerable groups of young people is also important.

### *Action to reduce vulnerability*

Young people's vulnerability to HIV can be reduced in many ways. Among possible approaches are, through:

- social networks and peer relations that model and promote norms for safer behaviour;
- increasing family and peer trust and support;
- the development of schools as more inclusive, gender sensitive and protective environments;
- ensuring access to commodities (e.g. condoms and clean injecting equipment) that have been shown to have a demonstrable effect in preventing HIV infection;
- the provision of health services in ways and at times that young people find appropriate;
- economic and political action to promote positive educational, employment and health opportunities;

6 [http://data.unaids.org/Publications/IRC-pub02/JC637-GlobalFramew\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/JC637-GlobalFramew_en.pdf) (accessed 18<sup>th</sup> February 2006)..

- legal provision to guarantee young people's right to the full range of information and resources to protect themselves (and their partners) against infection;
- systematic efforts to combat stigma, discrimination and denial;
- the reduction of economic and gender disparities that fuel the epidemic; and
- efforts to build supportive social norms and to promote social inclusion.

Reductions in vulnerability can be brought about by:

- legal, political and economic action and reform;
- the development and implementation of healthy public policy;
- social and community mobilization;
- the provision of rights based education for empowerment;
- the re-orientation of existing service provision; and
- social network development to cultivate a sense of trust and shared responsibility at grassroots level.

Once again, these actions may be taken across a variety of contexts to meet a wide range of young people's needs. Specifically, it will be important to focus upon those forms of policy and legal change that bring about reductions in young people's vulnerability to HIV through the provision of employment, education and health services that tackle gender disparities and inequalities, and that build norms of trust and social reciprocity in severely disadvantaged circumstances.

### *Action to mitigate impact*

Finally, the impact of HIV on young people as a whole, and on especially vulnerable young people in particular, can be alleviated in a variety of ways. Among the principal means of doing this are:

- efforts to reduce the financial and social impact of the epidemic on individuals, families and communities;
- action to enhance the access of those orphaned as a result of AIDS to health, nutrition and education;
- promotion of livelihood and vocational education for young people;
- improved access to care, social support, voluntary and confidential counselling and testing, and anti-retroviral therapy;
- improved access to services to prevent the mother-to-child transmission of HIV; and
- increased access to legal services and human rights protection.

Reductions in the impact of HIV can be brought about by:

- strengthening national and local systems of governance;
- developing sound economic and social programmes;
- support for more effective HIV programming;
- action to increase access to essential commodities (including anti-retroviral drugs);
- improving the capacity of community organisations to carry out their work;
- enhancing the role of schools and other forms of educational provision so that they can offer broad-based support; and
- increasing community and external investments in health, social services, education and agriculture, among other means.

Impact reduction measures of relevance to especially vulnerable young people include all of the above, but special emphasis needs to be given to actions that promote equity and reduce inequality. These include efforts to improve (or rebuild) access to health and social services in contexts of particular need; actions to strengthen vulnerable young people's access to employment and education; and actions that provide health, education and employment in ways especially suited to the alleviation of impact in serious and complex emergencies.



Each of the five principles outlined above is of fundamental importance in the development of HIV prevention programmes and activities that work. In the next section, we describe five examples of innovative and potentially effective work from different countries across the world. Each example provides an instance of how it is possible to apply these principles in the local context. We hope they offer inspiration on how to proceed.

## CASE STUDIES

### HIJOS, Buenos Aires, Argentina

#### Context

Argentina is a country in flux. Until recently one of the most economically successful countries in Latin America, and in the early decades of the twentieth century one of the richest in the world, the country has suffered greatly in the past thirty years. Many Argentines are still coming to terms with the brutal years of military dictatorship, 1976-1983, and in particular with the state-conducted 'dirty war' against so-called leftist elements in which an estimated 30,000 people were assassinated, kidnapped, tortured, imprisoned or exiled<sup>7</sup>. Every Thursday for the past 28 years, the Mothers of the Plaza de Mayo have protested about the lack of official information on 'the disappeared' - their loved ones, friends and family - in one of the main squares of the city, La Plaza de Mayo.

More recently, the economic collapse of 2001 (known popularly as El Crisis) led to a 28% fall in the gross domestic product (between 1998 and 2002), a poverty rate of 57.5%, an unemployment high of 24%, and an inflation rate of 40% (figures in 2002 - Saxton, 2003). At the height of the crisis, Argentinean society was widely reported as being in meltdown. Although there have been some signs of an economic recovery, particularly since 2003/4, it is still unclear whether this recovery is benefiting society as a whole. Certainly, inequality has risen dramatically since 2001<sup>8</sup>.

With this backdrop of economic and social disaster, it might be assumed that issues of HIV prevention and AIDS care in Argentina are not high on the national agenda. However, as with other Latin American countries, there is growing concern about new infections, the disproportionate impact upon the poor, access to information and education, and the impact on health services of many new cases of AIDS.

<sup>7</sup> [http://en.wikipedia.org/wiki/Dirty\\_War#/Notes](http://en.wikipedia.org/wiki/Dirty_War#/Notes) and [http://www.nuncamas.org/english/library/nevagain\\_000.htm](http://www.nuncamas.org/english/library/nevagain_000.htm) for further information (accessed 18<sup>th</sup> February 2006).

<sup>8</sup> For more information see: <http://pweb.jps.net/~gangale/opsa/ir/StrategyForArgentineRecovery.htm> (accessed 18<sup>th</sup> February 2006).

In Buenos Aires, the capital of the country, HIV prevention efforts are led by local government via the *Coordinación SIDA*, which leads and supports a range of campaigns and educational activities. Thanks to this organisation, we were introduced to a range of non-governmental organisations (NGOs) conducting interesting HIV prevention and AIDS care work, including an organisation called HIJOS, whose work is described here.

HIJOS (Children for Identity and Justice and against Forgetting and Silence) is an association of sons and daughters of 'the disappeared', established in 1995. It is a political/human rights organisation, with 26 groups forming a national network across Argentina. One of the key activities undertaken by HIJOS is protest and direct action against those they consider complicit in the 'dirty war'. The group also protests against the amnesty laws passed by successive governments that have prevented these people being brought to justice.

#### *HIJOS and the revolutionary struggle*

'The goal of the activities we are involved in is to continue to walk the same path that our fathers walked, though in different times and circumstances: vindicating the revolutionary struggle that they kept alive with their companions, their sheltered dreams and hopes; something their executioners never forgave.' *HIJOS publicity material, 2004*

Many NGOs in Latin America present a similar face of radical political action, while also working in a much more cross-cutting way across organisations and issues. HIJOS works in this way, forming strategic alliances with other national organisations, such as the Unemployed Workers Movement, and the Defenders of Human Rights. It also forges links across national boundaries, for example with groups in Brazil (The Movement of Rural Landless Workers) and Paraguay (Movement for the Free Homeland of Paraguay).

Perhaps most radically, within a nation where machismo is still a strong reinforcer of social norms (Gogna and Ramos, 2000), HIJOS is developing work with lesbian, gay, bisexual and transgender (LGBT) communities and activists. The group joins Gay Pride marches and campaigns for the rights of those who were imprisoned because of their sexual orientation or gender identity. HIJOS is also developing work on HIV prevention and AIDS care, although this is still in its early

stages. HIV-related activity began slowly, as the organisation itself was developing, and as some of the group members discovered they were HIV-positive.

It is these activities that we discuss here, and in particular the work of the group in the *zona* (area) known as *Once* (pronounced on-seh). We can not claim to represent the entirety of HIJOS's work here, nor do we focus on activities outside of Buenos Aires – as each group is organised individually, and works according to local circumstances. HIJOS's work on HIV is just beginning but has already uncovered a range of unmet needs. In particular, we focus upon HIJOS's work with a group of especially vulnerable boys and young men, and consider the difficulties of intervening at this extreme level of disadvantage.

## Approach

HIJOS is essentially a political and activist organisation, but the group members do not feel able to separate the national struggle in which they are engaged from the local, individual struggles that the most disadvantaged *Porteños* (the name for the people of Buenos Aires) face on a daily basis. HIJOS therefore becomes involved in providing a number of social care services, including youth work, sexual health work, health care services, and provision of basic services (such as food and clothing), as well as political activism.

The HIJOS Buenos Aires group has three bases, one of which is found in the *zona de Once*. The *zona de Once* is located a little to the north of the city centre, just three short metro stops from the centre of Buenos Aires. It is a mixed neighbourhood. Some of the area appears at first sight relatively prosperous, with fine buildings and quiet streets. The main square is a busy place, fronted on one side by the impressive building that houses the mainline railway station. However, walking even a very short distance, there is obvious poverty and deprivation. The station's grand colonial façade stands in stark contrast to the poverty of many who use it on a regular basis as a place to beg, sleep, or have sex for money in the station toilets. Behind the railway lines just outside of the station, a *ranchada* (shanty town) of temporary hut-dwellings used by homeless people, is tucked out of sight. Indeed, *Once* contains the highest number of homeless people within the city boundary. It has a high migrant population and sex work is reported to be common. The area is difficult for social or community workers to access, and young men and boys working in the sex industry are particularly difficult to reach.



The railway station in the zona de Once (reproduced with permission from [www.paionce.com.ar](http://www.paionce.com.ar))

It is in the *zona de Once* that HIJOS is developing work with some of the most vulnerable young people, including boys and young men who sell and trade sex and who face a range of problems, including drug use and homelessness. Although formal aims and objectives for HIJOS's HIV-related work have not yet been fully articulated (at least, in the sense of being written down), from our discussion with the group, their approach to HIV and AIDS issues could be described as follows:

- To work with a particular group of very vulnerable boys and young men, who are involved in sex work in the *zona de Once*;
- To develop HIV work from this starting point, taking into account the full context of disadvantage in which these boys/young men are living;
- To campaign against what the group sees as inadequate and discriminatory health policy/legislation, particularly in relation to access to services and drug treatment;
- To provide information on friendly counselling and treatment services;
- To continue to forge and develop links with other organisations in this and related fields.

## Activities

In the *zona de Once*, HIJOS have a house that is situated two blocks from the central square and is the base most publicly associated with the group. HIJOS uses the house as a base for a range of activities, including a library with accompanying learning support, a help centre for local unemployed people, cultural activities, drawing classes, and free legal advice. The key populations with which the group works from here are young people, homeless people, and those who are looking for work.

HIJOS also runs a *comedor* (canteen) here, one of two run by the group in Buenos Aires, using simple barbecue-like grills. These *comedores* are open to all local people and function as a way of feeding the poorest. The *comedores* provide a good way for individual workers to form links with locals, and encourage the development of trust between the organisation and the community. The local government has suggested that one of the reasons for the high numbers of homeless people in *Once* might be the presence of baseline social services such as this.

It was through this *comedor* service that HIJOS workers established contact with a group of seven boys and young men who were involved in sex work. The group were aged between 13 and 18 years and originally come from other parts of Buenos Aires, its suburbs, and Mar del Plata, a coastal city to the south. They have no permanent homes, except for the *ranchada* described above.

### *The seven*

'The group have very distinctive ways of functioning and have managed to put together a support network which gives them access to food, condoms, and places to sleep. One strange thing about the group is that they only take marijuana and alcohol; they say they won't use crack, after one of their friends died using it. Once you get in on the inside of the group, you can see the friendship, the care and protection that binds them together. It's that which distinguishes the seven from others in the same situation.' *Julio, HIJOS worker.*

*The seven* had left their homes due to abuse from their respective families. They had met one another in *Once*, the place to which they had all gravitated, and began to hang out together in an informal friendship group. Homeless and jobless, the young men became involved in sex work with men in the *Once* area. Approximately 18 months before the time of writing, HIJOS workers made initial contact with the group.

Sex work between men in the *zona* often takes place in the public toilets in the railway station, or in the porno cinema, both on the main square. The young men appear to have an arrangement with the owner of the porno cinema; if they bring clients to the cinema, they are allowed to stay overnight, which is preferable to sleeping on the streets or in the *ranchada*.

Work with *the seven* was initiated through the free food service in the *comedor* and via gifts of clothes that HIJOS was able to make. When one of the young men was kidnapped and found severely beaten (having been invited by another man to join him in a car), HIJOS decided to become more involved, by arranging for medical care to be provided to this young man through their contacts with *Coordinación SIDA* and other groups.

HIJOS's work with *the seven* comprised of a range of support services. HIJOS workers befriended *the seven*, facilitated their access to other services, and offered informal information-giving and condom distribution. HIV prevention and care was seen as only one element of the support provided by HIJOS to this group of especially vulnerable young men. Informal discussions through *charlas*, or 'chats', and informal outreach work (walking round *Once*, getting a feel for where the young men were hanging out and making time to talk to them) was seen to be the most productive approach to engaging this group.

However, there is still much work for HIJOS to do in *Once*, as it is estimated there are at least 60 other boys/young men who are involved in sex work in the area. Despite the number of boys and young men involved in sex work in *Once*, identifying and gaining access to this group of young men is particularly challenging.

'It's hard to get into the area, access is difficult even to these boys (*the seven*); but with other boys it's much more complicated. We haven't been able to get near other *ranchadas*.'  
*Julio, HIJOS worker*

## Reflections on work to date

HIJOS is a nationally-networked political rights group, yet one of its Buenos Aires branches is also working with a small group of vulnerable young men in their locality. Despite HIJOS's relative lack of expertise in the field of sexual health, they are beginning to think about developing more wide-ranging HIV and sexual health interventions, following the 18 months they have been working with *the seven*.

HIJOS's provision of broad social care services (such as free food and clothing, legal advice, learning support) not only enabled them to make contact with *the seven*, but also gives them locally a position of credibility, as they are seen as providing an important community resource. This points to the importance of developing a needs-led service, which in turn encourages the development of trust between the organisation and the vulnerable community groups it wishes to support. Through informal outreach and providing specific support when needed (as in the case when one of *the seven* was severely beaten), organisations can slowly foster relationships with those young people who are especially 'hard to reach'.

While HIJOS is itself an organisation run by young people and which operates in a democratic fashion, finding ways for *the seven* to actively participate in the development and implementation of HIJOS's work with young men involved in sex work has proved challenging. First, it is unclear how far *the seven* are able (or want) to interact with HIJOS to take on such a role given the nature of their day-to-day existence and, second, it may be HIJOS's activities with this vulnerable group are still too under-developed and informal for the young men to become more involved.

HIJOS is first and foremost a political group campaigning for the respect of human rights. It has been involved with rights-based work with LGBT communities, landless workers, the homeless, and sex workers. While fighting to promote the rights of *the seven* to housing and health care with the local state departments, HIJOS has encountered some legal barriers. Legal requirements aimed at placing minors (young people aged under 16 years) in state care, have hampered the extent to which the organisation can support the young men in securing outcomes that *the seven* will find acceptable.



Although HIJOS has links with a range of women's groups, including AMMAR Capital (*Asociación de Mujeres Meretrices de Argentina* - which supports women working as sex workers), HIJOS is still concentrating its work on young men and has not yet developed any formal programmes with women.

Perhaps the most interesting aspect of HIJOS's approach to work with especially vulnerable young people is that an organisation engaged in political activism has also developed a strong local community support service, and has found itself in a unique position to access and foster relationships with groups that state agencies would not be able to. While many community organisations make similar contributions to supporting local and national HIV prevention and care initiatives, HIJOS has had the added difficulty of having to negotiate a way of working in partnership (for the benefit of their *Porteños*) with those very state agencies it initially set out to oppose.



HIJOS take part in a public demonstration

## Health Matters Incorporated, Makoko project, Lagos, Nigeria

### Context

Health Matters Incorporated (HMI) is a non-governmental organisation, which was set up in Lagos in 1996 and which has received support for its work from a variety of agencies including the Ford Foundation. Working in two of the poorest areas of Lagos, Makoko and Olaleye, HMI is an enabling grassroots organisation seeking to develop innovative strategies relating to sexual and reproductive health among especially vulnerable young people, in particular (although not exclusively) those who are out of school. The core beneficiaries of the programme, which is called 'Support for Reproductive Health for Poor Communities', are young people aged between 13 and 24 years.

Makoko community, where HMI maintains its main project, is a multi-ethnic urban slum with a population of about 75,000. Makoko has existed in its current form since the 1930s. Inhabited by Nigerians and immigrants from neighbouring countries such as Benin, the community has several co-habiting and inter-marrying ethnic groups, including the Egun, Yoruba, Ijaw, Ibo and Hausa. The population is not stable. Conflict in the Niger Delta area of the country in 2001, for example, caused an influx of internally displaced people, which increased tensions in the community and placed increased pressures on HMI's programme.

Part of the Makoko settlement is built in the Lagos lagoon, consisting of one-roomed wooden shacks constructed on stilts in the water. Its residents, who are primarily from the Egun ethnic group, have developed a specialised livelihood centred around fishing, fish-smoking and the exchange of fish for local staples such as cassava, rice and yam. Transport is by dugout canoe. Compared with residents living in the mainland area of Makoko, these water-dwelling inhabitants are particularly marginalised in relation to access to health and education services. As a result, literacy levels are particularly low. Vulnerability increases with the distance from the shore. Some of the Egun people are immigrants or children of immigrants from Benin, and many have little contact with the mainland population. This both reflects and sustains their social marginalisation within the neighbourhood as a whole.



The Makoko settlement in Lagos lagoon

HMI's programme in Makoko aims to help residents transform and make the best of their lives. Due to extreme poverty, transactional sex and sexual networking for money are common practice both within the community and outside it, in the established 'red-light' areas of Lagos. 'People do what they have to in order to survive' observes HMI's director, Peter Ujomu. Sexual abuse is described by project workers as an 'everyday occurrence' in young people's relationships and, as elsewhere, is also not uncommon within families.

The challenges in Makoko are immense. There are no government services other than one primary school, reflecting a complete lack of governance or political interest in the community (except at election time). People's concerns relate primarily to poverty, crime, unemployment, and the need for small-scale businesses.

Many children living in Makoko do not attend school. A survey of knowledge, attitudes, practices and beliefs (KABP) conducted in 2000 in Makoko with 500 young people aged between ten and 24 years, and with 100 parents, found that 30% of young people surveyed 'never went to

school'. Gender disparities in educational access were also revealed, with 21% of men having been to senior secondary school, but only 2% of women. While primary education is in principle free in Nigeria, related costs such as books, uniforms and levies are unaffordable for many families. Many drop out after primary school or midway through secondary, in order to assist their families with economic activities. Nevertheless, among many residents there is a strong belief in the transformative value of education.

There are no clinics in Makoko itself, other than the small nurse-run clinic set up by HMI. Residents have no free access to contraception, which is only available at local chemists, and early pregnancy as well as unsafe abortion is very common. Programme workers say that there is an entrenched silence surrounding sexuality issues, although AIDS campaigns are slowly filtering through via radio. Radio is very popular in the area, including in the part of the settlement that is built on water (some households have generators and others tap into electricity wires). HIV-related illness is beginning to be seen regularly at the HMI clinic.

*One girl's story: published as a letter to 'Health Matters' (Vol. 5, Issue 1), the quarterly newsletter of HMI*

'I am a young girl who presently attends one of the state secondary schools in Lagos. I am from a very large family. My father died recently and left my mother to look after us. We are 14 in number, but three of my brothers are living on their own. My mother sells peppers at Oyingbo market.

To assist her, I started a relationship with one of my classmates whose brother has a shop at Tejuoso market. He is a nice boy, he gives me money to buy school books. At times he gives me money to buy food. Unfortunately I became pregnant but the boy refused to accept paternity. He said I was careless. I dropped out of school and had the baby.

My problem now is that I want to go to university, but I can't afford it and my mother said that she would rather help me to take care of my baby and set me up to start hawking oranges rather than go back to school. I don't want to go into hawking because I know the risks involved such as sexual molestation or rape. My mother said that if I want to go back to school, I should marry one of my uncles, who asked to marry me.



I don't want to get married without being economically empowered, because I know disempowerment puts a lot of women at risk as they have to condone whatever treatment is meted out to them, including sharing their husband with his other sexual partners and not being in a position to resist sexual advances from such a man due to the fact that they depend on him for basic needs and sustenance. Please, what should I do?"

This girl learned a vocational skill through HMI and went onto work as a youth worker with the organisation. She is presently studying at the local college of education.

## Approach

Poverty, not health, is the starting point for HMI's programme in Makoko. HMI's philosophy is to provide people with the means to access sexual and reproductive health in a way that is acceptable to them. Its central strategy is to empower girls against the exchange of sex for money and other material resources, through access to information, access to loans for micro-businesses, and skills and leadership training. This approach is underpinned by a recognition of the limitations of sexual health-related information provision alone in a profoundly impoverished setting.

A needs assessment conducted in 1998 with local chiefs and other stakeholders, including young people from Egun and non-Egun families, found that poverty and survival were the major challenges facing Makoko residents. In this context, HIV and AIDS were not in any sense seen as a priority by local people. Chiefs and parents were particularly concerned about the high rate of teenage pregnancy, and the anti-social activities of 'area boys' (young men who drop out and form small gangs, misusing alcohol and drugs). They also expressed concern about sustaining their livelihoods, saying that they felt they could do better but lacked resources. Young women's concerns revolved around how to market their fish, acquire more supplies, and roast fish (thereby increasing profits), as well as how to deal with being abandoned by the fathers of their children. In general, young people were concerned about their parents' inability to provide resources for their education, parental unemployment, and the unsanitary and cramped conditions in which they lived. Young people often expressed feelings of helplessness.

The KAPB survey conducted in Makoko in 2000 by HMI confirmed the findings of the needs assessment. Poverty was said to be the greatest problem in the community, with HIV barely featuring in people's list of priorities. Virtually all young respondents, however, said that HIV and AIDS were 'real', although a third said that they did not know how to prevent it. The survey revealed that 46% of the young women had been pregnant. Most parents thought that the main motivation for younger women's sexual activity was economic need.

In the light of the needs assessment and KAPB survey findings relating to early pregnancy, sexual coercion and low levels of literacy, HMI initially focused its activities on working with young women who were out-of-school. At first, HMI provided them with information on pregnancy and HIV, and enabled access to cash loans in order to improve their fish businesses. While initially the community were suspicious about these loans, with many beneficiaries attributing an occult motive to the provision of 'unearned' cash, acceptance of the loans and HMI's work grew once HMI project staff began a process of negotiation and clarification with local chiefs.

As time went on, the frustration of local boys and young men at not being invited to participate in HMI activities was becoming increasingly apparent. Focus group discussions revealed that they wished to be included and were threatening to derail the programme if it did not begin to involve them. HMI's strategy shifted towards a more inclusive approach that reached out to both young men and women, as well as to other community groups, in particular parents. In addition, the community lent HMI a piece of land and a youth centre was built on it. This provided a physical space for the programme. The youth centre, as well as HMI's project activities, now became highly visible assets in the community. Peter Ujomu, HMI's director, perceives that HMI's success is derived in part from the fact that project workers 'live and walk with them [the people of Makoko]'.

## Activities

### *The youth centre*

Most visibly, HMI runs a multi-purpose youth centre, which is a space where young people can spend time in discussions, watching films and developing a range of skills. The Centre has a counsellor and a visiting nurse. Project staff encourage community members to visit the nurse with basic health problems, publicizing the clinic through outreach and leaflet distribution in Makoko. Basic drugs are bought and provided to patients at cost price. Most health problems seen at the clinic relate to malaria, typhoid, diarrhoea, respiratory tract infections, and (increasingly) HIV. Patients who need voluntary and confidential counselling and testing (VCCT) are referred to specialist centres in Lagos.

HMI's youth centre runs a skills department, which provides six-month long training programmes to young women and men in tailoring, hairdressing, typing, dress-making, and catering. Young people come to learn a vocation, and are encouraged to see this as an opportunity to learn other skills, in particular leadership skills. Many attendees, for instance, become trained peer educators. Those individuals who display particular talents and leadership qualities are invited to participate in computer training courses. Computer literacy greatly enhances the chance of finding a good job in Lagos.



Young women on a vocational skills course

### *Peer education initiatives*

Once a week, the youth centre runs a music group for about 20 (mostly out-of-school) young people, led by a former typing trainee. This group uses music to teach other community members about a range of topics, including HIV and AIDS, the importance of non-discrimination and preventing early pregnancy. The group performs at vocational training graduation ceremonies, as well as in the community. The group sometimes even use canoes to reach those living on the lagoon with their music.

HMI trains some of the young people who participate in their programme activities to be peer educators. Mixed-gender groups of thirty are trained three times per year. While at its outset this project targeted young people who were not in school, some training is now taking place in the school holidays in order to include school-going young people. Training sessions typically last five days and are organized around a manual that was developed following a review of existing sexual and reproductive health resources. The manual's six modules cover relationships (including the broader notion of social justice), life skills, and sexual and reproductive health. Sexuality-related issues are also discussed, including sexual orientation and rights.

Peer educators try to discuss what they have learned in a variety of settings - with friends, schoolmates, at church, and in the marketplace. HMI staff are available to provide technical back-up, in case peer educators experience difficulties answering questions. Local young people also run a weekly youth forum, which HMI staff attend as well to provide any necessary support. During these sessions, young people from Makoko discuss a range of issues relating to reproductive health, their daily lives, leadership opportunities, and their ideas for community development.

### *The formation of a cooperative*

HMI staff realised that parents did not feel integral to the programme, so the project staff encouraged them to form a cooperative called 'Makoko Okunsewa Cooperative Association' (MOCA). Over two hundred parents from all ethnic groups in Makoko are now involved in the cooperative. The cooperative buys equipment for small businesses such as typewriters and sewing machines, and provides starter loans that can be accessed by young people and other community members.

Cooperative members have now divided themselves into small, ethnically mixed groups of five to ten individuals, who work together with the cooperative to provide loans for setting up waterpoints and generators, digging boreholes, fishing and fish-smoking, and purchasing grinding machines. Income is generated from these schemes and the loans are paid back. Some groups within the cooperative also fulfil social functions, for example organising weddings and funerals for their group members. Many also talk to other community members about the value of formal education, the importance of HIV awareness, and work to counteract HIV and AIDS-related stigma in the community.

On occasion, the cooperative finds funds to send members to wider fora and workshops taking place in Nigeria on relevant topics, such as AIDS and financial management.

### *Other activities*

HMI staff have also facilitated three inter-generational communication sessions, bringing together parents and young people to discuss issues of concern. This is a sensitive process. Both sides present their perspectives on a particular topic, and a mediated discussion follows.

Finally, in 2001, HMI initiated a mentoring project. Individuals who are interested in working in development, but who perhaps lack the training or experience, attend an annual training session during which they learn about the multiple aspects of development and AIDS-related community work. The training curriculum covers advocacy, report writing, project planning, fund-raising, community participation, and counselling. Participants form a supportive network, and are attached to senior project staff at HMI, for an apprenticeship period in Makoko and at other programme sites.

## **Reflections on work to date**

HMI's integration of sexual health issues into activities aimed to promote economic empowerment through skills training and micro-business opportunities for young people and their parents demonstrates the important principle of tackling sexual health-related risk together with broader vulnerability.

In an immediate sense, the youth centre's skills training programme has enabled many young people from Makoko to find employment, set up small businesses, and develop their leadership potential. In a context of deep poverty and marginalisation, AIDS is for many a remote issue that does not touch on their daily lives. Reflecting the community's priorities, economics - rather than health per se - is the starting point for the programme. Such a grassroots approach to sexual health provides a base from which to facilitate more direct work relating to HIV. As the programme progresses, and as AIDS becomes more visible in Makoko, people are beginning to perceive HIV as an issue of relevance to them.

Young people's participation and leadership development are an inherent part of HMI's programming. Various levels of youth participation opportunities are built into all activities. Consultation and feedback mechanisms are built into the programme cycle on an ongoing basis. But HMI also involves young people more actively in their programming initiatives, such

as using youth executives to help run each of the skills training schemes. In addition, HMI's mentoring programme aims to build local capacity in development fi the community leaders of tomorrow.

Conversations with beneficiaries revealed that HMI projects are helping young people to build their confidence and create a sense of themselves. Young people repeatedly said that they had learnt how 'not to feel inferior' and 'how to stand my ground'. Participation in activities such as sexual health peer education has enabled some to positively transform their lives, as it has provided them with the sense of being a role model in their community. As one young women explained, '[others] see the benefit of it [peer education] in us'. Importantly, involvement in the programme also helps individuals to find a sense of purpose in their lives. One 22-year-old beneficiary from a family of five children, who is now working at a primary school, explained: 'through HMI, I have been able to go out and interact with people, and know something more about my health especially HIV. It helped me to be where I am today. Without it I would be doing nothing; I would have become the father of children by now'.

HMI's inclusive approach to working with the community is notable in allowing different groupings in Makoko to feel actively involved in the programme. In particular, young women and men, out-of- and in-school youth, parents, and young people of varied ages (between 13 and 24 years of age) are all involved in HMI's programme in some way. The targeted involvement of young people in their late-teens and up to their mid-twenties grew out of an awareness of the particular vulnerabilities of older youth to negative life outcomes (such as unemployment, HIV and violence).

HMI's work also embodies a positive approach to gender. While the programme originally started with a focus on young women, the benefits of a more comprehensive, balanced approach came to be recognised, and young men were included. In recognition of the particular vulnerabilities of girls and young women in a patriarchal society, however, the programme remains geared towards young women, more of whom are allowed to register for computer and other skills training. HMI also aims to ensure the mainstreaming of gender equity at all levels of the organisation itself, including among its staff and the Board of Trustees.

### *Reflections of beneficiaries*

One HMI beneficiary, a now 25-year-old woman, completed the typing and hairdressing skills course, and went onto train in computer skills. She lives in Makoko with her trader mother, businessman father, four sisters and one brother. Introduced to HMI by her younger brother, she explained: '[HMI] helps us to achieve our goals, and not to feel inferior in front of others. I'm achieving something'. She is now employed as a youth worker by HMI, mobilising young people and representing their interests in the community. She encourages them to come to the youth centre. Before HMI, she was always at home. 'I had counselling at HMI in relation to how to face challenges. I was allowed to be myself and help myself. Without the project I would probably have had a child by now'.

Another beneficiary, a 21-year-old young man, comes from a family of five boys and four girls. His mother sells fish and he lives with his elder brother, who is a fisherman. He completed the typing training, followed by the computer course. 'I know that I am somebody through this place. I became involved in computers because of it. At first, I was afraid to come here because I was shy to interact with people. I came and discovered it was a good place. Because of this, I am proud of myself. If I hadn't come, I would be fishing or hanging around at the bus stop doing bad things'.

Another beneficiary writes: 'I joined HMI in 2000 to learn typing and in the course of my training, I also became a peer educator. After graduating from typing, I joined the hairdressing course and then did a six month training apprenticeship in hairdressing. I also worked as a volunteer youth worker at HMI. As a result of the peer educator training, I became a role model for my fellow young people to emulate, and with the different skills I acquired at HMI, I was able to work and save towards attending a degree programme. I am presently at the Lagos State College of Education, and I use my hairdressing skills to pay for my future. Without HMI, I would have been on the streets engaging in all sorts of risky behaviour to survive because I come from a disadvantaged family'.

## Carolina for Kibera, Nairobi, Kenya

### Context

Carolina for Kibera (CFK) is an NGO working in Kibera, one of the most densely populated, low-income, informal urban communities in Africa. It is estimated that more than 600,000 people (of whom half are under the age of 15) live in an area encompassing roughly four square kilometres on the edge of downtown Nairobi. Most of the houses in Kibera have no sanitation, running water or electricity. In the year 2004, the government bulldozed homes in one part of Kibera, displacing around a thousand people, to make way for the building of a new road.

The community is home to five of Kenya's six largest ethnic groups (Kikuyu, Kisii, Luo, Luhya and Kamba), in addition to the Nubians - a Muslim group who claim land tenure rights to the slum. Kibera has a recent history of collective violence, usually involving unemployed young people. This reflects ethnic and political tensions over access to resources, including land and rent payments. The slum is divided into eleven villages, most of which are dominated by a particular ethnic group. Many families survive through micro-businesses run primarily by women, such as hawking and selling.



Kibera

Poverty and a lack of access to health services in Kibera are having a dramatic impact on young people's sexual and reproductive health. In a context where abortion is illegal, there are high levels of unsafe termination of pregnancies. HIV and AIDS are serious issues for Kibera residents, and are underpinned by acute poverty. 'Survival' sex work and inter-generational sexual relations (often resulting in early marriage) are common. Zebah Akoth, a teenage girl who is involved in CFK, illustrates some of the challenges young women in Kibera face:

#### *'What affects most poor girls'*

I am Zebah. I have been living in the ghetto since I was born. I have seen many girls becoming street children, getting married when they are still young and getting sexually transmitted diseases. Sometimes this is because they want to buy fashionable things like girls from rich families.

When many girls reach adolescence, they start seeing that they have now grown up. Others do not like school and they want money. So they get sugar daddies and allow themselves to be mistreated. Maybe the sugar daddies have AIDS, so they give the young girls AIDS just because the young girls want money. This is why we see many slum girls between the ages of 15 and 20 dying of AIDS.

The second thing is that young girls leave school and get married to the young generation husbands who just want sex. When the girl becomes pregnant, he becomes violent and chases her away from his house. When she goes back home, the mother also chases her away and she is homeless.

These are some things that affect poor girls.

CFK was established in 2001 by Rye Barcott, an US graduate student who became involved with the community during the course of fieldwork he conducted for a dissertation on ethnicity and youth violence in Kibera. Currently supported by the Ford Foundation, the America Jewish World Service (AJWS) and private donations, the CFK programme has twelve salaried staff and many youth volunteers.



## Approach

CFK is committed to working with young people in Kibera using a bottom-up approach, to ensure its work is relevant to the context of their lives. Grounded in a philosophy of participatory development, the programme operates on the principle that young people living in Kibera possess many of the skills necessary to find their own solutions to the problems they face. While HIV did feature in the original vision for CFK, the intention was that CFK would not be another 'HIV project', but would address the issues indirectly and within the contexts of young people's daily lives, vulnerabilities and concerns.

CFK's aims and objectives include:

- To use sport (specifically football) to promote youth leadership, community development and ethnic cooperation;
- To enable young people in the community to seek their own solutions to the challenges they face;
- To address sexual and reproductive health, including HIV, within the context of young people's daily lives and challenges.

The programme was initially modelled on the work of the Mathare Youth Sports' Association, an NGO operating in a different slum in Nairobi. CFK's aim was to use football to facilitate young people's development, including the values of teamwork, understanding and cross-ethnic dialogue. Other activities have grown out of the football project, including *Binti Pamoja* (Daughters United), a young women's discussion and art group, and more recently a recycling project (called 'Trash is Cash'), which emerged out of young people's interest in developing income generation strategies.

## Activities

### Football

CFK runs a football programme for girls and boys. There are 200 teams grouped into different age bands: under-12s, under-14s and under-16s. Tournaments between different teams are organised and last up to six months. All the teams consist of young people from different ethnicities in order to promote dialogue, respect and enhance communication among the youth within the community. Setting up the project involved a long process of trust-building with the beneficiaries and their families, as sport had previously been exploited for political ends in Kibera. CFK was committed to involving girls in the football teams, so the organisation approached local schools, which in turn agreed to negotiate the girls' participation with parents. Alongside playing football, the teams also participate in regular community 'clean-ups'.



Two teams get ready to play a football match

### *Young women's discussion and artistic group*

*Binti Pamoja* ('Daughters United') encourages girls and young women to explore difficult issues in their lives. Topics such as HIV/AIDS, unsafe abortion and other sexuality-related matters are examined using group discussion, photography, poetry, writing and drama. *Binti Pamoja*'s mission is to bring together girls and young women of different ethnicities, empower them to make informed decisions about their sexual and reproductive health, and help them to develop self-confidence, communication and leadership skills.

Started in May 2002, *Binti Pamoja* now has three discussion groups involving 36 young women aged between 13 and 18 years. Young women attending local schools are recruited through an interview exploring their interest in the group, as well as the young women's talents and objectives. Many applicants say that they have seen the activities of *Binti Pamoja* in the community, and express interest in learning about HIV and other sexual and reproductive health issues.

Rather than imposing a top-down agenda (such as 'preventing HIV') the topics that are discussed at the groups are raised by the participants themselves and emerge from their daily lives and concerns. According to Caroline Sakwa, the programme officer who facilitates the groups, this bottom-up approach is motivated in part by the young women's own strong sense of independence and democratic values. Gossip was initially a problem, but the girls have learned how to manage this constructively with the facilitation of the programme officer. Developing trust within the group takes time.

The three *Binti Pamoja* groups meet weekly. A wide range of topics are discussed in the groups, many of which are related to sexual and reproductive health; including teenage pregnancy, domestic violence, unsafe abortion, drug misuse, how to care for a person living with HIV, family planning, how to set up a small business, anti-retroviral therapy, how to identify child sexual abuse, early marriage, and female genital cutting (which is widely practised in Kibera). Caroline, the programme officer, herself a young woman, facilitates the sessions and provides input and clarification when requested. On a monthly basis, speakers from local NGOs are invited to contribute to particular sessions.

Out of the three main discussion groups, further sub-groups are created in order to pursue particular artistic interests. One of these sub-groups produces a quarterly newsletter called *Tunanego* (Let's Talk), which is distributed throughout Kibera. Another sub-group writes poetry.

#### *Poem called 'It is rape' by 'Alice'*

It is rape  
And they don't care  
They molest the girl like an ape  
And run off as fast as a hare  
They feel little but not guilty  
But that girl feels pain her life is in danger  
No one cares she is tormented and tortured  
Again and again but we as girls of Africa  
Bold and strong now know the truth and light  
This is why we say no women are safe  
But this seems not to make sense to people  
I want to go to school  
I have a right to say what I want  
Why don't you see  
We are girls of Africa  
Bold and strong now know the truth and light.

There is also a drama group that conducts community outreach performances in Sh-Eng (the local mixture of Swahili and English which young people living in Kibera speak) every three months. Before these events, posters are put up in Kibera advertising the performances and a local drumming group is used to mobilise and attract community members. During the group's weekly rehearsals, the young women prepare skits on topics such as abortion, stigma, HIV/AIDS, and drug misuse.

During a community outreach performance, the skits are performed, lasting approximately 15 minutes, after which interactive discussion is encouraged with the audience.

*A skit developed by the drama group to raise awareness about HIV-related stigma and discrimination*

The father of a HIV-positive girl who has been infected by her boyfriend is furious and unable to deal with her status. Convinced that he himself will become infected from sharing cups with his daughter, he drives the girl and her mother from the house. He does not want the girl near him. The father's cousin, who is a HIV counsellor, comes to him and challenges the myths he holds about how the virus is transmitted. This new understanding enables the father to reach out to his daughter, and he encourages her to return home. The skit ends with the father and mother deciding to go for testing themselves.

*Binti Pamoja's* photographic project emerged from the recognition that young women can find it difficult to discuss the challenges they face in relation to sexual and reproductive health, and that this subject may be best approached indirectly. In the first phase of the project, the young women are given basic training in photography and take the cameras into their neighbourhoods in order to produce photographs illustrating the theme: 'a day in the life of a woman in Kibera'. During the second phase, the young women take photos relating to sexual and reproductive health. They write text to accompany their photos and discuss the issues further within their groups. As one young woman wrote in an internal evaluation conducted by CFK: 'I have learned how to use a camera and through the use of cameras, I have expressed my feelings about living in Kibera'. In 2004, exhibitions of the photographs were held in Kibera primary school and in the National Museum of Kenya in Nairobi.

The subject matter of the photographs includes images of daily life, women's everyday struggles for survival, and young women's aspirations. Examples include:

- a girl who (according to the caption) hopes to be an air hostess, studying her books;
- out-of-school boys smoking *bhang* (cannabis);
- men drinking in a local bar (the caption reads that 'men go there to get women even though they have wives, and they beat their wives if there is no food when they return home');
- the rubbish-strewn environment in which people live;
- a *Binti Pamoja* member doing a condom demonstration during a peer education session (the caption reads 'condoms are also important because we have cases of abortion where babies are thrown in the garbage');
- a child (the caption says that many children in Kibera have several siblings, often with different fathers, that their mothers are not working and struggle to feed them, and that their fathers sometimes 'run away');
- an image of a house in which five people are living, with the walls made of mud (the caption tells us that the residents face particular risk during the rainy season as houses can sometimes get swept away and people drown in the river which runs through Kibera); and
- a picture of a young girl whose mother (according to the caption) has died of AIDS, and whose father has re-married and his second wife is abusing the girl by sometimes depriving her of food.

Leadership opportunities are built into *Binti Pamoja's* activities. Members are trained as peer educators, and run sexual health and HIV/AIDS sessions with the football teams during tournaments. Peer educators also try to discuss what they have learnt informally with friends and peers, and at monthly community fora, during which boys' and girls' football teams come together. Peer educators meet weekly to discuss the challenges they face and to decide which new topics to



introduce into their sessions. Challenges brought up by peer educators include: 'running out of ideas' to convince friends of certain facts (e.g. that condoms do not contain holes); lacking time or the confidence to talk to people; not being listened to because of having been 'branded' rude or being an inappropriate role model.

### *Clinic and home-based care programme*

CFK also runs a 24-hour clinic, which was originally set up by Tabitha Festo, a retired nurse and community member. Four nurses and an on-call doctor offer voluntary and confidential HIV counselling and testing, ante-natal care, birth delivery facilities, family planning services, and treatment for common ailments such as malaria, diarrhoeal disease, TB and sexually transmitted infections. In addition, staff provide group education to community members. The clinic also runs a home-based care programme, whose ten trained community volunteers visit around twenty families twice a week. They provide counselling and food parcels to families. Some of the clinic's patients are receiving anti-retroviral therapy for HIV through donor-funded programmes.

### *Recycling project*

A recent addition to CFK's programme is a recycling project called 'Trash is Cash', which is still in the early stages of development, but whose ultimate objective is to create a sustainable community-based recycling industry. This is a pilot project funded by the Ford Foundation and being carried out in partnership with four other NGOs. The project seeks to address economic vulnerability among unemployed out-of-school young people in Kibera. Recycling is seen simultaneously as a strategy for income generation and a form of community service.

So far, five groups of young men and women have become involved. Some of these individuals are members of existing community-based youth groups and initiatives. Organic waste, plastic and metals are collected from the community and regular clean-ups are carried out. Some groups have dug compost pits. Project members receive training; for instance, some groups have taken part in exchange visits to a local waste management institution to learn about the products of recycled materials. Leadership capacity is also being developed within the groups.

## Reflections on work to date

CFK's projects cater for a wide age range of young people, from the ages of eight to those in their early twenties. Programme officers recognise that out-of-school young people, and specifically those over the age of 18 years, are often neglected by NGO programmes. The 'Trash is Cash' project specifically targets these young people to become involved. In the football project, young people aged over 18 years are trained to be football coaches and referees, which enables them to become or remain active participants in the programme.

Young people's participation and leadership are at the heart of CFK's programme. Project officers, as well as Salim Mohammed, the programme Director, are under 30 years of age, and many are in their early twenties. The football and 'Trash is Cash' projects are run by the young people themselves. Leadership roles for young people are promoted within all the initiatives. Within *Binti Pamoja*, for instance, young women are trained as peer educators, and each artistic sub-group has its own leader. Responsibilities for organising the newsletter and community drama performances are taken on by members of *Binti Pamoja*.

CFK also appears to be facilitating and increasing young people's participation in their community. The football project, for instance, has identified and reclaimed public spaces in which young people can play football, and both the football teams and recycling groups engage in regular, free community 'clean-ups'.

Caroline Sakwa, the *Binti Pamoja* programme officer, organises regular training sessions for young women to raise awareness of rights and gender issues, including sexual rights, child rights, access to family planning, and so on. One young woman in *Binti Pamoja*'s internal evaluation wrote: 'it helps us young women to understand our rights and equalities'.

However, as CFK staff point out, rights-based training and awareness-raising must be set in context. Young people's ability to demand their rights is influenced by the acute poverty in which they and their families live. For example, while young women are aware that they have a right to education, this can be meaningless if their parents cannot afford school fees, or if they have to stay at home to nurse a sick relative. This underlines the importance of addressing poverty in order to support young people to realise their rights.

CFK actively assists young people in Kibera to access health and education, which are basic rights set out in the United Nations Convention on the Rights of the Child. Thirteen *Binti Pamoja* members have received scholarships to complete their secondary schooling. Furthermore, several participants in the football project have also been able to continue their schooling as a result of CFK finding them sponsors who pay their school fees.

Gender equity is promoted through, for instance, girls and young women participating in the football project. It has proved hard at times to negotiate such gender equity. For instance, the parents of girls and young women from Muslim families have expressed concern about their daughters being exposed to sexual opportunities and harassment through playing football and socialising with young men. CFK staff have addressed this by separating the girls' and boys' teams (though they do sometimes play against each other) and closely supervising the tournaments whenever possible.

One 17 year-old girl involved in the football project explained how she 'feels good' when playing football and perceived that 'it is my talent and I don't have any other talents'. She explained that it kept her and others 'busy', and that without it she would be 'doing nothing'. At first, the boys would say 'you can't do it, so I showed them that I can'.

Promoting gender equity underpins the *Binti Pamoja* programme. Increasing self-esteem in girls and young women and 'lifting their heads up' are seen by project staff to be as important as facilitating awareness about sexual and reproductive health issues. The following young woman's comment in *Binti Pamoja*'s internal evaluation reflects what many other young women felt: '*Binti* has made me be myself'.

Many young women say they appreciate the learning opportunities offered through the *Binti Pamoja* programme, as well as the chance to practise self-expression and increase their confidence through discussion and various forms of art.

J (not her real name), a *Binti Pamoja* member who lives with her parents and five siblings, says 'without *Binti*, I don't know where I would be'. She appreciates the group's existence as there are not many programmes for young people in Kibera. She has made many friends through *Binti* and says it stops her 'hanging around' and prevents her from being vulnerable to unwanted

attention or rape from young men. She discusses what she has learnt at *Binti Pamoja* with her mother. J says that of all the topics discussed, HIV is most important to her as it is affecting older and younger people alike, although the young women in the group are often too afraid to say openly that they have relatives who are suffering from HIV. She has learned about ABC (prevention), signs and symptoms of HIV, and anti-retrovirals. J also shares her new knowledge with friends who are not in *Binti*. When J started out in *Binti*, she says that she was 'afraid and ignorant', But with time the group has given her 'great confidence' in terms of socialising and speaking with others.

J's mother is a hawker in Kibera, making and selling chips. She perceives *Binti* to be very 'helpful' to the girls. She feels that the girls are safe when they are there, and that it prevents them from 'idling in the community'. She comments that she has observed how the girls' personalities have changed over the course of the group. They have, she says, become more 'assertive'.

A key aspect of the *Binti Pamoja* programme is the way in which it approaches issues relating to sexual and reproductive health and HIV in a grassroots manner. Sexual health is thereby integrated into the broader context of the risk and vulnerability of young women's daily lives and concerns. Through the photographic project, for instance, young women are given the opportunity to explore and express their feelings in relation to the daily struggles which women (in particular) face in Kibera. Alongside images of environmental degradation and poverty, matters relating to women's sexual and reproductive health feature prominently in this body of photographs, in particular issues concerned with HIV, sex work, unsafe abortion, teenage pregnancy, domestic violence and child rape. Danger and the broader vulnerabilities underpinning the lives of women and children are recurrent themes.

Further to setting sexual health work in the broader context of young women's lives, CFK is also increasingly actively addressing the broader vulnerabilities faced by young people in Kibera, through economic empowerment initiatives such as the 'Trash is Cash' project. Young women in the *Binti Pamoja* groups are also receiving training on savings and business plans. In the future, there are plans to establish a micro-credit programme for young men and women.

## Persepolis and the Triangular Clinics, Tehran, Islamic Republic of Iran

### Context

Lying along major drug trafficking routes out of opium-producing areas of Afghanistan, the Islamic Republic of Iran is currently experiencing a concentrated HIV epidemic among injecting drug users, both in community and prison settings. Two thirds of reported cases of HIV in the country are related to injecting drug use. Drug use in Iran generally involves opium (the most widely used drug), a preparation of opium called *shireh* which is usually smoked or ingested, and heroin which is sniffed, smoked or injected.

While Iran has had a centuries-old tradition of opium consumption, recent years have seen a change in patterns of use, with increasing numbers of users turning to heroin. A temporary opium ban in Afghanistan in 2000, in addition to the low purity and increasing price of heroin, are thought to be responsible for the escalation in injecting.

The great majority (more than 90 percent) of drug users are male and nearly 80 percent are employed; about 40 percent have a history of incarceration (Mokri, 2002). Around 20 to 25 percent of drug users in Iran have a history of at least one drug injection in their lifetime, and 10-15 percent admit having injected in recent months (Mokri, 2002). In one 2002 study, HIV prevalence was found to be 25 percent among service users in Kermanshah (a city in Iran) - the majority of whom were injecting drug users (World Health Organisation, 2004).

The typical age for beginning illicit drugs (usually opium) is 22 years (+/- 7 years); however, there is evidence that injecting drug users are younger and begin using drugs earlier than non-injectors (Mokri, 2002). It is also suspected that those who become regular users when very young - before the age of 15 years - are more at risk of HIV than those who start later. While chemists are an important source of low-cost needles for most drug users, about half admit to sharing needles (Mokri, 2002). This figure is higher among user living on the streets, 70 per cent of whom say they have shared needles.

One major trend is that drug use has been moving to the younger generations, and this is of great concern in a country where more than two-thirds of the population is under the age of 30 years. Significantly too, nearly 47 per cent of drug users report having at least one first-degree

relative, usually the father, using drugs (Mokri, 2002). Many younger users start smoking or sniffing opiates as teenagers and, for some, a combination of family circumstances, mental health difficulties, peer influence and lack of educational and recreational opportunities lead to serious involvement with drugs.

For many young Iranians, the period of switchover from smoking to injecting is short. For a significant number, the change happens in prison, where smoking is not practical and injecting is quick and more discreet. Younger drug users have particular difficulties in accessing health, including harm reduction, services.

In response to the dual HIV and injecting epidemic in the country, the government of Iran has adopted a pragmatic, public health approach to drug use in the form of a comprehensive harm reduction strategy, which is combined with access to treatment and care for those living with HIV. Methadone maintenance therapy has recently been piloted in the country, with significant success, and is in the process of being scaled up. In recognition of growing injecting drug use and the limited effectiveness of abstinence-oriented approaches to treatment, harm reduction has wide and growing support from a range of constituencies. A recent statement of support for harm reduction interventions by Ayatollah Shahroodi, the head of the judiciary in Iran, has been crucial in contributing to an enabling environment. While drug use remains a crime, the provision of drug treatment and seeking treatment have not been illegal since 1994 (Mokri, 2002).

This case study gives an overview of the work of two complementary organisations which work with drug users and are underpinned by principles of human rights, participation and equity. The first is Persepolis, a non-governmental organisation based in Tehran which runs a drop-in centre and outreach service for those living on the street - an especially vulnerable group of drug users. The second are the Triangular Clinics, which offer integrated HIV prevention, and AIDS treatment and care in two settings: in community-based settings, under the Ministry of Health and Medical Education (MoHME), and in some prisons, under the Prison Organisation. Although both programmes work with especially vulnerable populations (drug users in particular), neither focuses specifically on young people; however, young people form an important part of their clientele.

## Persepolis

Persepolis is just one of several non-governmental organisations across the country (including in Shiraz, Tehran, Esfahan and Kermanshah), which are active in HIV/AIDS and harm reduction. The organisation was set up in 1999 in Fras province, Marvdasht City, in the south of the country, and subsequently moved to a poor area of Tehran in 2001. Highly unusual as an organisation working in community settings with drug users, and a successful pioneer (supported by MoHME) of methadone maintenance treatment in Iran, it runs a drop-in centre and outreach service. The organisation sees 300 service-users daily, and escalating demand recently has led it to upgrade its main premises to a three-storey building offered to them by the municipality. It runs three additional smaller centres in the neighbourhood. Many of Persepolis' clients are living with HIV/AIDS and other infectious diseases: in 2003, 900 drug-using clients were tested, and 25 and 78 per cent of injecting-drug users were found to be HIV-positive and infected with Hepatitis C respectively.

Persepolis works mostly with people living in the street in poor urban areas of the city, many of whom are separated from their families - an especially vulnerable and marginalised group who sleep rough and inject in derelict spaces, such as under bridges, and in parks, train terminals and cemeteries. The vast majority of their clients are men, including young men aged between 18 and 25, and most, being unable to pay fines, have been in prison for variable amounts of time. Half of their clients are under the age of 30. Usually imprisoned for short periods, many switch to injecting drugs while in prison, using home-made syringes created out of pen nibs, watch parts and dropper bottles. Many of Persepolis' younger clients started using drugs because they have a parent or other close relative who is a drug user.

## Approach

Persepolis is an organisation which operates a bottom-up, peer-driven model, offering a 'one-stop shop' at their drop-in centre. Significantly, the majority of the team consists of current and ex-drug users, who are provided with relevant training; only around ten percent of the thirty-strong salaried team are professionals. In keeping with the participatory ethos of the organisation, expertise is considered to belong to the current and ex-drug users on the team:

as Persepolis' founder and director describes it, 'they are our teachers and we have learnt everything from them'.

The intention is to create a safe, relaxed and non-judgmental space where drug users can come to socialise, talk and spend time with their friends and peers; since police carry out regular crackdowns on drug users in the streets, periodically conducting mass arrests, this is the only environment in which they can safely gather (other than prison). In this context, multiple services are on offer, both in the drop-in centre itself and in the course of outreach visits, which are made daily by the team. Most clients reach the service through peer referral and outreach contact. The idea of outreach is to take services to the clients, and conduct harm reduction activities in drug users' natural environments.

## Activities

### *Drop-in centre*

The drop-in centre is open between 8am - 2pm every day. While this offers a range of services, in particular voluntary and confidential counselling and testing (VCCT), wound management, needle and syringe exchange, and methadone maintenance treatment (see below), on initial visits clients are not formally offered these, but are assisted on the basis of their immediate needs, which often include clothes, food and tea. Others come to the centre to spend time there with their friends. While in the environment of the drop-in centre, they come to learn about Persepolis' services through their friends and other service users. They are not offered VCCT unless they ask for it, and even then are given information and asked to return for blood to be drawn. Those enrolling in VCCT (in addition to others who contact the service) are registered, and basic demographic details are recorded, in addition to their history of drug use, unsafe sex and incarceration. The drop-in centre also has self-help groups, and organises creative activities such as ceremonies celebrating the birthday of Shia saints.



Clients using the drop-in centre can access free needle and syringe exchange packs

### *Methadone maintenance treatment*

One of Persepolis' most important services is free methadone maintenance therapy. The organisation was the first to offer this kind of agonist treatment in Iran, with the support of MoHME and the United Nations Office on Drugs and Crime (UNODC). The programme was piloted in December 2002, and is highly sought after by users and their families - mothers regularly come in begging for their sons to be given it. Tens of drug users are currently enrolled daily.

According to Persepolis' director, most of the drug users who come to the drop-in centre want methadone maintenance treatment - the waiting list in this centre alone is 1500. The methadone tablets are dispensed on site by a nurse who crushes them and dissolves them in a solution for the clients to swallow. The effects on people's lives are dramatic: many are able to find and maintain jobs, are re-united with their families, and stop spending money on drugs. Likelihood of relapse is lessened by methadone-using clients' ability to continue spending time

with their friends and peers, for example through participation in a range of social activities being run at the drop-in centre. The relapse rate is however currently around 30 per cent, most of these cases resulting from short-term prison stays, where methadone supply is not maintained. However, the Prison Organisation is working to expand access to methadone maintenance therapy through its Triangular Clinics (see below).

### *Outreach work*

In order to reach drug users who do not wish, or are otherwise unable, to come to the drop-in centre, Persepolis runs an outreach service. Every morning, the current and ex-drug users who make up the outreach team put together small packages containing four syringes and other equipment needed for safe injecting. They distribute these packages to clients in several injecting places which they know to be favoured by drug users. Since the police get to know of these places, they constantly shift. As well as giving HIV prevention advice, the team is also trained to undertake wound management on site. On occasion, they find, or are told about, people who have died of overdoses; in other cases they have had to resuscitate people on site. The team also carries out safe disposal of contaminated needles in various sites on a daily basis.

Ali (not his real name) is a 33 year-old former drug user and outreach worker with the programme. He smoked heroin for a period of two years and then spent five months on methadone, having come off this two months previously. He described the outreach work as follows:

'We prepare the packages in the morning [clean syringes etc] and go to the parks and the areas we know [to be frequented by drug users]. We sit and wait for them - some are clients known to us, some are new. Step by step, they look at us and gain trust. They run away if they see police, and in this way we lose some of our clients; then we try to find them again. We do wound management in the parks. People know when we will be there, and they gather at that point. If there are no clients, we move on to another area - in each park, we have special clients - we know their times and places. They are injectors'.

One 19 year-old man interviewed during an outreach visit to a small park behind a railway station in Tehran offers an example of a service user who accesses the outreach team for clean needles, but does not attend the drop-in centre. He described how he started using drugs when he was 14, while studying at school:

'I had a friend, I used to go to his house and stay there. One day, I woke up and saw that he and others had gathered and were injecting drugs. They offered some to me and it was my first experience. I didn't know anything then - I had only seen addicts in the street. For one month, I was a guest in that house and was offered free drugs. Then I got addicted. This friend stopped giving me drugs for free and started selling them to me instead. I left school and my family, and started living in the streets. I was arrested two or three times by police in my home town, and went to prison there. I was in contact with my family and they gave me money while I was in prison. I used it to buy drugs. After that, I came to Tehran because it is a big city, where it is easier to hide [from police].'

Another outreach worker described how he had injected drugs for five years. When he was 22, he began injecting. Ever since a friend introduced him to the centre, fifteen months previously, he has been on methadone maintenance treatment.

'I began smoking opiates while at school, because of needing to be awake for exams. A friend offered me the drugs. At that time, I was in a sports team, and the drugs helped me at first [to maintain wakefulness]. Eventually I started injecting. I don't know why exactly. One day, when I was sick from not smoking drugs, a friend offered me a needle and I took it. I used it for five years.

Before I injected drugs, I had a carpet business and a decent income, and I lived with my family. I passed the entrance exam to university, but because of the drugs I couldn't continue with my education. I lost a lot of money. My family never left me, and tried many times to treat me [using the abstinence model]. With methadone, I feel good and am still living with my family. Now I work for this organisation.

When you're an addict, you feel the come-down after being up and it makes you very upset. Every day when I had this feeling, I asked myself 'can I be alive any more?' - I felt useless in my

family and community, I saw how others felt about me, looked down on me. On methadone, at first I had some desire to use more drugs but finally I accepted it and methadone has helped me sort out my mind. Now I go [to places] as an outreach worker and I don't feel any desire [to use drugs] when I see others using them.

For young people, the problem is a lack of information and education, both among the youth and in families. I didn't have much idea what drugs were. A major problem for young people who use drugs is that they lose their family support: some lose their parents because they die from using drugs; others are rejected when their parents find out that they are addicts, and this makes their situation worse. When they are not in contact with their families, peer pressure works on them more.

My experience, when I am doing field visits, is that they cry, ask me 'how can I stop using drugs? Tell me what you have done'. Others have no idea - they are not able to even think about not using. Drugs are the only thing they see. It is very hard to talk to someone who needs drugs about HIV. I knew a "spoonfeeder" [someone who is paid to prepare the drugs for a group of users] who was HIV-positive, and he used his infected needle while preparing the drugs; I asked him why he did this, and he said he needed the money. I know another guy who is so addicted he collects used needles and injects the blood from them. In the parks, when we go and encourage some of them to come to the centre and get tested, some say 'why test?', and others said 'I know that I am [HIV] positive, but what can I do?'

## Triangular Clinics

The so-called Triangular Clinics are another key institution working nationally with drug users using a harm reduction approach, both in community settings and in prisons. Consisting of integrated HIV prevention and AIDS treatment and care clinics, they are being rapidly scaled up, and currently total 73 in community settings, and 45 in prisons and drug rehabilitation centres. Begun in Kermanshah in the western part of Iran in 2000, they are supported by the MoHME and the Prison Organisation, which is the government office responsible for health and drugs issues in prisons.

The Triangular Clinics adopt an integrated approach to the following three issues (hence their name):

- injecting drug use, through harm reduction and methadone maintenance treatment;
- prevention and treatment of STIs;
- care and support for people living with HIV, including access to anti-retroviral therapies.

## Approach

Operating with a fundamentally 'client-centric' and non-judgmental approach, the Triangular Clinics provide integrated services to a range of clients, including drug users, people seeking VCCT, those living with HIV and their families, people with STIs, and those (such as health workers) who have been exposed to potentially contaminated blood. Most of their clients are drug users, their partners and family members. Although the clinics offer specialised support for those living with HIV, their work is conducted without a specific focus on HIV, in order to reduce stigmatisation.

Links with other relevant organisations, as well as advocacy with a range of stakeholders, to create an enabling public health policy environment for harm reduction work, are central elements of the clinics' work.

### *Triangular Clinics in community settings*

The West Tehran Triangular Clinic is one of seven such clinics in Tehran. A number of young people, particularly those over 20 years-old, are accessing it, although access remains a challenge for many others, especially those under the age of 20. One obstacle for some younger people, many of whom are at school or working during the day, is that the clinic is open from 8 a.m. until 1 p.m. every day (Triangular Clinics in other cities, such as Khorramabad, are open until 5 p.m.).

VCCT is the centrepiece of the West Tehran Triangular Clinic's work, and a range of other services are offered. Where appropriate, referrals are made to specialist medical services and relevant community-based organisations. The clinic integrates HIV prevention and care through VCCT, harm reduction counselling (notably the provision of condoms and clean needles), the diagnosis and treatment of STIs, and the provision of anti-retroviral therapies. Injecting drug users who are tested and found to be HIV-positive have access both to the clinic's methadone maintenance treatment programme, and to anti-retroviral therapies, where appropriate. Their partners and families are also encouraged to come to the clinic. The introduction of the methadone maintenance programme has increased client numbers dramatically, being regarded positively by many drug users and their families. Methadone has helped many street-living injecting drug users to be re-united with their families.

In other parts of the country which do not have active NGOs, the Triangular Clinics are the main coordinators of outreach services.





A man receiving medical treatment at the Persepolis drop-in centre

### *Triangular Clinics in prisons*

In prisons, Triangular Clinics are run by the Prison Organisation, having first been established in some adult prisons (for prisoners aged over 18 years) in Iran in 2002. Clinics inside prisons continue to be scaled up, and have recently been started in three juvenile facilities (for prisoners under the age of 18 years) in Tehran, Esfahan and Kermanshah. The establishment of Triangular Clinics in prisons is a direct, pragmatic response to the HIV problem in prisons by prison authorities, as well as to advocacy efforts, and to the lessons learned by the MoHME in running the community Triangular Clinics.

Triangular Clinics in prisons are based on the same model used in community settings. Peer influence is important in prisoners attending the clinics; many refer their friends. Staffed by trained physicians, clinical psychologists and nurses, the clinics offer VCCT, STI treatment and counselling. Condoms are given to long-stay prisoners entitled to conjugal visits. Methadone maintenance treatment is offered to long-stay prisoners who are addicted to drugs.

Many prisoners remain in prison less than a month, however, and on release are referred to community Triangular Clinics, and to Persepolis (the NGO described above) for needle exchange, or to other drop-in centres (run by NGOs or government) if they exist in the districts where they live. Released prisoners who are living with HIV are also referred to community Triangular Clinics for follow-up.

In addition to overseeing the Triangular Clinics, the Prison Organisation trains a small number of prisoners in the 18-25 age group (as well as older age groups) to provide peer education relating to drugs and HIV/AIDS to fellow prisoners.

## **Reflections on work to date**

Persepolis' work offers a clear example of an organisation which approaches its target group using a bottom-up, participatory approach. Peer referral is also central to the work of the Triangular Clinics, both within community settings and inside prisons. In the case of Persepolis, the team is mostly made up of current and ex-drug users, whose expertise is acknowledged by the professionals on the team. Most of the staff come to work at the organisation after initial contact as service users. They have intimate understanding of their clients' lifestyles and needs, and quickly develop trust with service users. Respect and non-judgmentalism for all their clients, regardless of lifestyle and need, are fundamental to the approach of both Persepolis and the Triangular Clinics.

In addition, these programmes recognise the multiple and multi-faceted nature of clients' needs and in addressing these as, when and in the manner clients wish, fundamentally put the person, including the young person, first. The mixing of different services and activities attracts a range of clients. In the case of Persepolis, rather than having VCCT imposed on them, service users come to choose it for themselves, usually after hearing about it from other service users who are their peers.

Currently, given the enormity of the need, there has been an overwhelming focus on risk reduction, but staff at Persepolis and at the Triangular Clinics are acutely aware of the need to tackle service users' broader vulnerabilities. In the case of Persepolis, the organisation currently lacks a core grant, but staff hope to be able to expand their services to include vocational training



as an important way of beginning to tackle vulnerability. Many service users have worked in the past, but are unable to return to their previous job status. Vocational training would enable them to earn money and keep them constructively occupied away from the police.

Another major challenge is the issue of access. Two important groups are under-represented in Persepolis and the Triangular Clinics: women, and children and young people under the age of 18 years. Some women do attend their services, but they remain a tiny minority of their clients. While this clearly reflects the demographics of drug use in Iran, in the view of Persepolis' director, the small number of female clients points to the need for a dedicated centre for female drug users.

In view of the difficulties young people under the age of 18 have in accessing their (and other) services, Persepolis has recently developed a short-term budget enabling them to link up with community-based youth organisations in order to try to make contact with this younger age group. This is work in progress and is proving to be a major challenge. This age group tends to run away from outreach workers, thinking that they are from welfare organisations and intend to institutionalise them in homes. Other strategies for accessing this group continue to be explored. Persepolis' director believes that, in the future, there may be a possibility of providing after-care services for those released from juvenile correctional facilities, in collaboration with the Prison Organisation.

Methadone maintenance treatment is highly sought after by drug users and their families, and reducing current waiting lists and increasing access remain key challenges. The issue of continuity also remains. Some drug users relapse due to a break in their methadone supply while they are serving short-term prison sentences. However, the Prison Organisation is working to address this.

Finally, one of the greatest challenges relates to coverage. Persepolis staff estimate that there are 40,000 injecting drug users in Tehran alone, and calculate their coverage (defined in terms of numbers accessing the services for a period of one month or longer) to be currently less than 10 per cent of the need in the city. There remains a great need for outreach services in particular, especially those which make use of ex- or current drug users' knowledge and experience.

## **Praajak, Kolkata, West Bengal, India**

### **Context**

Kishalaya is one of the bigger residential homes for children and young people in West Bengal, India. Around 150 boys and young men, aged between six and 18 years live here. Children are often brought to the home by the police, after they are found living on the streets or at local railway stations. Many of the boys and young men are unwilling or unable to give their home address. In some cases, both parents have died and they have nowhere to live. Others have fled from home to escape physical, sexual or emotional abuse. Yet others have been abandoned or made homeless due to natural or anthropogenic disasters.

Often, while struggling to survive on the streets or railways, these boys and young men have experienced further abuse. Many arrive at Kishalaya in poor physical health - particularly with scabies, physical injuries, and many are dependent on drugs. In Kishalaya, many of the boys and young men find it difficult to adapt to the institutional routines. Furthermore, many of the new residents are mistrustful of others, finding it difficult to form new relationships with both the staff and the other residents. Education is provided in Kishalaya for boys aged six to nine years-old. From the age of 10 years the boys attend a local school outside of the home, most staying on until they are 16 years of age.

Praajak is a community organisation committed to promoting the rights of children. Praajak works with Kishalaya to support the boys and young men to become responsible and productive citizens.

### **Approach**

Given the negative experiences most of the boys and young men at Kishalaya have had, Praajak project workers start their work from the principle that to prepare the residents for adult life they must develop new and positive understandings of themselves and others. The boys and young men are therefore encouraged to talk about their past and current experiences, to appraise how they have been treated and how they have treated others. Central to the residents' development of a sense of self is also their understanding of what it means to be male.

At Kishalaya, older residents or *dada* (elder brothers) are encouraged to take responsibility for their younger brothers or *bhai*, and form 'brotherly' relationships. These relationships often mirror those found among boys and young men outside the home. *Dada* may have a number of younger 'brothers' or followers. While these 'brotherly' relationships can provide a degree of affection and security for younger boys when they are living on the streets, they can often be sexually and economically exploitative. These types of brotherly relationships can also continue to be abusive at Kishalaya.

The realisation that sexual abuse between older and younger boys was occurring in the home led Praajak workers to try and tackle this issue within their broader citizenship development work at Kishalaya. However, project workers found that government officials who oversaw Kishalaya viewed discussions around sexuality among residents as highly inappropriate. Praajak have therefore had to develop a programme that indirectly tackles the issues of sexual abuse.

## Activities

In the course of a year, residents take part in the *Festival Wheel* programme which puts on between six to eight performances for the other residents at the home, staff and members of the local community. The performances mark the various seasons of the year, usually drawing on festivals (and the heroes and demons associated with them) that are popular in West Bengal.



A performance as part of the Festival Wheel programme - enacting the story of the defeat of the buffalo demon by the Goddess Durga

Staff at Praajak use the stories and characters associated with festivals to encourage discussion among the boys and young men of themes such as good and bad, retribution, celebration, discord and ethical issues. Participatory activities are used to encourage residents to speak about the 'unspeakable' - to put into words some of their most difficult past and current experiences. The activities include role-play, story-telling, body-painting, mask work, visualization, poetry, sculpting and movement.

*The Festival Wheel programme includes:*

The pan-Indian spring festival that is celebrated on a full moon during February-March. This festival is known as the festival of colours and is celebrated mainly by people throwing coloured powder called *abir* or squirting coloured water on each other to celebrate the advent of spring after winter.

The typical associations of the festival are those of new leaves on trees, flowers blooming (especially the fragrant mango blossoms), balmy evenings and nesting birds, including the cuckoo's mating call which reverberates through wooded areas. Most people celebrate this festival as commemorating the romantic (and often sexual) love of Krishna and Radha, who are worshipped as gods, and celebrating youth, sexuality and the rejuvenation of nature.

This festival is the main festival that allows Praajak staff to explore the themes of sex and sexuality, of adolescence and puberty, and of romantic love and relationships.

Guided discussions with the boys and young men leads to the creation of a performance script replete with dance, song and rituals such as the lighting of the *Holi* bonfire. Once the performance is ready, the group are taken through art and theatre exercises that help them to understand the significance of the 'spring-time' or *Holi* songs chosen. Themes such as love, youth, rejuvenation, colours, puberty (and so on) are explored both at the group and individual level.

These discussions are then reflected in the movements, dances and ritual sequences devised by the boys and young men during performance designing workshops to bring out the meaning of the performance script. Issues such as the use of available space within the residential home, costumes and make-up, and the creation of sets, are all discussed and finalised together with the boys and young men during the workshops.

The Praajak workers have found that although the boys and young men were initially hesitant to talk about their emotional and sexual experiences both in- and outside the home (including their 'brotherly' relationships), slowly residents felt more able and confident to start discussing some of these issues. The degree of rapport that was developed between the residents and Praajak staff as well as the assurance of confidentiality during workshop discussions are crucial in facilitating this process.

*Examples of small group work activities:*

During a 'mind mapping' workshop, small groups of boys and young men outline their thoughts and feelings about being an older and a younger 'brother'. This activity appears to make the young men more comfortable and open to discussing their personal feelings. Praajak staff follow up the small group work with one-to-one sessions. Finally, a residential camp is run which focuses on gender and sexuality related issues.

Praajak have also run activities which facilitate the *Kishalaya* residents to think about their involvement in day-to-day decision-making at home, such as the food they are given, the quality of the clothing they are offered, and rules about who is allowed to take trips out of the home.



**Boys and young men work in small groups to develop the performances**

Praajak staff have helped to develop a children's council or *Kumar Parishad* at the home. Council members are drawn from all age groups and are elected to represent the views of residents at the weekly Kishalaya meetings. Praajak feel their work on the *Festival Wheel* has been crucial in fostering the boys' and young men's confidence and skills to participate in the *Kumar Parishad*. The council members run focus groups with residents to explore what problems they are experiencing and to generate possible solutions. *Parishad* members also work with those residents involved in the *Festival Wheel* to support them with the organisation of the performances and to increase the participation of the younger residents.

Recently, *Parishad* members have brought up the issue of non-consensual sexual behaviour among the residents, especially within the brother pairs. Members have asked that regular sessions on sexuality and related issues are held for all residents. Praajak would like to support those boys and young men who have participated in the *Festival Wheel* programme and the *Parishad* to take on a peer education role about issues related to sexuality and sexual health.

## Reflections on work to date

Praajak is committed to working with, and involving, residents of all ages at Kishalaya. As the vast majority of boys and young men have had negative and abusive prior experiences, project workers have had to slowly build up a relationship of trust with residents. Through creative group work, often followed-up by one-to-one work, the *Festival Wheel* programme has offered an indirect approach to supporting the boys and young men to begin expressing and sharing their own feelings and attitudes to a range of issues.

Expression through performance art, the assurance of confidentiality, and slowly developing residents' voices through the *Kumar Parishad* have been central to changing the previously imposed institutionalised routine of the home. Gradually, Praajak have increased the residents' active participation in developing the performances that are staged six to eight times a year, and the residents' council is increasingly making demands to improve the care they receive.

Praajak seeks to help boys and young men understand their sexuality within the context of citizenship. Project workers support the boys and young men to explore what it means to be male and what they feel are appropriate values and behaviours in their interactions with others.

This is particularly crucial given the abusive relationships many of the residents have experienced (and in some cases perpetrated themselves). Some of the young men have begun to recognise the importance of this work in light of abusive brotherly relationships that often exist between residents.

However, Praajak's efforts to meet the residents' needs have been hampered by Indian society's general reluctance to directly discuss sexual health and sexuality-related issues. Praajak has also had to intermittently discontinue the programme due to administrative decisions made by Kishalaya officials, who have in the past attributed run-away attempts by some young men to their increasing self-confidence, gained, officials believe, due to Praajak's work with residents.

Having experienced the minimum level of care provided to vulnerable boys and young men living at Kishalaya, Praajak is committed to working in partnership with other organisations, such as the West Bengal Human Rights Association, to campaign for a change in the way residential care is provided in India. Praajak believe residents must be actively supported to develop and practice citizenship skills while under the care of the local government, if these vulnerable young people are to be adequately assisted in their transition to adulthood. While Praajak see the promotion of sexual health as integral to personal development, it sets this within the wider context of citizenship.

## SOME LESSONS LEARNED

The case studies presented here illustrate innovative work that is taking place with especially vulnerable young people across the world. The projects demonstrate commitment to all or most of the five core principles and three areas of action underpinning effective HIV prevention programming set out at the beginning of this guide. While some of the programmes focus their work on specific groups of especially vulnerable young people (young men involved in sex work, injecting drug users, or boys and young men in residential care), other programmes work with a wider range of young people who live in an especially vulnerable community (Makoko slum in Lagos, Nigeria for instance).

Fundamentally, all the projects **place the needs of young people at the heart of their programme planning**. Using a bottom-up approach, the projects are committed to ensuring young people are involved in directing the development of the services offered by identifying what would support them to make informed decisions about their future health and education. While some initiatives have developed more organically (HIJOS), other projects have set out with a more developed objective in mind, but remain flexible in the way this is implemented in practice, responding to the beneficiaries' evaluation of the activities set up (see for instance HMI and their inclusion of young men in a programme initially developed to work with young women only).

Most of the projects offer relatively structured activities (young women's discussion groups, *Binti Pamoja*, CFK or *Festival Wheel*, Praajak), while activities undertaken by HIJOS and Persepolis work in a more informal way. HIJOS workers offer support and advice during outreach sessions or when the young men come to get free food and clothing at the HIJOS house. The relatively unstructured nature of HIJOS's work may be due, in part, to the fact that this is a new area of work for the organisation and because the young men they are working with are especially hard to reach.

Out-of-school young people in Makoko and Kibera are also likely to be a difficult group to engage due to their marginalisation. However, the sheer number of socially excluded young people in these urban slums and the fact that many of these youth hang out in locality gangs, means they are far more visible. Furthermore, HMI and CFK have been involved in running relatively large programmes of work in their respective communities for a longer period of time,

which has resulted in the 'word of mouth' promotion of their services between young people, lending the projects credibility. For these reasons, it may be easier for HMI and CFK to run structured programmes of work than it might be for HIJOS.

Initiatives such as *Festival Wheel* and *Binti Pamoja*, while incorporating key sexual health promotion messages, are first and foremost concerned with supporting young people to reflect on their experiences and the context in which they live; develop their communication and assertiveness skills; gain a sense of personhood; and increase their self-confidence. Developing this awareness and these skills should in turn facilitate young people's active engagement in determining their future. Comments from HMI and CFK project beneficiaries illustrate how personally transformational their involvement with these programmes have proved: '[I have learned] not to feel inferior' and 'how to stand my ground' (HMI); '[I have developed] great confidence' (CFK).

All the projects, except HIJOS, have managed to involve young people in the development and running of their services. Youth participation<sup>9</sup> can occur at a number of levels (see Hart's ladder of participation<sup>10</sup>) and can bring real benefits to programmes. **The projects offer young people a range of opportunities to become involved in their initiatives**, from setting the discussion agenda in the *Binti Pamoja* groups (CFK), to helping with the organisation the *Festival Wheel* performances (Praajak), to peer education projects (CFK and HMI), to leading activities (football coaches, CFK and youth executives for the skills training programme, HMI). Of particular note is Persepolis' commitment to employing current and ex-drug users to run their services in Tehran. Only ten percent of their salaried team are recruited from outside the especially vulnerable group the organisation aims to support.

Actively involving young people in programme development and implementation has a number of benefits: it increases 'word of mouth' promotion of the project (CFK and Persepolis), widens the reach of the initiatives' message(s) (through formal peer education or the informal sharing of knowledge between friends), strengthens sustainability (as more young people use and help to run the programmes), and helps to develop the skills and capacity of the community's youth

<sup>9</sup> 'Youth-adult partnership' is another term found in the literature (Klindera and Menderweld, 2001; Family Health International, 2005).

<sup>10</sup> For further information see: Save The Children (2001); Howard et al. (2002); Family Health International, 2005).

both to make informed decisions about their individual futures, but also to contribute to the development of an improved collective future for their neighbourhood or wider peer group (see 'Trash is Cash' recycling project, CFK).

Both HMI and CFK have recognised that older youth are often neglected in programme development and may in fact face greater vulnerability at the crucial transition point between leaving school and being expected to assume adult responsibilities. Both projects have therefore actively incorporated older youth into their work, supporting them to take on leadership roles (such as becoming voluntary youth workers, HMI; or co-ordinating the football tournaments, CFK). Such a development promotes sustainability of the project, while at the same time tackling broader vulnerability factors facing young people in the community (who have no gainful employment opportunities or may lack aspirations).

Despite the clear advantages of youth participation and leadership for programmes, it is important to note that not all young people will be equally interested in or able to become actively involved. The context within which especially vulnerable young people live is by its nature one usually characterised by abject poverty and day-to-day survival. Young people may want to be provided with a service where there is not an expectation that they should 'give back' by becoming actively involved. This does not negate the importance of putting young people and their needs at the centre of programme development, or facilitating opportunities for them to determine what services should be offered and how they should be delivered.

It is also likely that youth leadership only becomes possible or sustainable when a project has completed its initial development phase and a degree of community mobilisation has occurred. In Buenos Aires, the young men known as *the seven* were surviving on a daily basis through sex work and had no access to permanent housing. Not only did a relationship of trust between them and HIJOS need to develop first, before they could become more involved in the development and delivery of services, but they also needed to have the time to do so. The young people involved in work in Kibera, Makoko and Kishalaya while living in poverty, usually either had families or the state government to support them in meeting some of their more basic needs, which possibly increased their capacity to become involved in the projects.

By placing young people's needs at the centre of planning, programmes and projects are making a statement about their commitment to supporting young people's right to health (CRC Article 24), education (CRC Article 28), information (CRC Article 13), and to have a voice (CRC Article 12). By providing, or facilitating, young people's access to health services (Triangular Clinics in community and prison settings in Iran; the nurse-led clinic at the HMI youth centre; Persepolis' daily outreach service offering clean needles and abscess management; or HIJOS co-ordinating medical treatment for a severely beaten member of *the seven*), and educational provision (HMI's vocational skills training programme; education scholarships and sponsorship through CFK), projects are actively assisting in **supporting young people to claim their rights in practice**.

The case studies raise two key points to remember when implementing the principle of 'a commitment to rights' in programmes. First, CFK emphasizes the need to place rights awareness-raising for young people in context of their real lives. Some rights will initially seem more significant for survival than others, and some rights may only be attainable once others have first been secured. For instance, the right to education (CRC Article 28) will come second to the right to life (CRC Article 6) and a good enough standard of living to develop properly (CRC Article 27), and the right to protection from exploitation (CRC Article 36) most likely needs to be secured before young people can focus on achieving spiritual development (CRC Articles 14 and 30). Second, the work of HIJOS highlights a significant tension between working within the law that has been put in place to protect children, while trying to find a way of supporting young people, who may still under the age of 16 years but are effectively independent, to secure rights usually only available to those recognised as 'adults' in law.

Given the challenge (and slow pace) of campaigning for changes in the law to benefit young people and facilitating their access to the rights set out in the CRC, organisations such as HIJOS and Praajak have formed partnerships with other NGOs (either working in the same field or committed to supporting other vulnerable groups) to increase the capacity and impact they can have in promoting the rights of young people.

The projects presented in the case studies either have a single gender focus (HIJOS and Praajak only work with boys and young men) or work with both young men and women (but offer opportunities for single-sex as well as mixed-sex interaction). Praajak and CFK's *Binti Pamoja* groups



explicitly explore the influence of gender on their beneficiaries' sense of identity, life experiences and opportunities, and their understanding of sexual health. The photography project, part of *Binti Pamoja*, illustrates this approach powerfully.

Mixed-sex run peer education projects offer young men and women the opportunity to work together, discuss their views on a range of issues, and jointly take on leadership roles in an inclusive, supportive environment. Such an atmosphere often stands in stark contrast to the gender segregated community (both socially and economically) they live in. CFK takes the principle of 'promoting gender equity' one step further by involving girls and young women in the football project they run. Young women are not only able to 'show [young men] that [they] can [do it]' (female CFK beneficiary), but also get the opportunity to compete against young men literally on an 'equal playing field'. These initiatives **promote equal gender relations** and arguably offer the opportunity for social transformation.

A commitment to gender equity does not negate the possibility of supporting affirmative action. HMI, for instance, reserves a larger proportion of their vocational skills course places for young women in an attempt to make up for women's overall lower access to educational opportunities. Such an approach also aims to reduce the social and economic vulnerability experienced by women, which places them at increased risk of a range of negative outcomes, including HIV/AIDS.

All projects are involved in HIV prevention and **risk reduction** work. Persepolis and Triangular Clinics in Tehran offer needle exchange programmes, HIJOS distributes free condoms to the seven, HMI's peer education programme tackles issues such HIV/AIDS and the prevention of pregnancy, CFK offers voluntary and confidential HIV counselling and testing through its nurse-led clinic in Kibera, and Praajak explore how relationships can be sexually abusive with the boys and young men at Kishalaya. However, what is significant about all the programmes of work discussed here is that their work also focuses on **reducing young people's vulnerability**, and HMI and CFK further aim to mitigate the impact of poverty and HIV within the wider community. By tackling all three areas of action as set out in *HIV/AIDS prevention and care for especially vulnerable young people: a framework for action*, programmes are likely to make a more significant contribution to fighting the HIV epidemic.

HIJOS is keen to sustain its contact with a small group of especially vulnerable and 'hard to reach' young men. By gaining access to and developing a trusting relationship with a group of usually invisible young men, HIJOS is likely to be able to support *the seven* to become less marginalised and gain the confidence to access other services. HIJOS has observed that *the seven* have developed a strong peer group with specific behaviour norms. By supporting this close-knit group and perhaps introducing them to safer behaviour norms, HIJOS could directly help to reduce their risk of contracting HIV. Furthermore, if over time, *the seven* become more versed with respect to their rights to housing, education and health and/or were to become involved in supporting HIJOS to reach out to the other 60 young men who sell sex in the *zona de Once*, *the seven* may create opportunities for themselves that would allow them to move out of sex work and into a less risky way of making a living.

Praajak aim to support boys and young men who have experienced abuse and homelessness to become skilled and assertive citizens, who understand what impact their previous experiences have had on them, treat themselves and others with respect, and are able to assert and claim their rights. This work should reduce the boys' and young men's risk of abuse while at Kishalaya, as well as reducing their broader vulnerability to poor social and economic outcomes once they have left the home. Praajak also work together with the residential unit staff and local government officials to raise their awareness of issues affecting the boys and young men. This mix of campaigning on behalf of the residents, supporting the young men to develop their own voice through the children's council, and increasing the capacity of the home staff to meet residents' broader needs, Praajak are likely to have a larger impact than if they confined their work to just running the *Festival Wheel* programme.

Persepolis and the Triangular Clinics in Tehran target their support to drug users and their families. The outreach and drop-in programmes provided by these organisations are often the first point of contact this vulnerable population group has had with a support service. The organisations' 'peer-driven' (Persepolis), 'client-centred' (Triangular Clinics) and non-judgemental approach is crucial in gaining the trust of such a 'hard to reach' group of people. Persepolis, for instance, develops trust with potential service users through employing current or ex-drug users to run the daily outreach programme. Persepolis and the Triangular Clinics support drug users to reduce their risk to HIV by providing condoms, harm reduction information, clean

needles, STI and HIV voluntary confidential counselling and testing. Crucially, both programmes also run a methadone maintenance programme (and the Triangular Clinics provide access to anti-retroviral therapies), which have had some success in reducing drug users' vulnerability to HIV by providing the means whereby individuals can regain employment, reconnect with the families they have often lost touch with, and slowly begin to rebuild their lives away from the daily focus on drug procurement and use. Finally, although both initiatives are relatively new, they have developed strong referral networks, both within their target population, but also between the organisations that are likely to work with drug users (prisons, community-based clinics and outreach programmes). This has been key to ensuring that such a mobile population can maintain their participation in a methadone and/or anti-retroviral therapy programme.

HMI and CFK perhaps best illustrate programmes working across all three areas of action. Their initiatives help to tackle HIV-related risk, while also reducing young people's broader social and economic vulnerability, and building community resources to mitigate against the impact of poverty and AIDS. Peer education programmes promote safer sex behaviour, develop awareness of the way context influences vulnerability, support the development of youth leaders and peer networks that challenge discriminatory norms and behaviours. As the HMI and CFK programmes grow, more young people become involved and benefit. HMI and CFK have also begun to involve parents and other community members in their initiatives through HMI's Makoko Okunsewa Cooperative Association and inter-generational communication sessions, and CFK's clinic-run group education session for parents and other community members. These programme elements appear to have generated significant momentum, which strengthens the impact the initiatives can have on the wider community and will further support the reduction of young people's vulnerability.

The vocational skills training and community development mentoring programmes at HMI, and the educational scholarships and 'Trash is Cash' recycling projects at CFK, actively mitigate the impact poverty and HIV/AIDS have on young people's vulnerability. As a result of these projects, more young people have gained skills that increase their employment opportunities, or have secured loans to enable them to set up their own enterprises, which will support them to contribute to their families' livelihood. The provision of health services through community clinics have also increased the community's access to contraception, HIV anti-retroviral medications,

drugs to treat common health problems, and supported the development of a home-based care programme in Kibera.

Of particular note is the work of HMI and CFK who have focused not only on working with young men and women across a broad age range, but also on bringing together the previously segregated ethnic groups that live in the same slum. HMI has found ways to bring the music peer education initiative to the marginalised water-dwelling Egun people, while the Makoko Okunsewa Cooperative Association members work in small ethnically mixed groups. In Kibera, ethnically mixed teams of children and young people work together to win their matches in the CFK-organised football tournaments.

The work described in these case studies is mainly focused on young people yet, during the initial development phase of the projects, workers had to gain the approval and trust of key stakeholders (such as the local chiefs in Makoko; the parents of Muslim young women in the CFK football project; and the authorities responsible for running Kishalaya). Negotiations with these gatekeepers had to be initiated alongside attempts to develop credibility and trustworthiness with other community members (the young men and women of Kibera and Makoko, the migrant population of *zona de Once*). It appears as if the provision of a visible community resource such as the HIJOS house in the *zona*, Persepolis' drop-in centre in Tehran, and HMI's multi-purpose youth centre considerably supported these organisations to establish a presence within, and gain the trust of, the community.

Finally, all the projects point to the invaluable contribution community organisations/NGOs can make in work with especially vulnerable groups and communities. In the case studies described, these organisations started by putting the (young) person at the centre of their programme and followed a grassroots approach to project development. These principles help to gain the trust of the community and to ensure that initiatives actually meet the needs of the target group. However, there is a limit to what these organisations are able to provide on their own. The high levels of need found within these communities and groups require that projects work in partnership with other NGOs and state agencies to ensure groups can gain access a full range of services. For political activist organisations such as HIJOS, this might prove particularly challenging where both the organisation itself, but also the community it serves, are particularly mistrustful of government bodies.



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