Preventing HIV/AIDS and Promoting Sexual Health

Among Especially Vulnerable Young People

safe passages
to adulthood

World Health Organization

DFID

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Safe Passages to Adulthood

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

Entitled the ***Safe Passages to Adulthood programme***, and 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 programme supports research to enable young people to improve their sexual and reproductive health.

The programme is working to increase the research capacity of developing country partners and to generate new knowledge that will lead to the development of systematic guidelines for action at programme and policy levels.

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.

For the purposes of its work, the programme does not define young people through the use of specific age boundaries. Rather, it adopts a life course perspective in which the focus of interest is on young people 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 the role of policy makers, practitioners and other 'gatekeepers' to effective work to promote young people's sexual and reproductive health.

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Foreword

It is often assumed that young people are - or ought to be - 'innocent' about sexual matters. Yet evidence from around the world shows that many young people are sexually active from their mid-teens. Furthermore, the gap between first sexual experience and the formation of a regular partnership or marriage has increased in recent years. Given this, it is essential that national and international health and development efforts focus on the special needs of young people, particularly in relation to their sexual and reproductive health.

Youth is a critical time for laying the foundations for healthy sexuality. Many young people make good use of familial and societal resources to acquire the knowledge, skills and means they need for developing positive approaches to sexuality. However, where such supportive environments are unavailable, a range of inter-linked sexual and reproductive health problems may occur - including HIV/AIDS and other sexually transmitted infections, unwanted pregnancies, unsafe abortions and early childbearing.

Globally, HIV/AIDS poses an unprecedented threat to the health of young people. The highest rates of infection occur in people aged between 15 and 24 years old. Moreover, in the hardest affected countries, millions of children and young people have lost one or both parents to the epidemic. Yet, not all young people are equally vulnerable.

The epidemic is structured so as to affect most seriously those who are already disadvantaged - young migrants and refugees, those involved in sex work, and injecting drug users.

Progress in prevention and care has been slow and reinforced and realistic public health responses are urgently needed.

The expert meeting on 'Working with Especially Vulnerable Young People', jointly sponsored by the World Health Organization and the UK Department for International Development (DfID) supported Safe Passages to Adulthood Programme, provided an opportunity to take stock of what has been achieved in this vitally important field, and to disseminate lessons learned. This report demonstrates what can be achieved when prevention efforts put the most vulnerable young people first, and it stresses the importance of giving their needs top priority in the international response. I commend the report to national policy makers, programme developers and local practitioners alike.

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Section One
Introduction

All over the world, young people have been identified as being at special risk of sexually transmitted infections (STIs) including HIV/AIDS. An estimated 11.8 million young people are living with HIV/AIDS and each day 6,000 young people become infected with HIV.[1] While the majority of these infections occur as a result of unprotected sex, some are the consequence of sharing contaminated injecting equipment.

More than twenty years into the epidemic, the majority of young people remain unknowledgeable about sex and STIs. While many may have heard of the word AIDS, continuing stigma and discrimination may prevent them from finding out more about the disease and its consequences. While some may understand the mechanics of sex, few have been provided with the opportunity to consider or think carefully about the consequences of unprotected sexual relations. As a result, they may be ill prepared to protect themselves and their partners against STIs including HIV.

A similar picture prevails with respect to unplanned pregnancy, particularly in the teenage years. The majority of the world's young people remain ignorant about the range of options available to reduce the likelihood of conception. Even where such knowledge may be available, young people are frequently denied access to the resources and services that might enable them to put into practice what they have learned. More seriously, gender inequalities operate so as to systematically deny young women the resources and opportunities available to their male peers.

Open discussion of sex, safer sex and drug use remains a taboo in the majority of societies. Young women may lack access to knowledge and the means of protection in the belief that their innocence should be protected. Young men on the other hand may remain ignorant and ill prepared because adults assume they have already learned about sex. Dominant ideologies of masculinity may prevent boys and young men from asking about sex (for fear of appearing ignorant and therefore 'unmanly'), while dominant ideologies of femininity may silence the voices of young women, who could be fearful that their 'reputation' may be at stake if they appear too knowing about sexual matters.

In working to promote the sexual and reproductive health of young people, therefore, it is crucial to recognise that not all young people are the same. Young people's experience differs according to gender, ethnicity, culture and social status among other variables. Major differences

[1] UNICEF/UNAIDS/WHO (2002) *Young People and HIV/AIDS: Opportunity in Crisis.* New York, UNICEF.

exist, for example, between affluent youth able to access television, the Internet and other elements of 'global youth culture' and their counterparts whose educational, employment and recreational opportunities are seriously limited. Moreover, the risks and vulnerabilities associated with sexual and reproductive health are not randomly patterned. Instead, they are structured so as to systematically render some young people more likely to experience health problems than others.

Vulnerability to sexual and reproductive health threats usually arises from economic and social factors. Some young people, for example, may find themselves having to leave their homes as a result of war, famine or civil disturbance. Cut off from their communities of origin, they may become migrants or refugees, having to fend for themselves (and their friends and families) in the most difficult of circumstances. In contexts where it may be difficult to find work, and where social services may be non-existent, some may trade or exchange sex in order to survive. Others may find themselves in circumstances where illicit drug use is the norm - and where injection may be a preferred mode of consumption. In these circumstances, the risk of HIV infection may be very real indeed.

Not infrequently, however, the vulnerabilities associated with HIV/AIDS and other sexual health concerns interact with one another. Some young people, for example, may simultaneously trade sex and inject drugs. Others may find prostitution and sex work a rational option in the context of other survival options. Yet others may find that as a result of forced migration, they become involved both in sex work and in drug use through no will of their own. These especially complex vulnerabilities pose special challenges for efforts to promote young people's sexual and reproductive health. Yet little has been written about them in the international literature to date.

It was for this reason that an international expert meeting took place in late 2001. The goal was to identify instances of innovative and effective practice with the intention of drawing out from these examples some principles that might inform future work.

The expert meeting

Sponsored jointly by the DfID supported Safe Passages to Adulthood (SPA) Programme and the World Health Organization's Department of HIV/AIDS, the expert meeting on Working with Especially Vulnerable Young People took place in Brighton between 6-8 December 2001. Participants from a wide variety of countries were invited to describe their experiences working with young people, with special emphasis being placed on HIV/AIDS preventive work. The groups of young people represented fell into three main categories, although it is recognised that the associated vulnerabilities often overlap:

- young people who sell sex;
- young people who inject drugs;
- young migrants and refugees.

More specific objectives of the meeting were:

- to bring together selected programme and project leaders from Africa, Asia, Eastern Europe and Central and Southern America;
- to learn about the key principles of programme and project design and implementation associated with successful interventions;
- to discuss barriers to implementation and ways of overcoming these;
- to identify key research gaps and priorities in the field;
- to assist in the development of a network of researchers and advocates in these areas.

Participants came from a variety of projects in developing, transitional and developed countries, with a focus on programmes conducted in resource-constrained settings. Representatives from a number of NGOs, as well as from UN sponsored projects and activities, discussed their experiences and approaches to work with especially vulnerable young people. The sharing of expertise from around the world served to emphasise the reasons why such young people should be placed high on the agenda for sexual and reproductive health promotion work. It also highlighted the importance of context in looking at sexual and reproductive health issues in different countries, and the implementation of culturally appropriate programmes and interventions.

The people, projects and organisations were:

Africa

- The work of the Organisation for Social Services for AIDS (OSSA) together with the International Organisation for Migration among migrant and refugee young people, including goldminers, in **Ethiopia**.

- The African Soccer Against AIDS Tournaments (ASAAT) project in **South Africa**, which has sought to promote young people's sexual and reproductive health through involvement in organised sport.

- The **Tanzania** Family Planning Association (UMATI)'s work among young Burundian, Congolese and Rwandan refugees in the Western part of the country.

- The World Health Organization's work to develop Rapid Assessment and Response tools for use with young refugee and asylum seekers in **Liberia**, **Tanzania** and **Guinea**.

- The Omari Project's work with young heroin injectors near Malindi on the coast of **Kenya**.

- Work by the Groupe d'Action de Suivi et de Lutte contre d'Alcoholisme et la Drogue (GASLAD) using Koteba theatre to address the sexual and reproductive health and mental health issues and problems among young people in **Mali**.

Central and Southern America

- The Health Voucher Scheme operated by the Instituto Centroamericano de la Salud (ICAS) in **Nicaragua**. This has sought to broaden access to sexual and reproductive health services among young sex workers and glue sniffers in Managua.

- El Salon, an innovative project to address the health needs of young male sex workers in **Costa Rica**. Here, sexual and reproductive health concerns, together with drug use issues, have been addressed via a holistic model responding to a wide range of perceived needs.

- Harm minimisation, drugs education and sexual health projects run by the Drug Abuse and AIDS Advanced Study Centre at the University of Rosario in **Argentina**.

- The 'Sidewalk Girls Programme' run by PIM (Integrated Programme on Marginality) in Rio de Janeiro, **Brazil**, which has sought to meet the sexual and reproductive health needs of young women involved in sex work through employment and enhanced cultural participation.

Asia

- Outreach work and service provision by the Society for Service to Urban Poverty (SHARAN)'s work among injecting drug users in New Delhi, **India**.

- Work among street youth in the **Philippines** by Families and Children Empowerment and Development (FCED), with the support of the World Health Organization. This has resulted in the training of Junior Health Workers who play a key role in helping other young people access health services.

Europe

- The work of the AIDS Infoshare Project among young women sex workers in Moscow, **Russia**. This has highlighted the importance of working at several levels and with several kinds of intermediary in order to bring about desired effects.

- The work of the Tvoi Vybor ('Your Choice') in Tver, **Russia**, which has established a young people's resource centre, training and other forms of support. Work has also been carried out with especially vulnerable groups of young people at summer camps in the region.

Section Two
Background

Throughout the international literature on reproductive health, and more especially within that pertaining to HIV/AIDS, young people are frequently characterised as being an 'at risk' group for STIs, unwanted pregnancy and a variety of other sexual health problems. In some accounts, it is their very 'youthfulness', which is seen as the cause of the problem.

Young people and risk

Adolescence, as a phase of life, is often said to be characterised by biological and psychological changes that have their correlates in behaviours that predispose young people to health risks. Less biologically deterministic explanations of young people's risk-taking focus on sex roles, early socialisation and its consequences.[2] Overcoming what are sometimes called the 'developmental challenges' of adolescence involves developing the kind of stability of behaviour that is said to characterise the adult population. Young people, but especially young men, are often brought up to value hedonism and thrill seeking. It is sometimes suggested that they think only of themselves and of the present and find it hard to consider what the longer-term consequences of their actions may be.[3] Their actions are reinforced by media stereotypes and peer group pressures, which encourage thrill seeking and living for the moment.

It is important to recognise the historical and cultural 'locatedness' of these types of account. Much existing research on young people has been conducted in the richer countries of the world, and especially in the USA, where the gap between the onset of puberty and entry to adult life is typically large, and where young people are expected to spend progressively more time in full-time education. Our understanding of youth typically derives from studies of college populations and/or on 'deviant' cases such as juvenile gangs and those young people whose actions have brought them into conflict with the law. Rather less is known about mainstream or more conventional young people, especially those who weather the transition from childhood to early adulthood with relatively few difficulties.

Where research has been conducted in the developing world, it has typically been framed in terms comprehensible to affluent Western countries such as the USA, Canada, the UK and other European nations. While some efforts have been made to test out the 'fit' of Western explanations of youth and adolescence in developing world contexts, more usually it has been assumed that these frameworks do match the experience of young people in the majority of world contexts, and that adolescent 'risk

[2] See for example, Moore, S. and Rosenthal, D. (1993) *Sexuality in Adolescence*. London, Routledge and Heaven, P. (2001) *The Social Psychology of Adolescence*. Basingstoke, Palgrave.
[3] See, for example, Kroger, J. (1996) *Identity in Adolescence*. London, Routledge.

taking' is a global phenomenon. This is especially true with respect to matters of sexual and drug-related risk. But is this really the case? Are young people around the world and en masse really risk takers? And might there be other more contextually relevant ways of understanding the issues at stake?

Risk and vulnerability

In 1998, UNAIDS published an important document entitled ***Expanding the Global Response to HIV/AIDS through Focused Action: Reducing risk and vulnerability: definitions, rationale and pathways***. This offered a more sophisticated understanding of the nature and dynamics of HIV/AIDS epidemics than hitherto existed. It carefully distinguished, for example, between concepts of risk and vulnerability, and between risk reduction and vulnerability reduction as measures that might be taken in confronting HIV/AIDS.

In the context of HIV and other STIs, ***risk*** is defined as the probability that a person may acquire infection. Certain behaviours create, enhance and perpetuate such risk. With respect to HIV, these include unprotected sex with an infected partner, multiple unprotected sexual partnerships and injecting drug use with shared needles and syringes. Internationally, the initial response to HIV/AIDS was aimed mainly at reduction in risk-taking behaviour through the targeting of individuals and groups. Examples of 'targeted interventions' include the provision of information and education, the promotion of condoms, the prevention and early treatment of STIs, needle and syringe exchange, and programmes to enhance women's and young people's capacity to ask for protection.

Programmatic experience has shown that successful HIV/AIDS prevention requires focusing not only on risk-taking behaviours, but also on the environmental and societal factors that influence such actions.[4] In perhaps the majority of societies, decisions, such as those relating to first sex and having children, involve the family and community as well as the individual, with the influence of older people being particularly strong. Young women may be pressurized to remain ignorant about sexual matters and physically abstinent, whereas young men may be encouraged to brag about sex while gaining experience through liaisons with girl friends and sex workers.

Social inequalities play a key role in influencing sexual and reproductive health. The opportunities available to wealthy young people in developing world contexts are very different from those confronting their poorer counterparts. While the former may have access to high quality health services including, in some cases, private medicine, the latter may have to make do with nothing. In conditions of poverty, not only may opportunities to seek care be restricted, but also the care available may be of a qualitatively different nature to that accessed by those who can pay. All of these concerns relate to what is best understood not as risk, but as social and sexual ***vulnerability***.

Young people's vulnerability to sexual and reproductive health problems, including HIV/AIDS, is influenced by the interaction between at least three sets of variables:

[4] UNAIDS (2000) *Innovative Approaches to HIV protection*. Geneva, UNAIDS

(i) social 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 relates very much to the networks of which an individual is a part. Some young people, for example, may find themselves more likely to experience a sexual health problem by virtue of their membership of a specific group (e.g. young drug users, young homeless people, young sex workers). Service and programme factors on the other hand include the cultural appropriateness (or inappropriateness) of sexual and reproductive health programmes, the accessibility (or inaccessibility) of services due to distance, cost and other factors, and the capacity of health systems to respond to a growing demand for care and support. Broader, societal factors influencing vulnerability include cultural norms, laws, social practices and beliefs that act as barriers or facilitators to health promoting messages and resources. 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.

Age inequalities, gender inequalities and inequalities linked to poverty and social exclusion are among the many things influencing young people's vulnerability to sexual and reproductive health problems. They do so in complex ways. With respect to gender, for example, inequalities in access to education, in income distribution, in the ownership of property, in employment opportunities and in the area of customary practices, are some of the many factors enhancing women's special vulnerability. The position of younger women is especially acute, since age and gender frequently intersect with one another so as to systematically deny younger women access to the information, resources and access to services they need which is their right in terms of the UN Convention on the Rights of the Child.

In the case of poverty, internal economic disparities within a country are as critical as the overall level of wealth in determining vulnerability. Violations of rights, physical abuse, sexual exploitation, and the withdrawal of entitlements can deepen the gap between those who benefit from economic growth and those who suffer its ill effects. Development policies and programmes themselves may have negative effects on the spread and impact of sexual and reproductive health problems. They may, for example, increase disproportionately the economic gap between their immediate beneficiaries and others. The latter may become vulnerable to HIV/AIDS as a result of increased marginalization on economic grounds, and the need for dependence on alternative means of livelihood (e.g. sex work), which may expose them to sexual health threats.

Designing policies and programmes to address vulnerability can be complex because the interaction between factors such as gender, poverty and age may reduce vulnerability in some contexts but enhance it in others. For example, while in most cultures, poverty exacerbates the conditions in which STIs are transmitted, the trend is not uniform. In some countries, for example, there are epidemics of

HIV among the better-off sections of society, due partly to their economic power to buy sex or inject drugs. Similarly, economic power also creates possibilities for engaging in safer behaviours, such as buying and using condoms, or ensuring the single use of needles and syringes. Which forms of behaviour - unsafe or safe - are adopted depends upon a range of individual as well as situational and contextual factors.

Vulnerability-reduction measures are, of course, necessary in themselves as part of broader moves towards enhanced social justice and overall development, and they are especially needed in relation to work with adolescents and young people. All over the world, young people are denied access to the knowledge and resources to promote sexual and reproductive health in the belief either that they should not know about such matters, or that to talk too openly about them is to encourage sexual activity.

Just as not all young people are 'risk takers', not all young people are equally vulnerable. Young people in poverty, for example, may be more systematically disadvantaged than others. Young people displaced by internal migration, war and civil conflict may find themselves without access to their families, education and employment. Young homeless people may find themselves exchanging sex for food and a place to stay. Young sex workers may find themselves in contexts where drug use is common. Young drug users may trade sex in order to purchase the drugs that make life seem more bearable.

In contexts of complex vulnerability such as the above, the agency of young people to take charge of their lives may be very limited. Multi-levelled actions, sensitive to the contextual and environmental factors structuring young people's lives, will be required in order to bring about change. With respect to the promotion of sexual and reproductive health, such measures should aim to create an enabling and supportive environment in which risk reduction can occur. Health promotion efforts therefore consist of two principal components: the reduction of risk through specific prevention, care and impact-alleviation efforts; and the reduction of vulnerability through more broad based social, cultural and economic change.

Such an approach, which recognizes the need for both risk and vulnerability reduction among young people if sexual and reproductive health are to be promoted, is not especially new. Examples of successful programmes and interventions exist in countries all over the world. What is new, though, is a concern for the needs of young people in contexts of ***especially complex vulnerability*** - including young people who inject drugs, young migrants and refugees, and young people trading and exchanging sex in order to survive. This was the focus of the expert meeting, which sought to provide opportunities for a sharing of experience, and the identification of principles for success.

Section Three
The Projects

Participants in the expert meeting were invited to describe their experiences of working with especially vulnerable young people to improve sexual and reproductive health. They were asked to describe the setting in which work had been carried out, its aims and objectives, the strategies adopted and outcomes to date. Descriptions of each project below are augmented with short case studies. Case study descriptions are organised regionally to facilitate comparison.

Africa

Participants from six countries - Ethiopia, South Africa, Tanzania, Guinea, Kenya and Mali - described their work with especially vulnerable young people. While the focus of each project's work is different, a number of themes recurred, including the frequently synergistic relationship between different forms of vulnerability as they interact in young people's lives.

In **Ethiopia**, the work of the Organisation for Social Services for AIDS (OSSA) operating under the umbrella of the UN's International Organization for Migration (IOM) working together with the Armed Forces Medical Services, Regional Health Bureaus and the National Aids Council, was described. Funded by UNAIDS, DKT and Save the Children (USA), this work has sought to address the needs of a wide range of young people living through the aftermath of a period of sustained border conflict.

By the end of 2000, it was estimated that 2.6 to 3.2 million people were infected with HIV in Ethiopia (9 percent of the total infected worldwide). In Addis Ababa, more than one in six adults are reported to be infected (16.8 percent), while the level in urban areas is 13.6 percent. In rural areas, the rate is estimated at 5 percent - although there are fears of a rapid increase because of high mobility in the aftermath of military conflict. In consequence, the target groups for this one-year project included sex workers, truck-drivers and the demobilized soldiers from the last Ethiopian-Eritrean war (many of whom end up in goldmining areas, trying to make a living) and their communities. Project work has been largely focused around Chakiso and Kembatta.

In 2000, Ethiopia and Eritrea ended a two-year border conflict. Ethiopia had put together a massive military operation that had involved the large-scale recruitment of around 650,000 young combatants, with 280,000 soldiers being expected to return to their communities by the end of June 2001. The reason for targeting these

demobilized soldiers was that, in common with many other migrant groups, they carry the risk of spreading HIV infection when returning to their rural communities, especially since they commonly engage in high risk-behaviour during the migration process.

The reintegration of demobilized soldiers into their home communities is often difficult. They have been exposed to travel and other experiences, including violence and sexual freedom and, on their return, they may find themselves in the situation they had originally tried to escape - without a job, income or responsibilities. They are viewed with suspicion and stigmatised because of fears of their past violent behaviour and HIV/AIDS infection. Yet such young soldiers have to be considered not simply as bringers of infection to their communities, but as a vulnerable group put at a higher risk during a demobilization process that includes their return and reintegration. In addition, their socio-economic needs have to be recognized and this was a reason for integrating other NGOs and donors into the project.

The overall goals of the project were:

- to provide assistance to the demobilized young men and their families, and to take advantage of the dynamic of the reintegration process to enhance HIV/AIDS awareness and implement prevention programmes to benefit the returnees' communities;
- to give demobilized young men an active role in the fight against HIV/AIDS, helping their social reintegration, reducing the possible stigma and, where feasible, providing them with job opportunities (counselling, condom sales, health activities and community related activities);
- to provide the support of mobile units, offering personal counselling, VCT and STI treatments to demobilized young men and their communities;
- to create a positive environment and offer returnees responsibilities and possibly job opportunities, along with other self-help initiatives.

Information on HIV/AIDS was provided to the soldiers, either during their stay in the army and/or in demobilization centres. Condoms were regularly distributed. Despite being tested for HIV/AIDS at recruitment (a sero-negative status was a condition for entrance to the army) the soldiers often did not know their current sero-status and, being aware of the risks they had often encountered, they had to confront both their own fears for their health and of the stigmatisation they would face in their communities.

To prepare for the work, a rapid assessment study was conducted amongst the demobilized soldiers as well as among local sex workers. The main objectives of the project were subsequently met through the training of project personnel, peer educators and health workers and the launching of fully equipped mobile units in selected sites. A micro-savings scheme was launched in the goldmining areas to enable the miners to hold onto their earnings instead of spending them overnight on alcohol and sex. Basic activities such as promoting condom use, including female condoms, have been integrated with other health promotion messages into a 'communications project', to encourage

ownership of the scheme on the part of the groups concerned.

Among the difficulties encountered by the project have been the challenges of dealing with government bureaucracy although, when operating in the goldmining areas, there has been relatively little interference. The plan for the project is to broaden the approach by including refugee communities and other vulnerable groups and strengthening the care and support component.

ETHIOPIA – the Goldminers

In Chakiso, a gold mine area in Ethiopia, 65,000 internally displaced persons, mainly demobilized soldiers, live as illegal gold mine workers. The communities in Chakiso live in 'tunnel' shelters, made of plastic and metal frames, many of them shared part-time between night and day 'shifts'. These communities are organized in separate sites by origin and by religion. The migration pattern is continuous, although open air gold mining is only possible when there is water around in the rainy season. The sex ratio is 300 women (of which about 100 are married) to 2,000 men. A few women are engaged in goldmining activities, but the majority are engaged in sex work. Among this latter group, there is a rapid turnover. Fees for their services are high and, because of the prices they charge, it is not perceived as an option to discuss condom use with clients. However, great interest is shown in female condoms, for which women were quite prepared to pay.

The goldminers live in extreme conditions, digging for days for a few chips of gold. That same day, they can exchange the gold with a broker and be provided with money that most of them cannot save (due to lack of bank access or a secure place to keep it). The money is usually spent on alcohol and sex workers on the same night.

The Mobile Unit visits the different sites on a regular basis (every two weeks, or three for a more remote place). The team in Chakiso includes two counsellors, one head nurse and one health assistant - two men and two women. Peer educators are trained mainly by the counsellors and participate in group meetings, focus group discussions and condom promotion, as well as helping to erect the temporary shelters. Recently demobilized young men are still organized hierarchically, and it has therefore proved necessary to include one 'Captain' in order to respect this. Their participation in the mobile units gives them more social visibility. In their communities, educators assume the role of peers and make referrals where needed. Working on a volunteer basis, they are provided with materials, regular training and a daily subsistence allowance which serves as a financial help and incentive. Personal and confidential counselling, VCT and STI treatment are the main activities delivered by the mobile units. Whenever a second rapid test is required, it is offered in the health centre.

In **South Africa**, the African Soccer against AIDS Tournaments (ASAAT) Project has been

supported by the International Organisation for Migration (IOM) together with UNAIDS. A pilot project entitled 'Migrants from Africa Playing Soccer against AIDS' was developed in 1999. The target groups were young migrants and refugees in Gauteng, South Africa's richest province. Refugees and migrants from countries adjacent to South Africa often experience xenophobic abuse and discrimination and form separate refugee or migrant communities within selected residential areas. Many are unemployed and live in poverty because of language difficulties and xenophobic attitudes. HIV/AIDS prevention messages do not always reach migrants as a result of these language difficulties and because of disadvantage in terms of access to proper medical care and information. Additional challenges derive from the diverse cultural backgrounds of the migrant communities, the conservative attitudes towards sexuality prevailing in their home countries, and migrants' perceptions of the openness of South Africans towards sexual matters as 'crude' and offensive.

The main aims and objectives of the project were:

- to assess levels of awareness, knowledge and skills relating to HIV/AIDS and STDs by means of a questionnaire;
- to promote knowledge, awareness and skills of STDs and HIV/AIDS among migrant and refugee youth by means of soccer tournaments;
- to provide migrant and refugee youth and their families with recreational opportunities and, by doing so, keeping them away from environments conducive to crime;
- to encourage members of the target group to communicate more openly about HIV/AIDS and STDs;
- to increase awareness of HIV/AIDS professional counselling services in Gauteng Province;
- to increase migrants' willingness to utilise local services;
- to increase the effectiveness of services offered to members of the migrant community;
- to strengthen the ties between IOM and the migrant community in Gauteng Province.

An introductory three-hour discussion session was held for representatives from all participating teams in the soccer tournament during which the migration experience, cultural attitudes towards sexuality and levels of awareness, knowledge and skills relating to HIV/AIDS and STDs amongst the target groups were assessed. Two meetings were also held between IOM staff and migrant community leaders, in order to gain their support for the project.

A peer education scheme was subsequently developed and a local NGO - the Mamelodi AIDS Training, Information and Counselling Centre (ATICC) - was identified to conduct the peer educator training sessions, as well as to implement the HIV/AIDS information campaign throughout the tournament. ATICC was also briefed on the migration process and resulting vulnerabilities, the language proficiency of different migrant communities, their demographic characteristics, access to health care, and attitudes towards STDs and HIV/AIDS.

Four soccer tournaments were organised and successfully held. All spectators were provided with printed information on HIV/AIDS and STDs. Talks on HIV/AIDS were given at the matches and over 25,000 condoms were

distributed throughout the tournament. Contact details of six AIDS Training, Information and Counselling Centres (ATICCs) were provided to people attending the tournaments.

A broad evaluation of the project was conducted by means of a questionnaire, which was administered by the peer educators during two tournaments.The overwhelming majority of respondents indicated that they thought the project was generally supported by the migrant community and that it was helpful in communicating good quality information on HIV and STD prevention. Most respondents indicated that they had benefited from the project in the sense that they had gained more understanding of people with HIV/AIDS, and that they had received more information on how to use condoms correctly as well as where to go for help with regards to issues relating to HIV/AIDS.

Factors that aided the success of the ASAAT project included the ownership the young migrants felt towards the project, and the close working relationships between themselves, IOM, the ATICC, the peer educators and the wider community. The project was designed to be flexible and allowed for adjustments to be made based on feedback and recommendations. However, some unanticipated problems were caused by a limited understanding of the structures of migrant communities as well as the fact that these communities constantly change, due to the response of migrants to job and other opportunities in other regions of the country. The direct impact of xenophobia was also underestimated. For example, a central concern among young migrants was the limiting of their freedom of movement because of xenophobic attitudes amongst local South African populations. High levels of poverty among young migrants also caused problems with regard to movement and transport, leading to sometimes lower spectator turn-out than expected.

The most important lesson learned during the course of the work was that cultural perceptions regarding sexuality have to be taken into account in order to ensure that HIV prevention messages are not disregarded by the target group. Sexuality is dealt with much more openly in South Africa compared to other African countries, which means that some prevention messages were initially perceived as explicit and offensive. Knowledge of cultural values and cultural sensitivity is the key to successfully communicating prevention messages.

Fundraising for a further related project activity is underway with the possibility of extending the reach to other communities in South Africa. Recommendations for future work based on an evaluation of activities so far include (i) holding on-going discussion sessions with community leaders to secure long-term support despite the changing nature of migrant communities, (ii) using community meetings for the HIV/AIDS education component and using soccer (and other sports) events to bring the communities together, (iii) including small business incentives for migrant workers; e.g., instead of using the football stadium's kiosk, inviting refugees/migrants to set up food stalls.

SOUTH AFRICA – the Case of Gouy

Gouy Osoundalo, a 19 year-old from Nigeria, migrated to South Africa like many young men, in search of a better future. Although he began making money in South Africa, there were some things that made his new life less positive than it should have been. One of these was the xenophobic attitude he encountered. The result was that he was essentially confined to the city centre in Pretoria for fear of being assaulted or abused by South Africans in the townships outside. This also meant that he interacted mainly with the other migrant communities who also live in the city centre instead of with South Africans.

Another thing that worried him was all the talk about HIV/AIDS and the fact that he did not have much information about it. When Gouy heard about the project, he immediately became interested in it. Firstly, he loved soccer and, secondly, he thought he might be able to find out more about HIV/AIDS. He contacted ASAAT, joined the discussion sessions and volunteered to become a peer educator. The training was quite intensive but, after day four, the peer educators indicated that they enjoyed the training and that a level of trust had evolved between them and representatives of the Mamelodi AIDS Training Information and Counselling Centre (ATICC), who were conducting the training.

But Gouy was more than satisfied – he was impressed and wanted to visit the ATICC, despite the fact that it was located in a township outside Pretoria. He went not once, but at least twice a week. He and a trainer from the Centre became friends to the extent that her children began calling him their 'uncle from Nigeria'. But more importantly, Gouy felt that he wanted to apply his new-found knowledge about HIV/AIDS. He decided to become a volunteer for ATICC to educate South Africans about HIV/AIDS.

He soon became the peer educators' leader. At the end of the project, he had convinced three peer educators to submit written suggestions for the future of the project and he also submitted an extensive list of suggestions himself. He hopes to be involved in the development of future projects involving the migrant community in the future and will take over fund-raising responsibilities. Gouy had privately counselled six of his peers who feared being HIV positive and has successfully referred them to professional services.

When the project ended, Gouy said that it helped him to find meaning in his life and that he would work hard for the continuation of the project. He also said that many of his main concerns – not having enough information about HIV/AIDS, being intimidated by xenophobia and not knowing South Africans – had been resolved by the project.

In **Tanzania**, the Family Planning Association, UMATI, has been active in promoting the sexual and reproductive health of Burundian, Congolese and Rwandan refugees in the western part of the country. Much of this work,

which has had a particular focus on young people, has taken place as part of broader humanitarian relief efforts.

The main aim of the work has been to increase awareness of adolescent/youth reproductive health issues among young people themselves, their parents and other influential people in the community. The project has also aimed to facilitate the uptake of health services by making them more 'youth friendly'. A combined approach has been used to reduce the problems identified.

First, baseline information on youth and adolescent reproductive health issues was collected during a survey carried out in November 2000 by project staff, with assistance from a John Snow International consultant. A monitoring and evaluation system was then put in place. Appropriate IEC materials were developed in conjunction with young people themselves and key implementers trained. Peer education and IEC campaigns within the community have been conducted with the aim of:

- encouraging young people to use reproductive health services;
- gaining community approval of marriage at an appropriate age;
- ensuring community involvement in disciplinary procedures against the perpetrators of rape, leading to the improved reproductive health status of young people.

With time, young people are slowly but systematically starting to utilize services, including seeking advice. Some parents are becoming aware of the problems facing young people in the camps and are beginning to accept the intervention. Involving all stakeholders from the planning stage onwards has been found to be important, although it can slow the process of implementation. Involvement should not simply be at the 'information giving' level. Opinions should be actively sought and project leaders should be ready to adjust plans to accommodate external requirements. An important change has been the establishment of a peer parent scheme to respond positively to parents who object to the project.

Plans for the further development of the project include strengthening community involvement and encouraging other implementing partners to extend similar services to other camps.

TANZANIA – Using Theatre and Dance to Communicate

As a way of reaching young people, participatory theatre work was developed in order to trigger discussions. In directly organised meetings or at events such as football matches, during breaks or at the beginning or end of the match, a drama group or traditional dance group performs. The performance conveys a message, which can be discussed afterwards. Communicating a message via dance is well understood among Burundians.

A popular local play is called *Ni Wewe Tu*, which literally means 'you are the only one I love.' In this play, a young boy meets a girlfriend. The girl is told "You are the only one I love." However, the boy then sees another girlfriend coming; he tells the first girl she must go but that they can meet the

following evening. The second girl gets the same message. About four or so girls are told the same. The next evening, they all find themselves coming to meet the same man in the same place. While he is busy dallying with the last girlfriend, he does not notice that he has been surrounded by the others and, with one voice, all five girls surprise him by saying, *Ni Wewe Tu!*

The play ends and the audience are then guided through a discussion about the events, what they saw, possible problems and their consequences. Then they discuss the real situation in their community and possible steps to be taken: who should do what and when. Finally, decisions are made between them that will be followed up. In this way, several messages can be conveyed at the same time: multiple partners; pregnancy in school-age girls; proper condom use. To supplement the performance, a videotape has been developed, addressing these issues in more depth.

Assessing the sexual and reproductive health needs of young people calls for a structured yet sensitive approach. The World Health Organization has therefore supported the development of a Rapid Assessment and Response Tool for use with especially vulnerable young people. Following pilot work in **Liberia**, a tool for assessing and responding to the sexual and reproductive health needs of young people has been field-tested in refugee camps in **Tanzania** and **Guinea**. A range of findings has emerged from research conducted utilising this tool to date.

While there had been no systematic testing for prevalence of HIV/AIDS among the refugee population, and the available data rarely disaggregate young people from other age groups, there is evidence of a low take up of sexual and reproductive health services amongst younger refugees, mainly because existing service provision is heavily directed towards maternal and child health. This effectively excludes most young people from the clinics. Beyond this, many young people believe that healthcare providers discuss their cases either among themselves, or with their parents. Therefore, attempts to provide services aimed specifically at youth are viewed with suspicion and steps need to be taken to respond to this.

A further problem derives from the gender make-up of the nursing body. In Guinea, nurses are predominantly male whereas in Tanzania, they are mostly female. This has an adverse effect on the take-up of services by the opposite sex in each case. Young refugees feel they are frequently treated with a lack of respect by health service staff and are considered 'second class citizens'. Beyond this, much of the literature currently being distributed in the camps was not in the languages most accessible to young people. As the camps have expanded, centrally located services have become increasingly difficult for some refugees to access. Moreover, an increasing number of young people are employed so, if services are provided only during working hours, they cannot access them.

As a result of the utilisation of the Rapid Assessment and Response Tool, work has sought to increase the use of sexual and reproductive health services among young people in the refugee camps, recognising that each sub-group

faces special problems and requires different approaches. A youth centre has been set up in one of the camps, and a health programme created for young people to be run by themselves.

TANZANIA - The Youth Centre in Karago

Karago is a camp for Burundian refugees situated in the Kibondo District of Tanzania and has been in existence since 1998. One of the problems affecting utilization of health services in Karago has been the reluctance of young people to share the same reproductive health facilities as their parents – it is very embarrassing, not to say difficult, for them to be seen accessing reproductive health services. Parents are unhappy to learn that their children – especially girls – are sexually active. Young people are sensitive about the lack of privacy. For example, their names are called out when they go to the clinic to collect condoms. Young people also express concern about lack of confidentiality and many believe that healthcare providers discuss problems among themselves and/or with parents.

In 1999, funding from a German organisation enabled the International Rescue Committee (IRC) to establish a Youth Centre for refugees. The Youth Centre provides recreational services such as video, games, traditional dances and other recreational activities, as well as a modest library and some vocational training. This facility, which is greatly appreciated, has succeeded in channelling the energy of the young people who previously did not have much to do, and in providing an opportunity for them to learn useful trades as well as accessing basic literacy, numeracy and health education.

In 2000, during an exercise to field-test the WHO Rapid Assessment and Response (RAR) tool, the Youth Centre was identified as offering an excellent model for the provision of reproductive health services for young people, as well as other functions. So, with WHO funding, condom distribution and contraception for young people has been introduced as one of the services provided at the centre. The service is reportedly much appreciated, but is accessed far more by young men than by young women. Some of the reasons for low female utilisation are lack of parental approval of the centre (they are suspicious of what goes on there) and the fact that young women are expected to do a lot of work at home and, therefore, have less free time in which to visit the Centre.

The Omari Project, near Malindi on the **Kenyan** coast, was originally a pilot scheme that grew out of a local response to the growing use of heroin in the area. With funding from National Lottery Charities Board, the UK Department for International Development's Small Grants Scheme and Muslim Aid/ VSO (Voluntary Services Overseas), the project has aimed to respond sensitively and in a culturally appropriate manner to the needs of young people who inject drugs.

Heroin use is becoming a major problem in East Africa, affecting large towns on the coast such as Zanzibar, Mombassa and Dar es Salaam and big cities such as Nairobi and Kampala. On the Kenyan Coast, heroin use has been increasingly affecting young people since the mid-1980s. The population of about 90,000 living in Malindi is mainly Swahili speaking and Muslim. It is estimated that there are at least 600 heroin users in Malindi, with the ratio of male to female users being about 20:1. About 50 percent of the heroin users in the town inject, but there are very little data on HIV rates in this population. Other substances used include cannabis, 'miraa' ('khat'), alcohol, Valium, Rohypnol and Piriton.

Recent research funded by the Economic and Social Research Council has shown that young heroin users:

- tried not to share injecting equipment, but it was common;
- rinsed syringes with water between use in an attempt to clean their equipment;
- saw unprotected sex as posing a greater risk of contracting HIV than sharing injecting equipment;
- dislike condoms because they are associated with sex workers; and
- tend to deny the importance of HIV/AIDS.

Injecting practices, combined with attitudes that are likely to lead to unsafe sex, make for a dangerous situation. While sterile needles and syringes can be bought at the local chemist, if users are caught in possession of a used needle they can be arrested. The project has therefore started sensitising the local community and the police to the value of dispensing needles and syringes at a drop-in centre, where information useful to vulnerable young people would also be provided.

The project liaises extensively with the Islamic community and, although it began by providing information and counselling at a drop-in centre, it soon became clear that this was not enough. Users wanted a residential centre and, in June 2000, a plot of land in a rural area outside the town was bought to build a residential centre. This offers counselling in a therapeutic community, and is currently the only free heroin rehabilitation centre in East Africa. This pilot took best practice from Europe and the USA as its model, but has adapted provision to fit local conditions. Most of the clients are men, reflecting the ratio of male to female users locally.

Success rates for heroin treatment and rehabilitation are usually measured according to whether clients are still heroin-free two years later. The residential rehabilitation programme has not yet been open for two years. However, early indications suggest that while some clients remain 'clean', others have relapsed. The biggest challenge for the former users is obtaining work and reintegrating into society.

In a short space of time, the project has formed close ties with the community. Young people know the resource is there for them and that they can approach staff when needed. However, it has been a challenge to find able and committed workers in an environment where everyone has had to be trained from scratch. Plans for the future include developing income generation initiatives for 'graduates' of the residential programme, and offering a harm reduction programme that would include (with the permission of the local community) the

dispensing of clean needles and syringes, together with referral to different agencies.

KENYA - Assessing the Numbers of Heroin Users in Malindi.

As a prerequisite for planning service provision, it was important to estimate the numbers of male and female users in Malindi. This proved difficult, despite there being some contact with local heroin users through the Omari Project. Four users of the project were asked to list all the other heroin users in the same area, but further estimation of numbers and patterns of use meant finding key informants and 'hanging out' in areas where users congregate.

The research involved locating individuals in different areas and finding their homes in a town with few road names and no house numbers. In addition, many heroin users were reluctant to speak to a foreign researcher about their illegal drug use.After unsuccessful trials with several users, one emerged as a suitable 'research assistant'.As a former dealer, a native of the town and a long-term user, Ali knew the heroin-using networks. He was interested in the work because he was considering the possibility of detoxification and rehabilitation through the Omari Project residential centre, due to open shortly.

After several *ad hoc* sessions in which he located users, effected introductions and vouched for the project's good intentions, a work pattern was established. Ali reported for work between 9 and 10am each day and users were visited in different parts of town. Special attention was given to locating 'hidden' women users. At lunchtime, he was paid 100 shillings and he went off to buy heroin and use it at home. In the afternoon, a similar routine was followed with payment at sunset.

Utilising such an approach, it was possible to access some of the roughest parts of town but it was always necessary to avoid areas where hostile dealers were operating. Ali made the decisions about what was and was not safe, and movement around town involved trusting in his ability and concern for safety. With time, he took on some of the functions of a peer educator on his own initiative. He stopped any users he knew on the street, introduced other project workers and explained that a residential rehabilitation centre was opening soon, urging the user to start thinking about whether he/she wanted to stop. In addition, he encouraged the project leader to talk to and provide counselling for users whom he considered to be particularly vulnerable.

Over a period of about six weeks, it was possible to build up estimates of the numbers of heroin users and get to know a great deal about patterns of use and users' daily routines. The users also found out about the proposed treatment services of the Omari Project and, having been introduced, could more easily approach the project for information and counselling. With time, Ali reduced his intake

considerably. When the residential programme opened, he was amongst the first clients admitted to the centre.

The above case study highlights some of the mental health issues that intersect with other concerns in the lives of especially vulnerable young people. Addressing such issues in their own right is essential for a successful response. In **Mali**, the Groupe d'Action de Suivi et de Lutte contre d'Alcoholisme et la Drogue (GASLAD), an NGO working with government support located at Point G Hospital in Bamako, has been using traditional theatre to address young people's sexual and reproductive health concerns as well as drug use and mental health problems.

Mali is a multi-party democratic republic. It is a poor, heavily indebted country and, although the population is 90 percent Muslim, there are many diverse ethnic groups. Superstition remains strong and influences everyday life - a popular belief is that sex with a mentally ill woman is good luck. There are little data available on rates of HIV and AIDS among young people, but current estimates suggest that 3-4 percent of the general population may be HIV positive. Initial surveys conducted in hospital, prison and rural settings found that reproductive health and mental health services are poorly integrated. Data show that drug users mostly smoke heroin rather than inject and that patterns of rural to urban migration threaten to increase the risk of HIV transmission, particularly among young rural women coming to the cities for work.

The project has subsequently set out to raise awareness amongst high school pupils about reproductive and sexual health issues using traditional resources. A form of traditional theatre called Koteba has been used to address these concerns, enabling the discussion of previously taboo subjects. This is a similar approach to one taken in Senegal, which also encourages community healing. Koteba therapy includes dance and the wearing of masks to enable people to express their feelings. It is a culturally appropriate and effective means of offering HIV and AIDS education. In addition, the project has organised conferences, debates and seminars and training for peer educators. It has also undertaken advocacy work with community leaders and decision makers.

While young people's response to Koteba theatre therapy has not been formally assessed, an increased demand for sexual and reproductive health services has been observed, and traditional healers have begun to help integrate marginalized people. Hospitals have begun to make services more accessible to marginalized children and parents. Lessons learned to date include the importance of presenting clear information, and the widespread ignorance of the consequences of drug use amongst most people. The project's next steps are to identify strengths and weaknesses within current methodologies. There are also plans to widen the target groups to include street children, rough sleepers and refugees.

MALI – the Case of MBC and KK

MBC is a young man who was born in Kayes and fostered by his paternal uncle, a rich merchant who lived in Bamako. The uncle looked after all his needs and MBC was very popular with his peers. However, when he was 19 years-old, his father died and his uncle had a stroke and became paralysed. MBC then started missing school and made friends with a number of young people using amphetamines, barbiturates, cannabis and alcohol, and who led him to adopt their lifestyle.

MBC was later approached by a group of peer educators working in his neighbourhood. This group had decided to help their community by organising social and sporting events and looking after each other. The group was supported by the outreach services of Point G Hospital, which brought Koteba theatre to their area. As a traditional form of theatre that enables people to address taboo topics related to stigma or social isolation, Koteba serves to resolve social conflicts in the community through humour. MBC was helped, through Koteba, to address his problems of loss, social isolation, truancy and lack of affection. In addition, he began to take an interest in football and started to join in the peer educators' activities. He began to help young people with similar problems and today he is a peer educator himself.

KK was 18 years-old and came from a village near Kolokani - 70 km from Bamako. He had developed a manic depressive condition that his relatives believed was due to supernatural causes. Their solution was to bind his hands and feet and immobilize him. Bound in this way, he was brought to Point G Hospital. He was given medication to calm him down as he was very agitated and gradually, he improved sufficiently to participate in Koteba theatre. Through this, he was allowed to talk about the fact that he felt isolated and discriminated against within his family because his mother was not the favourite wife of his polygamous father. He had never been able to express how he felt to his father before, and Koteba theatre enabled him to address these issues of discrimination and disappointment. Other Koteba participants played the role of his father and the village chief and he was able to talk about his feelings openly. On other occasions, he watched the Koteba theatre addressing other people's problems. Although he has had one or two relapses, going to Koteba performances has always been able to stabilize him. Now, he himself is part of a travelling Koteba troupe and is helping others with mental health problems.

Central and Southern America

Participants from four countries - Nicaragua, Costa Rica, Argentina and Brazil - described some of the very different ways in which the sexual and reproductive health needs of very different groups of young people might be met. Among the techniques used were voucher schemes enabling homeless young people to access health services and outreach work in the streets and other contexts where especially vulnerable young people meet.

In **Nicaragua**, the Instituto Centroamericano de la Salud (ICAS) has been working with other NGOs and public and private sector health providers to meet the needs of especially vulnerable young people in the capital city of the country, Managua. Of particular concern have been young people involved in prostitution. Funding for the work has been provided by a variety of donors including the UK Department for International Development, the Elton John AIDS Foundation and the Dutch organisation NOVIB.

The organisation of sex work in Managua reflects the recent political history of the country. In 1979, prostitution was declared illegal and most brothels were closed by the Sandinista government. Organised prostitution was condoned in a limited number of sites, and prostitution became semi-clandestine and itinerant. As a result, Nicaraguan sex workers are now generally independent workers. They tend to operate in groups of up to six in bars, discotheques, particular streets and markets. Pimping is not very common, but is found among groups of adolescent glue sniffers, particularly around the market area (where female pimps rent small rooms to women) and in the massage-parlours.

Since the Sandinista Government lost power in 1990, more brothels have begun to open, as have nightclubs and massage parlours. Relations with the police vary; sexual blackmail from police officers is not uncommon. However, women can bring charges against clients who have abused them. Relations between glue-sniffers and the police are very poor. The former are regarded as 'natural enemies' in the street environment and seen as the most persistent law-breakers. Homeless children and young people complain of frequent violence, abuse and sexual blackmail at the hands of the police.

Nicaragua has an inadequate public health system and vulnerable populations have limited access to reproductive health care of low quality. The traditional approach to providing health services for vulnerable populations in developing countries has been to fund or subsidise specialised programmes. This is tackling the problem from the 'supply' side. An alternative approach is to work at the 'demand' side, making use of the existing health service infrastructure and social organisations. Such approaches are less expensive, more effective, and more acceptable to vulnerable populations than setting up a whole gamut of specialised services catering to the needs of each separate group.

A programme began in 1995, trialling the use of vouchers as an innovative way to provide high quality sexual health services to vulnerable population groups such as sex-workers with

special health needs. Its success in reducing the incidence and prevalence of sexually transmitted infections has led ICAS to turn the voucher scheme into an ongoing programme as a way of preventing a major AIDS epidemic in Nicaragua. From the beginning, female sex workers were heavily involved in the design of the programme, the vouchers and with the content of the accompanying booklet. Vouchers can be redeemed at any one of 8 to10 public, private and NGO service providers for access to health services. The scheme also reaches the clients of sex workers, another group that can be difficult to target, as well as young glue-sniffers who have very limited access to health services and who are reluctantly treated (if at all) by health care providers.

Now in its seventh year, the scheme has been highly effective as the following data demonstrate:

- over 15,000 vouchers have been distributed to vulnerable groups;
- over 6,000 medical consultations have been provided;
- of a population of approximately 1,150 female sex-workers (including glue-sniffing girls), over 40 percent redeemed their voucher;
- some of the highest rates of redemption have been among the poorest women and amongst those groups with the highest initial rates of sexually transmitted infection;
- among female glue-sniffers who used a voucher more than once, the prevalence of gonorrhea reduced from 13.7 percent to 8.6 percent at the most recent medical visit. The prevalence of syphilis reduced from 15.6 percent to 8 percent and that of trichomoniasis from 22.1 percent to 12.4 percent.

The voucher scheme for sex workers, their clients/partners and other vulnerable populations is one of the first demand-side interventions to be tested. Vouchers can be successfully used by governments and other public bodies to purchase services from the private sector whilst targeting the poor and vulnerable, creating a competitive environment to drive down costs, and utilising the contractual mechanisms needed to guarantee quality and accountability. It has been shown to have a demonstrable impact on rates of STI infection among young people in especially difficult circumstances.

Plans for the future include expanding coverage to all the vulnerable groups in Managua and to other areas of Nicaragua, with greater involvement from the Ministry of Health. There are also plans to develop a manual describing the key features of voucher schemes for application in other settings and countries.

NICARAGUA - Observations on the Voucher Programme

Clients

One of the sex workers, Angela, when asked what she thought of the Voucher Programme said: "These vouchers help us. When somebody goes to a public health centre, you have to wait or they give you an appointment, but with the vouchers they see you immediately. It is not

Nicaragua – The Voucher Programme

necessary to make a big effort in order to get examined. The doctors know what kind of tests you need... they don't bother you with a lot of questions." Another sex worker, Bianca, said that for her the important thing was: "I don't have to tell the doctor what I am, what kind of work I do, since he already knows that, because of the voucher and he knows what I need." One of the male glue-sniffers 'Sergio' said: "Of course I want to go to the clinic, we all sleep with those girls [the female glue-sniffers who survive through prostitution] so it is necessary to check our health."

Service providers

A director of one of the reproductive health clinics said: "The work has been very important, we have received good literature. Although our work was of a good standard, ICAS treatment protocols are more up to date. Now we use theirs for our patients as well. We also think that the quality control of ICAS is a very good thing, both for the project and for our clinic. We have also started to introduce quality control on our work."

Doctors have found that over the course of the project they have become more aware of the problems facing sex workers (a new type of client for them) and young glue-sniffing girls (mainly street children). They also found that treating these women has been challenging and professionally enriching. After the first stage of the programme, the interest from providers wanting to participate in the scheme increased greatly as they realised, not only that the scheme was a legitimate and reliable source of income, but also that the female sex workers would not dress in a manner that 'put off' their other clients. In this respect, the medical director of another local NGO reports: "I don't believe the presence of the sex workers in the waiting room has diminished the attendance of other patients. Although in the beginning some patients were curious, we explained that it was the clinic's policy to attend to all people without excluding special groups."

In nearby **Costa Rica**, and with support from the Netherlands Government, 'El Salon', was established by the Instituto Latinoamericano de Prevención y Educación en Salud (ILPES) with the goal of promoting HIV and AIDS-related harm reduction among male sex workers. The project's principal clientele are young people involved in sex work, young migrants, young people involved in injecting drugs use and young male sex workers who live on the street. These marginalized groups often overlap. HIV transmission is increasing rapidly in this population, with more than 10 percent already infected, yet because Costa Rican society holds negative attitudes toward male sex workers, there is no official support for the programme.

At the start of the project, an ethnographic study was conducted on male sex workers and their needs. The majority of young men involved do not define themselves as homosexual or gay, but as 'men'. As a result, materials and approaches directed towards homosexual, bisexual or gay individuals are unlikely to work. Within the Costa Rican context, ideologies of ***cacherismo*** are strong. This sexual discourse differentiates

female and male roles along traditional lines; men are strong and women are weak. Prevention and health are perceived as feminine activities. As ***cacheros*** are anxious about activities that might tarnish their macho reputation, health prevention is perceived as a threat to their identity.

A further problem in reaching members of this population derives from the fact that ***cacherismo*** is a relatively invisible sexual culture. Young men who sell sex do not want to be publicly known as such (except to potential clients) and are generally unwilling to attend workshops or activities targeted specifically at them. This kind of sexual culture, which is characterized by violence and rigid sexual roles, is more likely to drive sex workers towards addictive and risky types of behaviour. Crime, drugs and violence are the major risk factors in their lives, and HIV/AIDS is low on their list of problems.

Working from a corner house established in a run down area of San José, Costa Rica's capital city, El Salon offers young male sex workers a safe place to spend time off the streets. Virtually unidentifiable from the outside except to those who know, the centre offers young men HIV/AIDS prevention education, counselling and support with alcohol and drug-related problems, washing facilities (a major problem for people living on the street), and creative activities including art work, games and movies. In accordance with a harm reduction philosophy, few direct attempts are made to deter clients from participation in criminal activities. Instead, El Salon offers a non-judgmental and friendly environment in which support and distractions from young men's everyday lives are offered.

Significant programme outcomes over a two year period have been the increased use of condoms among male sex workers and the increased number of support groups offered. Significant lessons learned include the need to develop new intervention models for male sex workers, the importance of music and distractions in working with members of this especially vulnerable group, and the extent of the positive impact of art work activities on male sex workers. Attempts continue to be made to educate the Government on the need to sustain such work. In the interim, however, other ways of sustaining the project's work are being actively explored.

COSTA RICA – the 'Locusts' of San José

El Salon aims to meet the needs of vulnerable young men living off the streets in San José, Costa Rica. Called 'locusts' in local jargon, many such men live off sex work and criminal activity. Despite class and educational differences, most perceive themselves as *cacheros*, a label used for men who have sex with men but do not define themselves as homosexual. Occasional homosexual practices do not threaten the young men's heterosexuality.

Because these young men see a world polarized by the masculine and the feminine, everything that goes against masculinity is looked upon badly. Their definition of a homosexual is a man who resembles a woman. These views about gender affect the way in which *cacheros*

behave and act. Their way of talking, acting, relating to others and expressing themselves is extremely masculine. Jonás tells us that he even exaggerates his masculinity sometimes, because he does not like anything feminine. Ernesto thinks a man should avoid, "Walking like a queen." He believes that a man should walk proudly, "Showing he's got something between his legs. People should know they're looking at a real man."

Two factors are important in confirming the *cacheros*' virility: success in sports and reproduction. Sex workers' sports are typically 'macho': pool, soccer, basketball, and boxing. Through reproduction, *cacheros* proclaim that they are different from many of their clients. Although they are aware that some of their clients are married and have children, gays for them "don't have families." *Cacheros* on the other hand, have them "early on." This means that they become fathers at a very young age - most of the interviewees over the age of 15 already had children.

These different perceptions of homosexuality amount to more than a simple appraisal. They reveal the cultural basis of a dominant local discourse on gender and sexuality. People are divided, not in terms of personality or sexual practice, but in terms of their physical power. Men are those who control other men and women. For this reason, *cacherismo* as an aspect of this model generates few contradictions. A *cachero* is a masculine male who exercises sexual power over another man. However, to be accepted as a *cachero*, there must be a hierarchy of power in which the prostitute symbolically imposes his rules.

For sex workers, homosexual practice does not make them gay, or homosexual, or even bisexual (although they use these words, the meanings they assign to them are different from those more widely understood). As long as sexual desire is expressed towards the opposite sex and their behaviour is masculine, they continue to be male.

Harm reduction has been widely applied as an approach to health promotion among injecting drug users. In **Argentina**, the University of Rosario has been promoting such an approach as part of its work with young people involved in drug use. Rosario is the second biggest city in Argentina with a high incidence of drug use and HIV/AIDS. It is estimated that 40 percent of AIDS cases are related to injection with contaminated needles and syringes. The most recent rapid assessment, conducted among the injecting drug using population in the Greater Rosario area, showed that 20 percent of users were under 20 years-old, and 60 percent were HIV positive. Until recently, the main prevention activity has been a simplistic 'just say no' approach. In terms of HIV/AIDS prevention, very few programmes have focussed on young people.

The Drug Abuse and AIDS Advanced Study Centre at the University of Rosario is responsible for running outreach programmes aimed at young people. It is generally difficult to make contact with drug users, so innovative IEC

models have had to be adopted. These include a poster campaign and graffiti in areas where drug users congregate. Information about the project and harm reduction messages are delivered. Cartoon characters have also been utilised in printed materials distributed at events such as rock concerts. Detailed information is given on 'safe' ways to use drugs, ranging from the importance of clean needles to diagrams of where to inject.

Elsewhere in shanty town neighbourhoods, an 'If you're going to do it, do it safely' approach has been adopted with an emphasis on a non-judgmental, accessible and friendly strategy. Other project interventions include:

- dispensing sterile injection kits;
- providing workshops for injecting drug users;
- training health care workers to deal with the needs of young drug users;
- training peer educators.

Issues raised during the project are the need to adapt the programme to include cocaine injection to place more emphasis on changing risk-taking behaviours. A key barrier to success has been the response of the authorities. Drug laws are still very punitive, whether for possession or selling. One of the project handbooks provides guidance on what to do if arrested and how to minimise violence in encounters with the police.

The extent of the programme's success has been assessed. For every ten injecting drug users contacted through the programme, three reportedly attended health services for treatment, HIV testing or drug and safe sex workshops. Another positive outcome has been the creation, through the project's work, of the Argentinean Drug Users Network (RADDUD). As for the future, the intention is to develop and adapt the programme across a variety of settings in Latin America through a WHO sponsored multi-centre study. Particular priority is to be given to the transition from other forms of drug use to injection amongst street children and glue-sniffers, and specific issues relating to young, new injectors.

ARGENTINA – 'Sex, Drugs and Rock and Roll'

The 'Sex, Drugs and Rock and Roll' programme run by the Argentinean Harm Reduction Association (ARDA) focuses on harm reduction among young people at raves and rock concerts, with the aim of promoting safer sex and safer drug use.

In August 2001, in Cordoba City, 50,000 young people from around the country attended a rock concert given by one of the most popular groups in Argentina, 'Los Redonditos De Ricota'. Diego, Maria and Marcelo were among the 20,000 young people reached by the programme with leaflets and condoms. They were with a group of ten youths from the cities of Buenos Aires and Bahia Bianca. Contact with this group was made in the camping area on the day before the concert. The materials distributed contained information on 'What to do if you are arrested' and 'How to deal with police abuse and corruption'. These particularly captured Diego's attention.

Argentina – The Drug Abuse and AIDS Advanced Study Centre

Diego was 20 years-old at the time, and said he had been using drugs since he was sixteen. He had been arrested four times for drug possession. On one occasion, he had been sent for compulsory treatment in a therapeutic community. Maria, who was 17 years-old, had run away from home because of family conflict over her use of drugs. Marcelo, who was 17 years-old, said that on the previous night in the camping area, a police operation had taken place and many young people had been arrested. Marcelo has injected drugs since he was fifteen but had never received specific information about HIV/AIDS and drugs.

Diego showed outreach workers an empty can with pills, an envelope of cocaine they had bought from a boy who had subsequently been arrested, and their one syringe. Maria showed Diego a condom, saying that it could have been useful last night. The two outreach workers who intervened with Diego, Maria and Marcelo focused on:

- disinfection techniques and bleach (clean injection equipment was not available as part of the programme in Cordoba);
- information about drugs, drug using and risks of substance combination (especially cocaine, alcohol and pills);
- information on the need-to-know characteristics of certain drugs, the purity of what they were using and where it came from;
- condom use and risks related to sexual intercourse without protection;
- information on the Argentinean Drug Law 23737 that punishes even personal use, and human rights.

The young people who were contacted emphasised the usefulness of the local phone helplines listed in the leaflets. They communicated the information they had received to the wider group, along with the key issues that had been brought up in their discussions with the outreach workers. Their friends subsequently came to speak to the members of the 'Sex, Drug and Rock and Roll' programme.

Adopting a holistic approach to sexual and reproductive health issues can reap dividends, especially in circumstances where young people may have other life concerns. In Rio de Janeiro, **Brazil**, PIM (Integrated Programme on Marginality) has initiated the 'Sidewalk Girls Project', to meet the needs of young women involved in sex work in the city. The project started working with adult sex workers in 1995 and trained them as health agents for their peers. Over the last ten years, PIM has worked with 3,000-5,000 women in twenty different sex work sites, running an outreach programme and workshops. The subjects range from practical matters such as how to handle client violence to sexual health and prostitution and gender relations.

As part of its work with younger sex workers, the project has also run workshops on art and the theatre. Devised as a means to attract the sidewalk girls to professional training, these have proved hugely popular. The young women attend training courses on making theatre props and handicraft skills. Many of them have only basic levels of education. They are taught about Brazilian culture and are taken on field trips to museums and cultural events as part of a process of learning about citizenship and their rights, fostering

self-esteem through a concept of themselves as producers and consumers of culture.

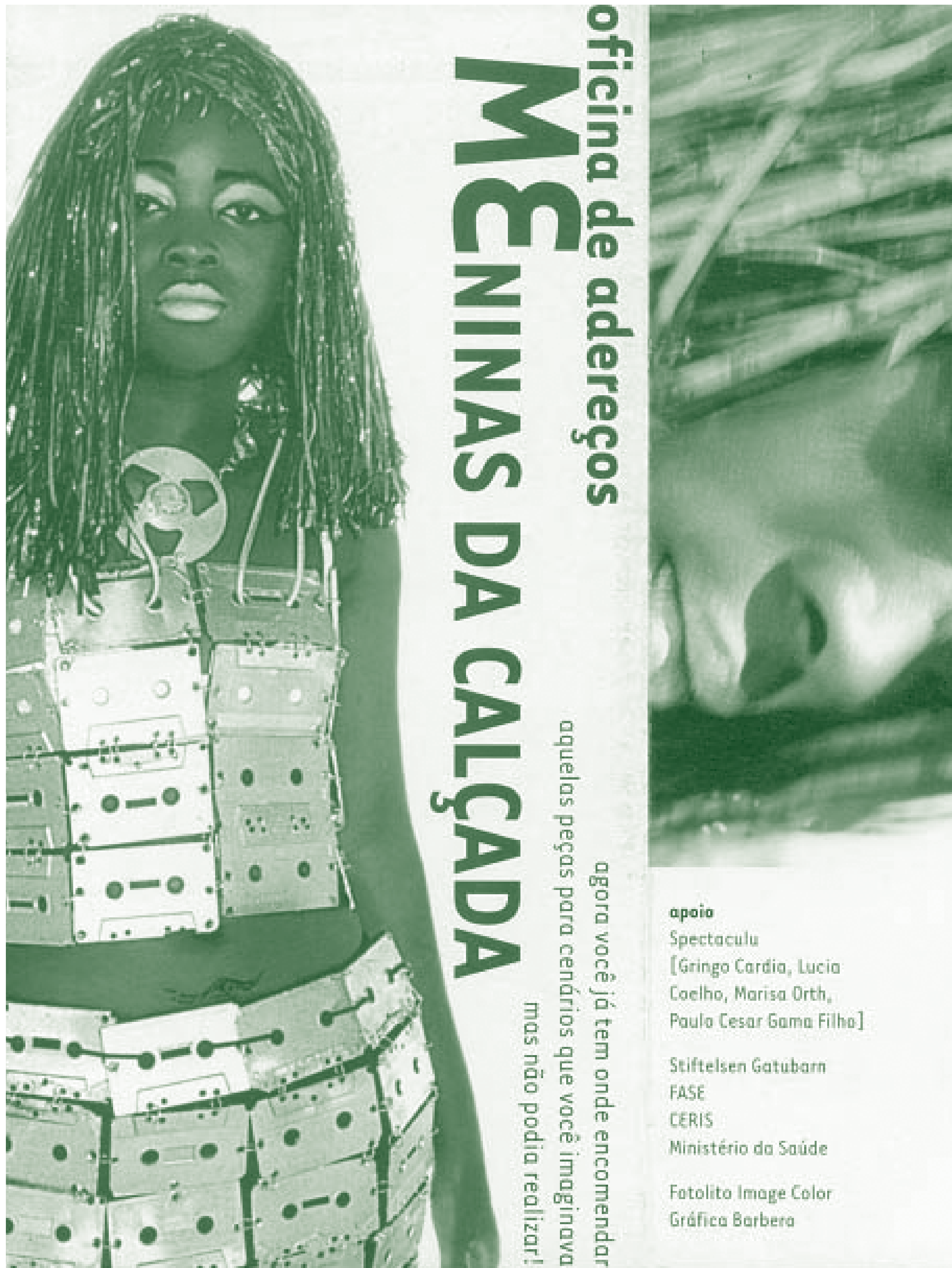
A successful co-operative has been set up in which the girls design and produce work for major ***carnival*** events, having received training in marketing and pricing their services. HIV/AIDS preventive work is run alongside these activities but is subservient to them. If the young women cannot earn money and their attention is not engaged by something that they find stimulating, they will not be open to health education messages. Young women are also involved in the design and production of posters and leaflets for the project. The slogan devised for International Women's Day was: 'Me and my sisters don't want to be recognised by our asses alone'.

Lack of public services in Brazil means the project has provided a valuable safety net for girls on the street. A major problem is the level of violence in Brazilian society and there is still a lot of work to do to improve the safety of street-based sex work. To date, the project has survived on small amounts of government funding and World Bank loans. Future priorities include addressing drug taking behaviour and alcohol use, working closely with other marginal groups (e.g. lesbian groups) and developing a safer-sex kit for sex between women, and placing more emphasis on HIV/AIDS prevention as an integral part of sexual health.

BRAZIL - The Sidewalk Girls Project

In 1995, Ivanilda, a woman who had been involved in sex work for thirty years and a community-based health worker, began to notice an increasing number of adolescent girls around some of Rio's many street sex work sites. She began to talk to these girls to find out about their needs and developed a technique called 'Flash Workshops' – quick and objective theatrical skits on safer sex that got their attention. As a former sex worker herself, she was able to gain their trust. Little by little, she began to introduce the girls to the staff at PIM who further investigated their needs. It became apparent that health was at the bottom of their list of priorities. The first was "making money", followed by "getting back to school" and "dealing with my family".

PIM began by thinking about what kind of professional training would provide the young women with the opportunity to address their priorities and still offer the chance to introduce health and preventive concerns. A 'Theatre Props' course was devised. By making these, the young women would get an education, they would have allocated time to talk about relationships with their family and friends, and they would be learning skills that could be used to generate an income outside of sex work. Arts educators were contracted to teach different simple art techniques; how to work with papier maché, plaster, foam, mosaic and other techniques. At the same time, the girls were encouraged to learn more about art in general by bringing books into the class and being taken on field trips to museums and the theatre.



Brazil – The Sidewalk Girls Project

Despite the girls' interest in attending the classes, many of them just could not afford to be there. A 'God- Parenting Programme' was subsequently started through a Swedish NGO that raised money by asking Swedish couples to donate a monthly sum to each girl to help her complete the course. At the same time, a leading-set-designer was contacted and asked for his support. He started to use the girls' work in his productions and the young women were happy with both the money and the opportunity to be at various glamourous events as an integral part of the show.

After 60 girls had finished the course, 15 of them were trained in self-management techniques and cooperative work. With adult supervision, they started to present the work of the cooperative to other designers and potential customers. In five years, they have developed an impressive list of customers. Commissions range from dressing the windows of the 'H. Stern' chain of jewellers in Brazil's main cities and Paris, to participating in Rio's major events, such as the Copacabana Palace Hotel 75th Anniversary celebrations, fashion shows and concerts by major Brazilian artists. Today, there are 40 girls actively engaged in building up the cooperative, 40 girls 'on call' for work, and a long waiting list of young women who want to join the course. Most of them have been trained as peer educators and are active in HIV/AIDS prevention work and harm reduction education.

Asia

Programmes from two Asian countries - India and the Philippines - were represented in the meeting. In each case, broad based harm minimisation approaches have been used in ways sensitive to the needs of different groups of young people. As in other programmes described in this report, a holistic approach was adopted in which the most pressing issues in people's lives are addressed first. This establishes a window of opportunity for later more focussed intervention around sexual and reproductive health.

In **India**, the Society for Service to Urban Poverty (SHARAN) has been working for over 20 years, primarily with people resident in the slum areas of New Delhi. Many of the organisation's projects address the needs of those vulnerable to HIV infection - i.e. sex workers and young injecting drug users. The services provided range from health and education to savings and micro-credit schemes, health programmes for injecting drug users and HIV-related services at regional and international levels.

India is a multilingual, multi-ethnic developing country with a population of over a billion, low levels of literacy and inadequate health service delivery. The capital, Delhi, has a population of 13 million with a third of people living in slums and 15 percent living below the poverty line. Heroin use was first identified in the early eighties, with users of opium and cannabis switching rapidly to unrefined heroin ('smack'), which began to flood the market. There was also a rise in

buprenorphine use. In 1998, a Rapid Situation Assessment documented that around 73 percent of drug users had injected on at least one occasion. The average age of onset of drug use was 15 years. Over two thirds of young men had their first sexual experience with a sex worker. There was a low level of awareness of HIV risk amongst all age groups. It has been estimated that in 1993, when testing began, the HIV sero-positivity rate was 2.25/1000. By November 2000, 1756 cases of HIV had been recorded - a sero-positivity rate of 13.53/1000. A surveillance centre for injecting drug users was established in 1999 and found that 44.5 percent of a sample of 200 intravenous drug users attending a treatment programme tested positive for HIV.

Following a Rapid Situation Assessment in five Indian cities (Chennai, Delhi, Imphal, Kolkata and Mumbai), SHARAN designed a comprehensive HIV/AIDS and STD treatment and care programme for injecting drug users and their partners. The projects began in 1999 and are managed by local NGOs. SHARAN manages the programme as a whole, directly implementing the Delhi component. The overall project goal is to improve the quality of life for drug users through a strategy of harm reduction. This strategy includes the use of buprenorphine as an oral substitute for heroin and other injectable drugs.

The Delhi programme is based near the banks of the Yamuna River, close to a park where many of the injecting drug users live. A drop-in centre is at the core of the Unit, with the specific aim of preventing HIV by offering a needle and syringe exchange, sublingual buprenorphine substitution, an outreach programme, peer education, primary health care services, referrals and condom distribution. Through this combination of services, the project has been able to draw larger numbers of young male drug users into health care settings to receive first aid, emergency and tertiary drug treatment. Contact has been established with drug users at high risk of HIV infection. SHARAN has also established good relations with other agencies in the field, in the wider community and with the police.

Over 4,000 drug users have accessed the service in Delhi. Despite these numbers, HIV prevention activities have only been delivered to a small sector of the city's population of injecting drug users. There is still a need for such services in other parts of the city. Language difficulties and a highly mobile population coming from all over the country have meant that the delivery of the outreach programme has often been limited. Among the problems the project has had to face are ever-increasing slum populations, low levels of literacy and awareness of risk, inadequate and often inaccessible health services, and the absence of a national policy on harm reduction. There have also been difficulties in reaching women drug users and strategies need to be developed to achieve this.

In the coming months, SHARAN is planning more activities specifically targeting young drug users, including street outreach programmes and non-judgmental service provision with a wide range of options, such as counselling and self-help groups, referrals for detoxification and rehabilitation. The organisation's primary strength is its participatory approach to drug treatment,

with the continued involvement of drug users - empowering people to reduce their vulnerability.

INDIA – the Case of Ali

Ali was aged around seventeen. Alone in a corner of the park near SHARAN's drop-in-centre, he was injecting a cocktail of buprenorphine, avil and diazepam into his femoral vein with a used syringe and needle. He had cleaned the equipment with water from a dirty plastic container. The outreach worker approached him and introduced himself and sat down. The two sat in silence. Finally, Ali spoke. He wanted to quit using drugs; if there was a treatment programme for him, he wanted help. This is how SHARAN's interaction with the young injector began. The outreach worker asked him to come to the drop-in centre. He saw the doctor and decided to enrol himself in the drug substitution programme. Upon enrolling, he was given a health-record card and a prescription for sublingual buprenorphine. The dispenser on duty gave him directions on the use of the medication.

Ali met with the outreach worker frequently and chatted over a cup of tea. He usually complained that the dose dispensed was inadequate, but he provided some new information too. He spoke about his profession, his drug-taking past from cannabis to smoking heroin and injecting, his sexual behaviour and preferences. The outreach worker used these opportunities to find out what Ali knew about HIV and AIDS. He did not perceive himself to be at risk since he shared equipment and drugs only with close friends. As he expressed it, his relationships with girlfriends were also 'intimate' and condoms were therefore redundant. Ali wanted to continue injecting. The outreach worker referred him to the drop-in centre's doctor to give him access to the needle and syringe exchange programme. The following day, Ali was upset that the person who offered him clean needles and syringes offered him condoms as well. He was under the impression that information shared in confidence was being passed on. The outreach worker explained his own role and the importance of confidentiality in their relationship.

After two months in the substitution programme, Ali chose to undergo detoxification at SHARAN's detoxification centre. On the third day there, his medication was reduced. He did not take well to it, but managed to last another five days at the centre and then found his way back to the park. SHARAN's outreach workers are constantly on the lookout for drug users who hang around the Yamuna Park and try to get the first opportunity to talk to drug users about their injecting behaviour. Initial efforts concentrate on establishing a rapport. Drug users also hear about SHARAN's drop-in clinic through fellow users. Opportunities for conversation are used to initiate discussion about unsafe behaviour and various options to avert the dangers of risk-taking are explored. Counselling happens both in the park and at the drop-in centre. Treatment

options for drug use are provided and the drug user given time to make a decision. After the decision has been made, the drug user is referred to the staff of the drop-in centre. The user is given a general medical check-up and enrolled in the buprenorphine substitution programme. Where clients choose detoxification or rehabilitation, appropriate referrals are made.

In the **Philippines**, the WHO Street Children Project was set up in 1991 in response to an increase in substance use among young people. The programme was used as an entry point to tackle other issues within marginalized groups, addressing a range of issues using the community development model. Sister projects operated across sites in India, Egypt, Africa, Central and Latin America. The project addresses sexual and reproductive health, blood-borne infections and substance use within the broader context of poverty and social disadvantage.

In Manila, 20 percent of substance users live on the street, the rest in slum communities. Problems facing the project included the normalisation of substance use behaviour among young people in contact with the project and the difficulty of forming attachments with traumatised young people. The challenge was to harness young people's enthusiasm and energy, and promote their self-esteem by involving them in improving the availability of health care services and their own quality of life.

The project used a simple but comprehensive model to look at factors affecting the behaviour of substance users across all aspects of their lives. Focus groups were set up to get a more accurate picture of what happened within the community. An emphasis on substance use had a valuable series of 'knock on' effects - enabling improvements to be made to the general environment as well as to the educational and other opportunities of the young people involved.

The project was implemented in partnership with the NGO, FCED (Families and Children Empowerment and Development). Initial work involved reviewing the structure of the NGO to make it more effective, strengthening the membership of the steering committee to facilitate effective partnerships within the community and with other organisations such as the Ministry of Health and funding bodies. Junior Health Workers (JHWs) were subsequently recruited from the ranks of older street children. To support them in their new roles, and to respond to the need for identification, they were provided with basic training in health issues and peer counselling and given specially printed t-shirts.

A comprehensive training kit was developed with the JHWs' full participation and input. The pack included case studies and a series of different manuals.Thirty JHWs over 16 years-old with literacy skills were trained in First Aid and more advanced techniques to work as Emergency Room volunteers at the Philippines General Hospital. In collaboration with the Director of the Emergency Medical Services, a further ten who had been ER Volunteers for at least 50 hours with 2 years experience as a JHW, were trained as First Responders, involving advanced training in first-aid, CPR and other techniques. Importantly, JHWs acted not only as a first point of aid, but also as advocates when taking street children to the clinic.

The project has shown that a focus on substance use could lead on to more comprehensive service development. An evaluation of Street Educators activities in one 3 month period in 1999 showed that 1,857 children were reached by 16 street educators; there were 10 family reunions; 271 children received individual counselling; there were 182 intake interviews; 170 young people received group counselling; there were 51 home visits; 75 children were referred to drop-in-centres; and there were 59 agency visits.

Funding for the first year of the project in Manila was only $10,000, making this a highly cost-effective intervention.

THE PHILIPPINES – Emilio, Monica and Juliet

Emilio is a 13 year-old street child. After being helped by a Junior Health Worker (JHW), he trained as a JHW himself. He lives with his mother, a 'Shabu' (methamphetamine) user on the streets of the Divosoria area of Manila near the Port. He collects cardboard boxes to sell and earns about $US1.50 per day. He is very small for his age and has been a glue inhaler, but now occasionally uses tobacco and 'Shabu'. He tries to discourage street children from substance use, and advises them to go to shelters and get an education. Many join gangs, which also include police officers. Despite his own problems, Emilio keenly assists other street children. He has even bought first aid kit supplies out of his meagre income for his JHW work. He was able to demonstrate basic first aid such as stopping bleeding and how to manage a fracture.

Monica is a 15 year-old street girl who was brought by Emilio to the Medécins Sans Frontières Street Children Project's Wednesday afternoon clinic at Sampoloc Bible Church. She comes from one of the most southern provinces of the Philippines and ran away from home after fattening a pig then selling it, giving half the proceeds to her father and using the rest to get to Manila. She quickly ran out of money and ended up in the Divosoria area. She found accommodation with a woman whose husband was in jail and collected waste with the other street children for four weeks before becoming ill with a chest infection. She did not know what to do. She had noticed the street children talking to a man she later identified as 'Butch', the FCED/CHAP (Childhood Asia) street educator in that area. He was friendly and helpful and the children seemed to like him very much. She met Emilio one day and he introduced her to Butch. By that afternoon, she had been given a medical examination and medication for her infection. Plans were developed with her to support her and enable her to return home.

Juliet is a 16 year-old street girl who has been involved with FCED/CHAP for some years, and has been a JHW for four years. She told of how she had found two children who had been seriously injured by a train. She took them to the nearest Emergency

Room via pedal rickshaw, but the staff on duty told her they were very busy and did not take her seriously. She told of other similar incidents, frustrated by the reactions of hospital staff to her and the needs of the children she accompanied. She revealed that she had been subjected to sexual and physical abuse in the past and that she had developed a means of working with children who were also being abused. She is very keen and committed in her role as a JHW and wants more training so that she can better help the young people in her community on the streets of Divosoria.

Europe

Major challenges to young people's health in general and sexual and reproductive health in particular, exist in the countries of Central and Eastern Europe and the former Soviet Union. Rapid political and economic change has created new challenges for health systems and for the expectations and life chances of young people themselves. Rapidly developing epidemics of injecting drug use and of sexually transmitted infections, including HIV, have been identified. These pose a major threat both to young people's health and to future economic and social development. A variety of responses have arisen in order to cope with this threat.

In **Russia**, the NGO AIDS Infoshare has been working with support from the Soros Foundation/Open Society Institute to promote safer sex and harm reduction among young women sex workers in Moscow.

Over 90 percent of women working in Moscow's sex industry are from other regions of Russia and the Newly Independent States (NIS). Their lack of proper residency papers means that they do not have access to basic services such as public health care. This not only dissuades them from accessing medical services on a voluntary basis, it greatly restricts the dissemination of accurate and up to date sources of preventive health information and other resources which could help to improve their living conditions. Instead of receiving information in school or from health care workers, women learn about sexual health issues and prevention methods through word of mouth, popular television shows, magazines and tabloid journals.

Prior to the financial crisis of August 1998, police statistics estimated that between 15,000 and 30,000 women were working in Moscow's sex industry. Immediately following the economic crash, official numbers rose to 70,000. However, female commercial sex workers on the street say that this is a gross underestimation of the true figure. There are currently almost 200,000 officially registered cases of HIV infection in Russia, with over 15,000 cases in the city of Moscow. In 1997, the average age of girls entering sex work was 20-24; it is now 16-19 years. Clients want young girls as a protection from STIs in the mistaken belief that 'younger is safer'.

In Moscow, sex workers find it safer to work with a pimp because many of the sex work locations are looked after by the 'Mafia' who pay regular weekly fees and monthly 'bonuses' to local police patrols for the maintenance of the site. The pimp (who is often a woman and a former sex worker herself) has more power of negotiation than the individual

sex worker. However, this does not guarantee that condoms will be used, nor does it ensure a woman's safe return. Even when the use of condoms is negotiated between the pimp and a single client, it is not unusual for more men to be waiting in the apartment or hotel room.

AIDS Infoshare was the first organisation to begin working with the marginalized and isolated group of younger sex workers. It provides free condoms and information materials (brochures, flyers, and fact sheets), on-the-spot consultations with qualified outreach workers and two venereologists, mini-workshops on the street, a telephone help-line service (one of only two in Moscow), launched on World AIDS Day 1999, and free STI medical services and social-psychological support for sex workers in collaboration with a medical NGO called TEMP.

Results of an initial needs assessment indicated that many women were unaware of the basic means of protection against infection and did not know how to recognise the symptoms of STIs in themselves or clients. Although abortion is still the most popular method of birth control in Russia, condoms are largely available in local pharmacy kiosks. It was found that when women did buy condoms in local kiosks, they were chosen not for their quality, or for their brand name or other features, but largely because of the erotic pictures on the packaging. AIDS Infoshare subsequently developed a series of five information brochures to accompany free packs of condoms, based on the detailed needs expressed by the women. The brochures are comprehensive and easy to read and provide referral addresses and telephone numbers for health, information and support services. They are small enough to fit conveniently into pockets and purses and use attractive images and colours. The women made it clear that stylish design was very important, so the brochures resemble small cosmetic or perfume magazine inserts, rather than starkly functional materials.

Seminars have also been held for sex workers, but these have been less successful since women are wary of police arrest. They were also reluctant to give up their free-time or the opportunity to make money. On a few occasions, a beautician has been hired to provide free make-overs at the workshop. This turned out to be extremely effective. While the women tried new and fashionable looks, make-up and hairstyles, they were able to discuss issues relating to safe sex with health workers.

In the Russian health care system, professionals view their role as primarily one of diagnosis and treatment. AIDS Infoshare has therefore conducted training workshops among medical professionals with the aim of increasing and strengthening the availability of pre- and post-test counselling, patient education and doctor-patient communication skills, gender sensitivity, discussing impacts of gendered roles and stereotypes, and a commitment to good quality medical ethics (informed consent and doctor-patient confidentiality).

Training seminars and printed materials have also been offered to the local police force on HIV/AIDS, condom use, anti-discrimination, stigmatisation and safety in the workplace.

The mobility of the women working within the sex work industry, their reluctance to identify themselves as sex workers and the tendency to work sporadically, have all been obstacles to establishing an effective peer education programme. Since many female sex workers are illegal immigrants, the threat of police arrest makes the women very cautious and keen to keep a low profile. Although there are disadvantages in the high mobility of the target group in relation to project activities, there have been some important advantages:

- women often receive copies of AIDS Infoshare materials from other sex workers on the 'site' who introduce the organisation to the new arrivals and promote services;
- high transition rates among the women can increase the potential for health information and prevention skills to be passed on to other women in other cities and regions;
- despite the younger ages of female street sex workers in Moscow, there is still an extremely high literacy rate in Russia. Migrant women are usually from the former Soviet Republics where the Russian language is still widely used and understood - factors that greatly influence service provision and material production.

AIDS Infoshare plans to continue the production of a small newspaper bulletin with sex workers. This initiative, among other things, will assist in promoting a sustainable peer education programme and will get more women involved in project activities on a regular basis. It is also planned to open a small drop-in centre providing a non-discriminatory, friendly environment where women can talk with counsellors, receive free legal consultations and receive additional informational materials and training. Information materials for clients are also in development. Many women have asked for these and have indicated that they would be willing to pass them on to their clients.

RUSSIA – Working with Young Women on the Road to Sheremetievo

Work started with sex workers in Moscow in summer 1997. It took almost six months to establish reliable contacts within this community. The most popular area for sex workers, or 'tochkas', was downtown Moscow. Following the 1998 economic crisis, however, the number of sex workers in the area increased threefold. Moscow's City Government announced a new prevention programme to eliminate prostitution in the capital with the city police force being responsible for its implementation. This was a crucial factor in the development of the sex industry in Moscow and the increased involvement of younger sex workers.

Prior to the crackdown, the road to Sheremetievo - just outside Moscow - was mostly occupied by girls working without pimps. But the City Government's new measures altered the geographical scope of the sex industry. Himki (the area where Sheremetievo is located) is not part of Moscow and so, to escape the new laws, many 'tochkas' relocated here from central

Moscow. It is a much more dangerous area and was also attractive to drug dealers and sellers of weapons.

AIDS Infoshare found out from the girls working in downtown Moscow that they were also working for some of the time in Himki. It was arranged to meet with a pimp who had previously worked in Tverskaya in order to conduct an initial situation assessment. In some places, there were cars with a driver in police uniform. After the initial 'tour', it was decided to go to the Chief of the Police department responsible for 'moral' crimes. A series of prevention activities for policemen was arranged, such as giving out free condoms, leaflets and lectures on HIV/AIDS. AIDS Infoshare would not have been so successful in its work, ranging from sex workers to policemen, without the cooperation and support of pimps, the girls themselves and the permission of the police.

Elsewhere in Russia, innovative work has been taking place to involve young people more fully in HIV/AIDS prevention efforts. In Tver, and with the support of UNICEF, the NGO Tvoi Vybor (Your Choice), has been using IEC, training and other activities to promote better understanding and risk reduction among young people. Tver is one of Russia's oldest towns, founded in the 12th century and located 150 km from Moscow. The population of Tver and Tver Oblast is one and half million people but the area of land is equal to the size of Germany. Tver is a city of students, with four universities, 23 colleges and 57 high schools.

The strategy and approaches adopted by Your Choice are based on a needs assessment conducted amongst young people in the area. Data from the organisation's recent research among 502 injecting drug users in Tver highlight the necessity of an urgent response to HIV/AIDS, which needs to include activities aimed at preventing sexual transmission. In this survey, it was found that 55 percent of injecting drug users have non-injecting sexual partners, 27 percent have multiple sexual partners, 4 percent have STIs, and 18 percent have HIV and Hepatitis B and C.

One of the first initiatives of Your Choice was the creation of an HIV/AIDS/STI Resource Centre for youth as part of the 'All Russia Information Network', established in partnership with AIDS Infoshare and other regional NGOs.

Together with a group of 18 young people from a local high school, Your Choice developed produced and distributed 17 different types of information materials including brochures, posters and stickers. In the last three years, about 70,000 informational items have been distributed through volunteers and staff.

In December 2001, the first HIV/AIDS Helpline in Tver was launched to provide information, support and a referral service for young people staffed by a team of professional psychologists, together with volunteers. There have also been 126 seminars over a six-month period. In addition, Your Choice has organised street festivals and concerts for young people, using popular Hip Hop music groups and even graffiti to communicate prevention messages. Local television has also played a supportive role and helped to arrange a talk show with members of the organisation and some of the volunteers.

Russia – AIDS Infoshare

A youth training centre has been established and equipped, and the Project Coordinator is responsible for a monthly progress report. Information sheets were produced and distributed in ten high schools in Tver. Factors that have helped the project to work include its participatory approach and a partnership with other NGOs such as AIDS Infoshare and governmental organisations. In addition, Your Choice staff are mostly below the age of 27 and have extensive experience of working with young people. Factors that have hindered the project include the criminalisation of injecting drug use and the lack of motivation amongst teachers in targeted high schools.

The next step is to open a drop-in zone with information and counselling services, involving volunteers as well as staff. Accumulated experience from running the project will be put together in a guide on 'How to develop effective prevention programmes for young people'. The project will also run summer camps, arrange a big rock festival in Tver, develop new materials and training programmes, hold monthly briefing sessions with journalists, and use all possible channels of information to bring health promotion messages to young people. An association of NGOs and governmental organisations working in the area of HIV/AIDS has just been created, with the aim of strengthening co-ordination between governmental and non-governmental organisations, developing inter-secteral collaboration and sharing knowledge, experience and resources.

RUSSIA - Your Choice

Your Choice has been working in HIV/AIDS prevention among young people since 1999. It has developed an original module of one-day training for young people aged 12-17. The programme is called 'Skills for Safety Behaviour' or 'How to Make a Choice'.

In the summer, most teenagers are sent by their parents to summer camps. Part of the Pioneer Organisation in the former Soviet Union, summer camps were established in 1921 and were located in the countryside. Today, the facilities of these camps (such as buildings, sports stadia, etc) are still largely functional and are used to allow young people to get out of the city for three months. There are three periods of four weeks' duration, then teenagers can choose to return home or stay for another four weeks.

Regular activities at summer camps include sports events, sightseeing and arts and crafts. Camp staff are responsible for implementing the programme of activities. In spring 2000, Your Choice agreed with the Department of Education of Tver that the programme 'Skills for Safety Behaviour' (which included one day's training and information materials) would be integrated into the activities of the summer camps. At the joint meeting of summer camp directors, the project co-ordinator presented the programme and drew up a time schedule for visiting all summer camps

in Tver Oblast during a period of three months. Altogether, 126 training days were planned. The programme involved five hours of interactive training, which included the following components: information on HIV/AIDS/STI including modes of transmission and prevention, drug and alcohol abuse, and skills transfer.

Participants are encouraged to develop their skills through role-play exercises on how to make an independent decision, how to cope with peer pressure; communication skills, how to express their feelings, and how to say 'no'. At the end of each training session, contact details on where young people can access other services after returning to the city are left at a drop-in zone.

Most of the work takes place in small groups. This enables trainers to maintain close contact with young people throughout the whole session. Sessions were conducted outdoors whenever possible. One trainer was assigned to each group and the camp staff were not present, which helped to create a confidential and friendly environment. Participants were invited to fill in questionnaires to measure their level of knowledge before and after the training. This included questions dealing with types of behaviour, sources of information, evaluation of the training itself and the trainers' abilities.

Constant monitoring and evaluation of the programme has helped to better address young people's needs. Partnership with a government office such as the Department of Education has offered a number of benefits including sustainability, reduced costs (expenses were covered by the city councils), and good coverage (using an established structure, such as the summer camp scheme, 2,500 young people were reached during a three month period).

Section Four
Some lessons learned

A variety of lessons emerge from the projects and programmes reviewed. In this final section, we will summarise some of these as a step towards identifying elements of best practice.

Perhaps the first lesson to be learned relates to the manner in which different vulnerabilities interact. Only rarely do young people in difficult circumstances face a single set of problems. More often, they encounter ***complex combinations of vulnerabilities*** (such as those linked to sex work and drug use, or being a refugee and involvement in transactional sex), which together pose a threat to health and well-being. In turn, rarely are these threats unidimensional. It is not at all uncommon, for example, to find that young people experience family problems, drug problems, mental health problems, economic problems and sexual and reproductive health problems simultaneously. This poses major challenges for knowing when and how best to intervene.

Generally speaking, ***holistic and multi-levelled programmes*** and interventions such as those described in countries as diverse as Mali, Ethiopia and Brazil, are those that work best. These recognise the complexity and inter-relatedness of health problems as they affect young people's lives. It is insufficient to intervene so as to promote the sexual health of young sex workers if their drug problems are to remain intact. Likewise, it is irresponsible to attend to the HIV/AIDS threats posed by the sharing of syringes and needles if little is done to enhance sexual safety at the same time. In real people's lives, health problems are rarely, if ever, unidimensional. Their multi-faceted nature calls for a multi-pronged response.

Working to strengthen ***positive responses*** is always a good strategy. Even in the most difficult of circumstances young people may display positive health behaviours that can be strengthened as part of a health promotion response. This was particularly clear here in work in the Philippines and in South Africa. This is no less true in the field of HIV/AIDS and sexual and reproductive health than in other areas of life. As programmers and policy makers, we must guard against the tendency to view young people's health behaviour as inevitably pathological and in need of change. Often, the task lies in reinforcing the already safe behaviours that exist, rather than in promoting behaviour change.

The programmes we develop and the interventions we make must be ***evidence based***. Having said this, there is a variety of evidence to

take into account. While the 'gold standard' for many remains the randomised controlled trial, we frequently have to make do with less rigorous forms of evaluation. The projects described have all evaluated their work, although they have done so in different ways. In each case, though, evidence has been amassed for the effectiveness of the approach advocated, and its appropriateness to the circumstances under which the intervention or programme took place. The various projects described here sought to amass evidence of success in a variety of ways appropriate to their goals and circumstances.

There is now a wealth of literature pointing to the importance of involving young people themselves in needs assessment, programme design and implementation, and evaluation. This way, there is likely to be a better fit between the model of intervention proposed and young people's experiences and needs. ***Young people's involvement*** in efforts to promote sexual and reproductive health, as well as in other forms of health promotion, is not only required by the UN Convention on the Rights of the Child, which asks that their views be taken into account, but it is also common sense. Otherwise, we run the risk of devising programmes and interventions that speak to imaginary, as opposed to real, needs.

Several of the projects described here, including those with sex workers in Brazil and young men in South Africa, emphasise the importance of ***distraction, pleasure, fun*** and ***having a sense of pride*** as factors affecting programme success. Yet all too rarely are these included in programme designs. Instead, more seemingly 'serious' approaches are advocated, in which young people are warned about the dangers of sex and drug use, and in which they are required to shoulder responsibility for changing their behaviours and lifestyles - even where the context makes this very difficult. To take complex and multiple vulnerabilities seriously means recognising that adults and young people must work together to change the circumstances that predispose them to risk. Partnership, not blame, should be the priority in future programme development.

Young people are a remarkably ***heterogeneous population***. Their diversity, and the corresponding variation in needs, calls for a differentiated response, such as was witnessed in Costa Rica and in different sites in Russia. Responding adequately to the sexual and reproductive health needs of educated young people from affluent backgrounds, for example, calls for a different approach than what might be successful in work with young people in poverty- who may have received little by way of formal education. Likewise, responding to the special circumstances of young migrants and refugees may call for a different style of work from that more suitable for use with less geographically mobile populations.

As the programmes and projects show, the needs of young women are frequently different from those of young men. A ***gender perspective*** is therefore essential, and was central to the majority of projects represented in the meetings. Beyond this, however, young same-sex-attracted youth may see life differently from their heterosexual counterparts. Young people living on the street may have a different perspective on events than their more affluent counterparts. Young people involved in sex work will not necessarily have the same sexual and

reproductive health concerns as those who are not yet sexually active. Taking these differences seriously, and structuring our response around them, is of the utmost importance.

At one level, the differences between young people may seem self evident; but at another, they pose a major challenge for our work. Taking the diverse needs of young people seriously calls for careful thought if we are not to promote too individualistic a response. While individuals differ, it is in fact the ***patterning of vulnerabilities*** that needs to be responded to if we are to make headway in contexts of especially complex vulnerability. This requires tackling the systematic nature of disadvantage (of gender, ethnicity, age, sexuality and of status) in order to promote sexual and reproductive health. Programmes and projects responding constructively to economic disadvantage included those in Nicaragua and Brazil.

Adopting a ***rights based perspective***, in which the validity of young people's claims to the knowledge and resources that will allow them to protect their sexual and reproductive health (and that of others), is part of the international recipe for success. Young people, regardless of their social status and background have the absolute right to the full range of knowledge that will allow them to protect themselves and others against sexual health threats such as HIV/AIDS.

Programmes and actions need to be ***sustained over time*** if they are to be successful. As demonstrated in India and Nicaragua, this requires strategic investment on the part of donors and funding agencies as well as project workers. Many of the projects described here were struggling to sustain themselves in difficult circumstances. Those that were most successful had forged durable relationships with funders, and had begun to build into their work processes and factors that would allow their efforts to be maintained over time. In several projects, for example, young people themselves were being trained as advocates. In others, peer education and peer counselling approaches were being promoted. In others, self-sustaining systems of provision, such as those allowed for by health vouchers, were being set in place.

The important role of ***non-governmental (NGOs)*** and ***community-based organisations (CBOs)*** was highlighted repeatedly throughout the meeting. Being close to where the action is, such bodies can respond quickly to young people's identified and changing needs. Where young people themselves are actively involved in the organisation and administration of NGO and CBO work, the benefits can be considerable. However, it is important to avoid allowing national authorities to be 'let off the hook' by grass roots action. Governments have clear responsibilities for the health and development of all young people, and their efforts with respect to those who are especially marginalized are often less than adequate. Actions that call governments to account, and which involve a broad coalition of interests and forces, are important in keeping the sexual and reproductive health needs of especially vulnerable young people high on the economic and social agenda.

Similarly, there needs to be greater ***connectedness*** between actions at different levels and in different contexts. Some of the most spectacular instances of success (e.g. in Mali, Nicaragua and Tanzania) have arisen when governments and the non-governmental sector work together, playing to their

respective strengths. An increasing number of programmes and projects are seeking to forge such links, dividing between them the work involved. Good links to 'mainstream services', where they exist, not only reduce costs but increase connectedness, giving respect to the rights of young people.

Not unrelated to the above, is the value of adopting a ***multi-disciplinary approach***. This is essential if the interactive nature of complex vulnerabilities is to be addressed. Poverty, homelessness, family difficulties, drug problems, sexual and reproductive health needs - all are perhaps best responded to by different combinations of individuals and agencies. Only rarely in the richest countries of the world do there exist 'one-stop shops' for all of these concerns. It is essential, therefore, that different professionals work together, as in India and Russia, sensitive to what their own discipline might bring but aware of the value of the contributions of others.

The majority of projects whose work has been described made efforts to take their work to where young people are. Several, including innovative activities in Argentina, Kenya, the Philippines and Russia, adopted an ***outreach approach***. Others took care to make their services accessible in places and on occasions that were important in young people's lives. Football matches, concerts, discotheques, summer camps were but a few of the options used. In each case though, there was concern not to wait for vulnerable young people themselves to access the project, but for the project to access them. In short, programmes need to work at many levels and in many locations if they are to be successful. They also need to work with many different groups, recognising the inter-relatedness of vulnerable young people's lives.

In working with complex vulnerabilities, there can be value in ***targeting transition*** points. This involves working with people before they become vulnerable, but it also means intervening strategically at moments when risk may be lessened. The international literature on substance use is replete with examples demonstrating young people's progressive engagement with more damaging kinds of drugs. While some of the 'gateways' to serious substance use have been identified, much less is known about the routes away from risk. How can young people be assisted in making such transitions, and what are the key points that should be targeted? Among the successful approaches highlighted here are employment schemes in Brazil that provide young sex workers with alternative ways of making a living, and peer-based activities (such as junior health worker schemes in the Philippines) that provide young people with status and a sense of worth.

Finally, it is important to recognise that sexual and reproductive health and HIV/AIDS are not 'stand-alone' issues, except when framed within the disciplines that make up professional lives. In young people's experience, on the other hand, they are intimately connected, both to each other and to the broader social circumstances in which they live. Having somewhere to live, having educational opportunities, having a job, having the support of adults who can be respected, having friends, having the chance to have fun - all these are integral parts of young people's lives. Together, they are the foundations upon which growth and development can occur. Yet when any one of these factors is threatened, instability arises. And it is this instability that characterises the lives of especially vulnerable young people. ***Greater connectivity*** is what we should be striving for, both in our understanding of these issues and in the responses we make. This is the challenge that confronts us all in seeking to promote young people's sexual and reproductive health.

Appendix One
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Appendix Two
Other Publications by Safe Passages to Adulthood

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