The Power of Prevention
Stories from JTF Projects in Africa and Asia
Acknowledgments

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This book, which is a collection of experiences from JTF-supported projects implemented in 2002 and 2003, would never have been completed without the assistance and contributions of many people.

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Finally, we are indebted to the many people in the field who generously gave their time to share their ‘voices’ with us. These voices offer important insights into how to bring real and lasting change to the lives of people throughout the world.
## Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>CBOs</td>
<td>Community-based Organizations</td>
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<tr>
<td>FPA</td>
<td>National Family Planning Association associated with IPPF</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>JTF</td>
<td>Japan Trust Fund</td>
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<tr>
<td>MA</td>
<td>Member Association (of IPPF)</td>
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<td>NGOs</td>
<td>Non-governmental Organizations</td>
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<td>PLHAs</td>
<td>People living with HIV/AIDS</td>
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<td>SMMEs</td>
<td>Small, Medium and Micro Enterprises</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TOT</td>
<td>Training of Trainers</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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## Member Associations of IPPF

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<th>Acronym</th>
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<tr>
<td>AIBEF</td>
<td>Association Ivoirienne pour le Bien-Être Familial</td>
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<td>ABUBEF</td>
<td>Association Burundaise pour le Bien-Être Familial</td>
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<td>ARBEF</td>
<td>Association Rwandaise pour le Bien-Être Familial</td>
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<td>ASFF</td>
<td>Alliance of Solidarity for the Family</td>
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<td>BOFWA</td>
<td>Botswana Family Welfare Association</td>
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<td>CAMNAFAW</td>
<td>Cameroon National Association for Family Welfare</td>
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<td>CFPA</td>
<td>China Family Planning Association</td>
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<td>FGAE</td>
<td>Family Guidance Association of Ethiopia</td>
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<td>FPAB</td>
<td>Family Planning Association of Bangladesh</td>
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<td>FPAI</td>
<td>Family Planning Association of India</td>
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<td>FPAK</td>
<td>Family Planning Association of Kenya</td>
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<td>FPAM</td>
<td>Family Planning Association of Malawi</td>
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<td>FPAN</td>
<td>Family Planning Association of Nepal</td>
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<td>FPAP</td>
<td>Family Planning Association of Pakistan</td>
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<td>FPAU</td>
<td>Family Planning Association of Uganda</td>
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<td>FRHAE</td>
<td>Family Reproductive Health Association of Eritrea</td>
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<td>GFPA</td>
<td>Gambia Family Planning Association</td>
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<td>MFWA</td>
<td>Mongolian Family Welfare Association</td>
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<td>NAPPA</td>
<td>Namibia Planned Parenthood Association</td>
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<td>PPAG</td>
<td>Planned Parenthood Association of Ghana</td>
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<td>PPAT</td>
<td>Planned Parenthood Association of Thailand</td>
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<td>PPASA</td>
<td>Planned Parenthood Association of South Africa</td>
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<td>PPAZ</td>
<td>Planned Parenthood Association of Zambia</td>
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<tr>
<td>RHAC</td>
<td>Reproductive Health Association of Cambodia</td>
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<tr>
<td>UMATI</td>
<td>Uzazi Na Malezi Bora Tanzania</td>
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<tr>
<td>VINAFPA</td>
<td>Vietnam Family Planning Association</td>
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Guided by the strategic plan (2000) of the International Planned Parenthood Federation (IPPF), the global network of IPPF Member Associations has steadily sought to integrate HIV/AIDS prevention and care into a broad package of reproductive health services. IPPF and its Member Associations worldwide seek to extend service provision to marginalized and vulnerable groups. IPPF members are well-placed to help ensure universal rights to HIV/AIDS information and services. In particular they are strongly positioned to play a key role in HIV integrated prevention: prevention that is inherently linked to care. For it is this way that prevention becomes personalized. One of the many global lessons learned is that the relationship between prevention and care is intimate. The stories here illustrate the exploration of IPPF Member Associations for new ways of approaching prevention. Integrated prevention is one avenue that has seen many of the Member Associations playing a pioneering role.

Member Associations have extensive knowledge and experience in the area of sexual and reproductive health. They work closely with women in reproductive health decision-making and they often provide outreach services and sexual and reproductive health care to young people and other vulnerable groups. Women are disproportionately affected by HIV/AIDS in the countries of sub-Saharan Africa where the pandemic is most widespread. For biological and social reasons infection rates among women are in some areas several times higher than that of men. The level of domestic abuse, rape and other forms of gender violence is also high in these countries. As well as bearing the brunt of HIV infection, women also carry the primary responsibility of caring for the sick and for the young - they carry the double burden of disease and care. Moreover, women often lack the political and social power to make their voices heard, a disadvantage they share with vulnerable groups such as youth.

IPPF has been involved in HIV/AIDS integrated prevention for almost 20 years. But while the Member Association network is extensive, individual organizations often lack the financial, institutional and technical capacity to effectively plan and implement HIV/AIDS prevention and care programmes. The Government of Japan and IPPF signed an agreement to establish the Japan Trust Fund for HIV/AIDS (JTF) in September 2000. The Government of Japan’s decision to commit funds to JTF has its roots in the Okinawa Infectious Diseases Initiative launched at the Kyushu-Okinawa G8 Summit in July 2000. Since then JTF has become a vital resource for the development of HIV/AIDS-related projects and has enabled many in the IPPF global network to initiate HIV/AIDS projects for the first time.

Since its inception, JTF has successfully raised HIV/AIDS awareness at IPPF Regional Offices, resulting in the appointment of dedicated staff. Member Associations have received training assistance with proposal writing, project management, monitoring and evaluation, advocacy skills and the development of partnerships and collaborative working relationships with other organizations. Many Member Associations have been provided with an opportunity to initiate and implement HIV/AIDS projects and to integrate a continuum of HIV/AIDS care with their current range of family planning and reproductive health services.

There are several key components of JTF. Grants are approved for Member Associations to carry out HIV/AIDS projects. Inter-regional training geared to boosting the capacity of MAs to propose and implement HIV/AIDS projects is organized annually, and projects to develop action plans focusing on advocacy work are supported.
The majority of funding goes to HIV/AIDS grant projects in the hardest-hit regions. All Member Associations supported by JTF over the last two years have adopted innovative approaches.

The spectrum includes:

- focusing on extending and promoting VCT services (Ghana, Kenya and Uganda)
- providing STI/HIV/AIDS prevention and management among sex workers (Vietnam and Cambodia)
- using rural networks to promote HIV prevention education (China)
- taking STI/HIV/AIDS education and counselling to mobile vulnerable groups (truck drivers and their families in India and prisoners in Rwanda)
- building peer educator networks for HIV/AIDS awareness education among youth (Pakistan, Seychelles, Cameroon, Tanzania, Mongolia and Zambia)
- developing sector-specific projects among workers (SMMEs in South Africa, garment workers in Bangladesh and Ethiopia, and bank employees in Gambia)
- targeting vulnerable groups via industry training venues (police colleges in Nepal)
- producing specialized media tools for use in prevention campaigns and behaviour change communications (video production in Botswana, multi-media materials project in Côte d’Ivoire and a youth AIDS media project in Cameroon)
- expanding Member Association service capacity in HIV/AIDS and extending service provision (Burundi)
- developing HIV/AIDS awareness and commitment among policy and decision-makers and opinion leaders (Liberia and Vietnam)
- enhancing the capacity of women and youth to negotiate safer sex with their partners and assert their reproductive health rights (Namibia)

The complexity of project design varies widely and in some instances intricate systems of cooperation with organizations outside the Member Association are required. Voluntary Counselling and Testing (VCT) initiatives in particular need collaboration with health departments and other non-governmental organizations (NGOs) working in the HIV/AIDS arena. Some projects demand intensive stakeholder participation in design and implementation (e.g. youth-focused behaviour change communication). At times a project needs both. But building relationships, deciding on roles and responsibilities and developing participatory approaches are time-consuming processes. The capacity-building element common to all the projects has fostered the meaningful mainstreaming of HIV/AIDS prevention initiatives into local sexual and reproductive health programmes.

This report provides a brief outline of the projects undertaken with the funds allocated in 2001 and 2002 and implemented in 2002 and 2003. The majority of the projects are now completed, although a few were suspended or delayed due to political unrest or civil war and others were interrupted by disruptive weather or natural disasters. The project in Liberia was, for example, postponed indefinitely because of the unstable security situation in that country.

The projects have been implemented in a diversity of environments and local circumstances and differ widely in their focus, scope and depth. Sustainable initiatives recognize the need to understand the socio-economic and political dimensions that impact on the messages provided to vulnerable groups, while pursuing their programmes in the broader environment. Unique approaches suited to their own grassroots experiences were developed by Member Associations in most countries.
The grant projects have been grouped into three themes – integrating prevention with care and support, working with vulnerable groups, and targeting youth – depending on their primary focus or intended beneficiaries. Of course there is overlap between the themes and some of the individual projects could fit into all three. Grouping them in this way draws our attention to where HIV/AIDS support is concentrated and also helps us to identify intervention priorities as well as any gaps.

The level of detail provided on each project is deliberately uneven and shouldn’t be seen as a reflection of the success of a project or the quality of reporting by Member Associations. The level of grant project funding ranged from US$15,000 for Advocacy Action Plan to US$75,000 for Grants Projects [see the project lists on pg 47–49].

Most of the projects have been dealt with very briefly while others have been considered in more detail. These were chosen to provide a more comprehensive insight into the type of initiative undertaken by Member Associations. While much of the detail links to a specific environment or situation, the lessons are pertinent and valuable across regions and borders.

A diversity of voices including rural villagers in India, peer educators in Mongolian colleges, street hawkers in Uganda, parents in Tanzania and Member Association staff across Africa and Asia share their experiences of the projects.
The inter-regional training programme funded annually by JTF is designed to boost the capacity of IPPF Member Associations in the integrated prevention of STI/HIV/AIDS. The South-South collaborative initiative was designed to help prepare the ground for other HIV/AIDS projects. The project helps provide skills, capacity and the initiative Member Associations need to develop and pursue HIV/AIDS projects in their home countries.

Organized once a year in Thailand – the first country in Asia to document the presence of HIV – the programme fosters greater collaboration among and between developing countries. The training allows Member Associations to share information and experiences of integrating HIV/AIDS prevention, care and support into their reproductive health services. Selected for participation by their Regional Offices, a growing number of Member Associations from Asia and Africa have been involved in the programme.

The Planned Parenthood Association of Thailand (PPAT) with its substantial experience in HIV/AIDS-related work has been organizing the training programmes since 2000. PPAT’s experience of advocacy work and establishing local partnerships was crucial to the development and delivery of the training.

The primary objective is to enhance the capacity of Member Association staff and volunteers to initiate and implement integrated prevention initiatives in their own communities. Broken into four modules, the training covers the development of common understanding on advocacy for HIV/AIDS prevention; successful advocacy strategies; development of advocacy statements and project proposals; and presentation skills.

Outside the structured programme, the training sessions provide valuable opportunities for networking which promotes strategic partnerships between organizations in their HIV/AIDS advocacy work, providing scope for the pooling of experience, expertise and resources.

The formal training comprises panel discussion sessions and field visits to observe the advocacy strategies being employed in Thailand. During the 2002 training, through visits to various areas in Bangkok, Songkla and Pattani Province in the south of the country, PPAT drew on the active involvement of a range of partners including local HIV/AIDS service providers – the local organizations were only too happy to share their knowledge and experiences with others. A special emphasis is placed on advocacy for youth participation in the design and implementation of HIV/AIDS integrated prevention programmes.

In 2002, University Students for AIDS Prevention in Thailand (SAT) gave participants a presentation on its own prevention activities, and the Union Footwear Company provided an overview of its workplace initiatives, demonstrating how these could be replicated in other sectors. The interactive nature of the visits gave participants a good understanding of the strategies employed and the success levels of the different approaches employed in Thailand, which later fed into the design of the participants’ own action plans (e.g. Bangladesh, Gambia and Ethiopia cases covered in this publication). Delegates were overwhelmingly positive and upbeat about the training, although some would have liked some time dedicated to the sharing of their own project experiences with other participants.

During the last few sessions of the training, participants worked on developing project proposals which, after being reviewed within the group, were put forward to IPPF for consideration for grant-funding.

“Bangkok provided me with the most inspiring training I’d ever received. It was directly responsible for encouraging us to pursue our project to improve the situation of Rwandan prisoners.”
Dr Laurien Nyabienda, Executive Director, ARBEF.

“We believe the knowledge we gained at the Bangkok training assisted us a lot in the development of our approach in our own projects, particularly in respect of advocacy with authorities that could provide support.”
FRHAE.

“The Bangkok initiative provided us with an opportunity to observe the involvement of religious groups in STI/HIV/AIDS projects, and gave insights into experiences in other countries in the Asia region. Shared with other staff, the training helps us not only to develop our own interventions but to implement the plans more effectively.”
Dr Surjit Kaur Sandhu, Mohali Branch President, FPAI.

“The Bangkok training session helped our staff understand the concept of peer groups and how to set them up among the young workers of the garment factories in Dhaka City, Bangladesh.”
Mr Shafiqul Islam Khan, Director General, FPAB.
If the tide of the HIV/AIDS pandemic is to turn, concerted, effective efforts must be made simultaneously in the spheres of prevention, treatment, care and support. The success of HIV/AIDS prevention, care and support, and mitigation programmes depends largely on the creation of an enabling service and advocacy environment. Such an environment facilitates behaviour change to reduce HIV transmission and promotes the quality of life for people living with HIV/AIDS (PLHAs) and their families. In a supportive environment, people are not afraid to seek the information or treatment they may need. Integrated prevention acts on the synergies between care and support while acknowledging that the emphasis in various scenarios will be dependent on a host of societal factors. HIV/AIDS activities must align with the wider development and public health goals of individual countries. But while significant social and development costs can be offset by prevention initiatives, they cannot be separated from the continuum of care required if the HIV/AIDS response is to be effective.

Prevention messages and projects can have negative consequences. Those emphasizing abstinence or morals may serve to blame people living with HIV/AIDS; they promote stigma and discrimination and can also create a self-stigmatization where PLHAs feel ashamed and ostracized. In reality, the notion of choice and negotiation around if, when or how to have sex is often elusive.

A growing number of IPPF Member Associations see care and support as an integral part of the HIV/AIDS services they provide within their mainstream sexual and reproductive health programmes. Most are now ensuring that HIV/AIDS services can be accessed at clinic level at the same time as family planning and other reproductive health services. The IPPF global network is extensive, promoting the realization of universal rights to HIV/AIDS information and services. A failure on the part of reproductive health facilities to fully integrate HIV/AIDS services would not only further the spread of HIV infection but would also encourage stigma and discrimination towards those infected and affected by the virus.

While prevention initiatives can limit the spread of HIV/AIDS, the provision of treatment and care helps to control its devastating impact. Effective prevention programmes therefore need to go hand in hand with improved access to treatment.

As the HIV/AIDS epidemic reaches an advanced stage across Africa, more and more Member Associations are responding to client needs through developing more integrated and holistic approaches.
Bangladesh is a low-lying, predominantly agricultural nation situated alongside India on the Bay of Bengal. Fertile floodplains cover about 90 per cent of the country which lies in the delta formed by the Ganges and Brahmaputra Rivers. HIV prevalence in Bangladesh was estimated at the relatively low level of 0.03 per cent by the World Health Organization in 2002, although the Family Planning Association of Bangladesh (FPAB) identifies several risk factors that could see the number of infections grow if the HIV/AIDS response is not strengthened. Particularly vulnerable are young people who make up the majority of city immigrants from rural areas. Poverty and illiteracy combine with unemployment and poor living conditions to increase unsafe behaviour, including unprotected sex and injecting drug use. With more than 60 per cent of the country’s women having experienced domestic violence, the level of gender abuse and inequality between men and women is high. The country also has a large number of ‘floating’ informal sex workers. Superstition and misconception thrive in an environment where few have been exposed to any form of sex education.

FPAB implemented a project in 2002 with the goal of “reducing morbidity and mortality and economic loss from HIV/AIDS” among 10,000 clothing workers in 15 factories in and around Dhaka City (a city of around 3.5 million people). Aiming to reduce unsafe sexual behaviour, the programme sought to develop the capacity of factory owners and management to implement an HIV/AIDS prevention programme.

Partnerships were formed with other NGOs to assist with the design and printing of Information, Education and Communication (IEC) materials. Literacy levels in Bangladesh are low, however, and access to broadcast media and communications technology is also very limited. The gap between female literacy (28 per cent) and male literacy (51 per cent) is one of the largest in the region. To help overcome communication drawbacks, the project tended to emphasize film-shows combined with personal interaction with peer educators.
Bangladesh

The clothing industry – the largest private sector employer in Bangladesh – draws its labour primarily from among young people. Mostly women, the garment workers are from poor socio-economic backgrounds and understand little about sexual and reproductive health. Many are thought to engage in casual sex work to supplement low incomes. A working day of 10–12 hours prevents the women from accessing affordable health services. Garment workers consequently know very little about HIV/AIDS or how to protect themselves and are extremely vulnerable. Workforce health and welfare has not traditionally featured on the agenda of garment factory managers, so the project required a shift in thinking for employers.

The project fits into the FPAB’s organized sectors programme, which is a main component of the organization’s five-year strategic plan and also aligns with national policy on health and population. Perhaps surprisingly, the project enjoyed the full support and cooperation of factory management and owners. Project workers say employer interest, motivation and commitment resulted in a positive outcome. The time factory workers were given to attend awareness sessions was limited but they still responded with enthusiasm and interest.

Lessons Learned

MANAGEMENT BUY-IN ESSENTIAL
As this was a ‘no personnel cost project’ unflinching support and cooperation from the garment factory owners and management was critical.

MONITORING PROGRESS
Periodic monitoring is required to see that objectives are met.
Botswana

Botshelo Ke Mpho – Life is a Gift – is the message conveyed in a video made to reflect the realities surrounding HIV/AIDS in Botswana. Made under the guidance of the Botswana Family Welfare Association (BOFWA) and the National Multi-sectoral AIDS Committee, the video is upbeat, encouraging those infected and affected by HIV/AIDS to live positively. The film-makers included advocacy statements from celebrities such as influential political figures, models and sports icons. Video facilities were set up across Botswana for ongoing screenings at post-offices, schools, hospitals and other public venues to maximize the impact of the video and to publicize the work of BOFWA and other organizations working with HIV/AIDS. The project should also help reduce the stigma and discrimination associated with HIV/AIDS and assist in exploding the myths surrounding transmission, prevention and treatment of STI/HIV/AIDS.

Burundi

Building local capacity in HIV/AIDS service provision

Lessons Learned

COLLABORATION BUILDS CAPACITY
No single institution can address the multiple service needs relating to HIV/AIDS – cooperation with other players in the HIV/AIDS prevention arena is essential.

GENDER SENSITIVITY IS ESSENTIAL
Messages addressing the different realities and approaches of men and women must be developed.

NEED SYNERGY OF SCREENING AND AWARENESS
The demand for voluntary counselling and testing (VCT) services increases with greater awareness and sensitization activity, creating a need for coordination.

MEDIA IS POWERFUL
Radio and television are valuable informational tools in encouraging positive behaviour change.

Efforts to reduce STI/HIV/AIDS transmission rates in Burundi were boosted with a JTF grant in 2002. Focused on two areas, Bujumbura and Ngozi, the project was in line with Burundi’s national plan of action for HIV/AIDS prevention. Priority activities included condom distribution, development of materials to encourage positive sexual behaviour change, the promotion of voluntary testing and post-test counselling, and STI screening and treatment. The Association Burundaise pour le Bien-Etre Familial (ABUBEF) conducted training for counsellors, established two new testing laboratories and extended its provision of reproductive health services to include STI/HIV/AIDS prevention. The Member Association recognizes a need to step up its work in the prevention of mother-to-child transmission and this will be a future focus.
Chinese youth and women of childbearing age often become infected and affected by HIV/AIDS as a result of ignorance, manifest because of a lack of access to appropriate and timely information. Young people often leave the countryside in search of work and are ill-equipped to meet the multiple challenges they face in the urban context. HIV rates among injecting drug users in China is exploding. By taking HIV/AIDS messages into rural areas, the China Family Planning Association (CFPA) hopes to engage young people before they move away to the cities, and to generate awareness within the broader family groupings. The programme built upon an earlier JTF/IPPF-funded initiative specifically targeting 'floating' youth in Huaihua City. During 2002 and early 2003, JTF and IPPF supported an intensive participatory training programme for CFPA staff with a view to developing an education movement in the Qixian area of Hunan province in the Chinese countryside. The specific aim was to develop the capacity of the vast network of CFPA volunteers – comprising local community members (service workers, farmers etc) – to deliver HIV/AIDS prevention and care and support services in resource-strained rural areas. The plan was to build capacity in rural areas and provide HIV/AIDS skills and experience in less developed settings. The project provides a cost-effective model for covering extensive rural territories which could be expanded to other regions of China.

Fear, stigma and misconceptions about HIV/AIDS thrive in an information-starved environment. As the first HIV/AIDS deaths were reported in rural villages, myths began to spread about transmission. Many believed it was possible to contract HIV/AIDS by speaking to a person who was infected; people often avoided travelling through villages housing anyone known to be infected with the virus. A sample of the target population surveyed indicated that more than 75 per cent believed that someone recently infected would no longer look ‘normal’. The high level of fear in many areas resulted in high turn-outs at local HIV/AIDS training activities – what were intended as small group activities often became gatherings of an entire community.

Local CFPA branches initiated a wide range of community activities, including meetings where HIV/AIDS experts would talk about the situation and provide facts about transmission and prevention. Knowledge contests were organized;
songs, stories, comedies and dramas were developed by a folk art performance team that travelled from village to village. Community media was also extensively used to increase local awareness and participation.

The project’s objectives included the training of more than 100,000 branch staff and volunteers on HIV/AIDS prevention; the provision of information to some 400,000 rural people including 200,000 women of reproductive age; the establishment of a condom distribution network and promotion of condom use; and the strengthening of Member Association capacity at national and local levels to participate in HIV/AIDS prevention programmes. The project reached all of its pre-defined goals and attained the targets that had been set.

Project workers report that the awareness of rural people on HIV/AIDS has been greatly increased, with most people in Qixian County now possessing a basic understanding of HIV transmission modes and prevention mechanisms. Before the project started more than 70 per cent of married couples surveyed said they never used condoms, a figure that has since dropped to just over 40 per cent. While more people reportedly believe in condoms as a means to protect against HIV transmission, the situation with access to free condoms has also improved. In 2002, 580,000 condoms were distributed free of charge compared to 390,000 in 2001.

Case Study
Mrs Ting first heard about HIV/AIDS when another villager returned home after working in Peking. He always seemed to be unwell and after a while rumours spread that the string of illnesses he was suffering was due to AIDS. “At first we all kept well away from the house and nobody would go near him or even his family if they went down the street," Mrs Ting said. "We all thought we’d get it too. That was many months before the project started in the village and they organized talks and shows here. We were all a bit curious so we went to find out more.

"Now we feel much more comfortable about HIV/AIDS. There wasn’t much anybody could do for our neighbour, but we can support his wife. At first she had to deal with her husband’s illness and our alienation. Now she’s also tested positive for HIV. But since the project we are more informed and empathetic, so we talk to her and give her comfort. And now we know how the virus is transmitted and how we can protect ourselves, we’re not as afraid.”

“The ongoing support of JTF has enabled us to target the general population in resource-scarce rural areas at a time when most funders are only interested in high-risk groups. The grants have helped us to realise our HIV/AIDS prevention principles which include targeting rural populations and vulnerable groups; covering large geographical areas (essential for vast territories such as China); testing cost-effective approaches; designing a simple but effective programme which would appeal to volunteers; and making the best use of our extensive network of locally-based FPAs.” CFPA

Key Achievements

PROJECT LEAD GROUPS
Some 22 local project groups were established at county and township levels.

PREVENTION INFORMATION
Around 250,000 families received HIV/AIDS prevention information developed specifically for rural people.

TRAINING
Interpersonal communication skills were developed with 100,000 CFPA members and they were provided with HIV/AIDS information and materials.

LESSONS LEARNED

LOCAL PARTICIPATION IS CRITICAL
The active participation of the target population was central to the project’s success.

GREATER UNDERSTANDING THROUGH PARTICIPATORY TRAINING METHODS
Transfer of skills and knowledge was enhanced through the use of participatory techniques.

LOCAL AUTHORITY BUY-IN
The support of local authorities and other community leaders was very important.
Gambia’s project in 2003 centred around the development of HIV/AIDS policies in the workplace, with a view to raising awareness and increasing safer sex practices among workers. Targeting banks, the Gambia Family Planning Association (GFPA) used a JTF grant to assess the needs and practices of bank employees in respect of HIV/AIDS and to consult with bank executives and managers in order to develop appropriate training projects. The first task was to sensitize senior bank managers to the need for staff awareness training and HIV/AIDS-friendly human resource policies. Middle-level managers in advocacy-type roles such as public relations and customer care were then targeted to form focal groups which would meet on a regular basis at the GFPA offices. As a result of the meetings, a supportive network was formed between different banks.

GFPA developed an action plan for HIV prevention, organized training and prepared seminar materials in three languages, including TV promotions and radio spots. The project included evaluation and report writing to ensure the process was recorded and that valuable lessons were not lost. A key outcome for the project was the new sense of commitment on the part of Gambia’s banking sector to HIV/AIDS prevention and control, and support for their workforce.

Lessons Learned

SECTOR-SPECIFIC APPROACH
The project must be appropriate to a particular environment and set of circumstances, and should be reviewed to ensure the best fit is found between the project and the project participants.

WORKING THROUGH DIFFICULTIES PAYS DIVIDENDS IN PROJECT OWNERSHIP
Following the initial reluctance of the banks to put resources into the initiative, a greater sense of ownership, responsibility and commitment developed to the approach eventually agreed upon.
**South Africa**

South Africa has one of the highest HIV prevalence rates worldwide. With an estimated 20 per cent of the adult population infected in 2002, there is a clear recognition that responsibility for improving awareness and service provision does not rest with the state and non-governmental organizations (NGOs) alone. The private sector, largely in response to declining productivity and worrying projections for future profits, is beginning to take a leading role in the development and implementation of HIV/AIDS projects. Yet many businesses are in need of guidance. Workplace HIV/AIDS policies and programmes in small, medium and micro enterprises (SMMEs) were therefore the focus of a JTF-funded project conducted in 2003 by the Planned Parenthood Association of South Africa (PPASA).

Two provinces, KwaZulu-Natal and Gauteng, provided pilot sites for a project with the potential to deliver relevant information and education programmes to around 50,000 workers and to encourage workplace policies to improve the lives of those living with HIV/AIDS. Participants would leave with a sound knowledge of STI/HIV/AIDS, universal precautionary practices, voluntary counselling and gender-based abuse. Meeting the needs of a diverse range of educational levels within a single workshop proved a major challenge.

Partnerships were developed with government departments as well as with beneficiary companies. Initially targeting three SMMEs, the project focused on developing the capacity of business managers to plan their own HIV/AIDS information and education activities, as well as on monitoring the implementation and success of the plans. Companies received assistance with materials development, training, advocacy and general support with the development of their policies and activities.

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**Lessons Learned**

**POST-WORKSHOP TECHNICAL ASSISTANCE REQUIRED**
Assistance was necessary following SMME participation in the project to help further develop the policies drafted in the workshops.

**IEC MATERIALS FOR SPECIAL LEARNING NEEDS**
The needs of people with low literacy levels and other learning needs must be catered for.

**NEED TO SEPARATE THE GROUPS**
Workshops would be more successful if participants of different levels of understanding and capacity were not grouped together.

**REFLECT SMME DIVERSITY**
Workplace projects must be styled to reflect the diverse range of SMMEs. A ‘one size fits all’ approach won’t work.
HIV/AIDS awareness campaigns have achieved considerable success in changing sexual behaviour in Uganda. However, almost two million people in Uganda require HIV/AIDS care and support services and around 1.2 million children have been orphaned as a result of the pandemic. **HIV/AIDS is now more serious than either TB or malaria, accounting for as many as 12 per cent of deaths annually.** In spite of the stress on the country’s health resources created by poverty, malnutrition and poor access to clean water, the success of Uganda’s HIV/AIDS prevention programmes has been widely acclaimed.

But while the country has achieved a dramatic reduction in its overall HIV prevalence rate, **some groups have missed out on targeted HIV/AIDS prevention, care and support programmes.**

These include those for whom access to health facilities is difficult and largely self-employed people working in ‘transient trades’ (few Ugandans are engaged in formal, waged employment). Many of those involved in these trades in the urban areas of Uganda are young and sexually active, often with multiple partners. **In addition, many of the traders face the often difficult and isolated job of coping with infected partners, friends and family members.** Like other vulnerable groups, transient traders are in need of specific and appropriate HIV/AIDS projects.
HIV/AIDS prevention messages have been taken to youth in schools as part of a presidential initiative, yet with only 12 per cent of Uganda’s children continuing education to secondary-school level, it is clear that the focal point of the youth HIV/AIDS response must be those not in school.

The Family Planning Association of Uganda (FPAU) partnered with communities of taxi touts, brick-makers, boda-boda cyclists (bike messengers and taxis), bartenders, car washers, hawkers, hairdressers and other transient traders as well as with poor rural communities in an effort to expand HIV/AIDS prevention, care and support services in the western Mbarara District.

The primary goal of the transient trader side of the project was to reduce the prevalence of STI/HIV/AIDS among young people in the town, whereas the rural outreach would provide health education and a reproductive health package to those normally too far away from centres offering these services. Voluntary counselling and testing (VCT) was offered along with family planning, antenatal and post-natal care, immunization, STI management and treatment, fertility, youth sexual and reproductive health and counselling services for any related problems. A greater awareness of health issues was evident.

Reaching marginalized rural communities became possible through innovative church-based VCT outreach sessions. Sunday church services provide a rare central gathering place for scattered rural populations. Fears that religious leaders would be reluctant to get involved proved unfounded. In fact, they became instrumental to the success of the project, in many cases making their changing rooms available for use as counselling chambers.

Transient traders on the other hand were targeted using mainly peer education, trade clubs and services based at a drop-in youth centre. Following appropriate training for clinic staff in VCT and diagnosis as well as treatment of opportunistic and sexually transmitted infections, the FPAU is now able to provide a comprehensive range of youth-friendly sexual and reproductive health services including psychological support and counselling.

Key Achievements

**HIV/AIDS CARE INTEGRATED**
The project strengthened the integration of HIV/AIDS care and support with the family planning services provided by FPAU.

**VCT SERVICES DELIVERED**
More than 500 clients accessed free or subsidized VCT services.

**STI TREATMENT PROVIDED**
More than 800 clients received treatment for STI.

**PEER EDUCATORS EXTENDED IMPACT**
Peer educator clubs were formed comprising around 20 members in each of eight different clubs set up to serve different trades. Trained peer educators conducted 3,000 home visits and created four drama shows, seven songs, four poems and two plays on HIV/AIDS themes in local languages as well as English.

**TOLL-FREE LINE SUCCESSFUL**
A total of 1,662 calls were made to a toll-free line set up for counselling.

**SERVICE AVAILABILITY IMPROVED**
Five service providers were trained in the provision of VCT and care and support services. Laboratory services were strengthened and capacity was built in the provision of static and mobile services.

Lessons Learned

**INTEGRATION IS COMPLEX**
Integration of HIV/AIDS services with family planning services can be successful provided consideration is given to strategic, management and operational factors.

**FAITH-BASED INSTITUTIONS INVAILABLE**
The church and other faith organizations provide a great opportunity to access large numbers with minimal resources and to develop valuable strategic alliances. Outreach through the rural churches recruited more clients than the static clinic in the city. Greater effort needs to be made to extend outreach to members of the Islamic faith.

**BUILD LINKS WITH OTHER ORGANIZATIONS**
Through linkages with other organizations, sustainability can be built and a multi-sectoral approach becomes possible.

**APPROPRIATE MATERIALS**
IEC materials need to be developed in local languages.

**PARTICIPATION**
The inputs of the beneficiaries in the development of the project resulted in far greater impact than would have been achieved if the project had been imposed from outside.
Uganda

Case Study

Just 19 years old, Mr Byaru has become one of the project’s keenest peer educators. His colleagues know where to come when they need condoms and Mr Byaru wastes no time making sure any new car-washers working his area become familiar with the realities of HIV/AIDS, how they can help prevent infection, and what help is available if they are already infected. “I encourage the other car-washers to know their status, but the cost of VCT is quite high which puts lots of guys off getting tested. Also, the fact that treatment isn’t easy to get makes people scared to learn they are positive. They’d rather not know.”

Before moving to the city of Mbarara from his rural farming community Mr Byaru had never heard of HIV/AIDS. “I understand through the project just how much risk we face every day. It’s like a gambling game – we have sex with lots of partners (some of the guys have sex with other men but they don’t like to talk about it). But now we understand the risks we can at least do something about it. And if we do have HIV we can learn to live more positively so we live longer.”

“Through behaviour change communications the fears surrounding HIV testing have been dispelled and awareness has increased.”
Hawker.

“The project created awareness among community members on the services offered by the FPAU other than the traditional ‘family planning’. This helped improve the association’s image in the community in that it is now seen to offer a comprehensive sexual and reproductive health package.”
Lab technician.

“Because we know VCT is an entry point to care and support, the project has been of profound importance in terms of changing unsafe sexual behaviour, not only to people who tested HIV positive but also to those who tested negative.”
Lab technician.

“The project was a blessing to the community – the capacity building left the branch staff and peer educators with new skills and the branch received valuable equipment which can be used on an ongoing basis.”
Sylvia Namulema, FPAU Mbaraba branch.
Many people have a higher risk of HIV infection through the work they do or because of the unsafe sexual behaviour of themselves or a partner. Projects falling into the theme ‘vulnerable groups’ cater to the needs of sex workers, truck drivers and their families, taxi-drivers, prisoners, police and military recruits and poorly educated migrants to fast-paced city environments.

IPPF Member Associations promote the interests of such vulnerable groups. Some of these groups may appear hard-to-reach, but the success of many of the projects included here demonstrates that this is rarely the case. Sufficient attention to planning, design, resourcing and implementation of HIV/AIDS projects can overcome most apparent stumbling blocks.

Several of the projects supported by JTF in 2001 and 2002 involved IPPF Member Associations working closely with vulnerable groups to ensure their rights to HIV prevention and support services were realized. The diversity of marginalized communities and their needs stimulated an equally diverse range of responses by MAs in the development of their projects. The success of the projects included on the following pages can be largely attributed to the use of innovative approaches which were well-suited to a specific set of needs and circumstances.
A JTF grant enabled the Family Guidance Association of Ethiopia (FGAE) to develop a project geared to advocacy for HIV/AIDS prevention among the workers of garment factories in the town of Nazareth.

The objectives were to increase awareness and to build management support for HIV/AIDS prevention initiatives in the workplace with a view to reducing the HIV infection rate among factory workers. It was also hoped that a greater understanding of how STI/HIV/AIDS issues relate to industrial productivity and general development of the business sector would be generated among factory managers. Following a situational analysis and the training of peer counsellors and technical staff – particularly health personnel – a programme of prevention and counselling activities was conducted. The programme had been developed in collaboration with factory management, workers and other stakeholders.
India

Uplifting the health status of truck drivers and their communities

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<tr>
<td>Adult HIV prevalence (end 2001):</td>
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Lessons Learned

ORGANIZATIONAL MOTIVATION
Contact with the Family Planning Association of India (FPAI) and IPPF was a motivational factor for the core project group. Active participation and visits to field work areas by senior staff and volunteers also helped in the implementation.

ONGOING TRAINING
Peer educators need support to continue their work after the project term.

GETTING THE LEADERS INVOLVED
Working with religious and other community leaders has been valuable in terms of generating buy-in for the project, but also in making available more venues for workshops and other facilities. Well-planned and timed interaction strategies for union leaders and other opinion leaders were key to securing their support.

AIDS first emerged as a major problem in India in the mid-1990s and has since been recognized as the country’s most serious health problem. As such, HIV/AIDS has become a central focus of government and NGO awareness drives. While the prevalence rate is relatively low compared with other countries in the region, with a large population of around one billion people a 0.75 per cent infection rate in 2002 means around 3.8 million people in India are currently living with HIV/AIDS.

A number of factors threaten to accelerate the spread of the HIV/AIDS epidemic including people migrating from poorly resourced rural areas to more sophisticated urban centres in search of better work opportunities; a low literacy level of 52 per cent (with a big gap between men at 67 per cent and women at only 43 per cent); stigma and discrimination; and widespread ignorance of the basic facts about HIV/AIDS and how it can be contracted. Stigma and ignorance have often resulted in people living with HIV/AIDS being denied equitable access to health services. Cases have even been reported of people living with HIV/AIDS being confined to hospital isolation wards because their illness was thought to be contagious. The caste system and the lower status of girls and women, although diminishing its impact due to organized resistance, are also factors. Gender inequality and social exclusion lead to discrimination in access to economic opportunities, health and welfare services (this is particularly the case in rural areas) and this also impacts on the spread of HIV/AIDS.

Truckers are considered India’s primary carrier of HIV, due to the distances travelled and the long periods away from home which encourages unsafe lifestyles. Multiple partners, men having sex with other men, alcoholism, regular contact with sex workers and irregular treatment for STI are among the high-risk activities truck drivers engage in. Unsafe sexual behaviour accounts for an estimated 86 per cent of reported HIV infections. HIV epidemics are currently concentrated in the southern states of India, with most of India having a very low rate of infection. Because the country has such a large population, the spread of HIV/AIDS will have a major impact on Asia and the Pacific region generally.
Truck drivers and their assistants were the focus of one of the two projects supported by the JTF during 2002 and 2003. India’s National AIDS Control Programme estimates that 15–35 per cent of India’s community of truck drivers is HIV positive. The role played by truck drivers as an HIV bridge to the general population has long been recognized – HIV/AIDS projects have targeted this high-risk group for more than a decade.

A project conducted by the Mohali branch of the Family Planning Association of India (FPAI) targeting truck drivers and local communities on a 35km stretch of national highway was extended by the JTF grant of 2001. A recent evaluation found the project’s main innovation to be the simultaneous focus on truck drivers on the road and their families back home, making it a higher value dual project. Unlike previous projects, the approach made use of the truck driver unions. This allowed for greater interaction between truck drivers and for repeat contact which helped reinforce the messages, resulting in a higher degree of behaviour change success. Even though numerous other projects had targeted truck drivers, a surprising 99 per cent of participants surveyed by the FPAI had not come across any other HIV/AIDS programme.

The aim of the project was to provide awareness, counselling and control of STI/HIV/AIDS and to promote safer sexual practices among India’s truck drivers. Advocacy programmes were organized with government authorities, non-governmental organizations, local voluntary groups, religious leaders, educators, parents, panchayat (local village councils) members and opinion leaders. Partnerships with other NGOs enabled the sharing of IEC material, which increased awareness of FPAI branches and brought in new ideas and experience in HIV/AIDS programme implementation.

In 2002 the project established partnerships with religious leaders for the first time. Apart from getting support from a key sphere of influence in the lives of truck drivers and their families, this opened up the possibility of using places of worship as readily accessible venues for project activities such as awareness sessions, counselling, clinic services and referrals. More than 6,000 truck drivers and their partners received counselling.

Women in the local communities were encouraged to become involved in self-help groups. These had links with the National Bank for Agriculture and Rural Development, opening up the possibility of economic upliftment. Training with the groups helped develop peer group educators to work with the project. Truckers were also selected and trained as peer educators. It was estimated that each of the project’s peer educators would convey messages to five peers, thus increasing the volume and geographical spread of HIV/AIDS knowledge.

Advocacy for condom use featured heavily and several new distribution outlets were established to improve access. Some 200 awareness programmes were completed, outreach workers were trained and behaviour change communication materials were widely distributed. As well as organizing mobile exhibitions,
Case Study

Mr Singh owns three vehicles. Aged 50, this ex-farmer is looking forward to his son and his nephew (who currently drive for him) taking over the business. The project provided him with real information on HIV/AIDS for the first time. He’d heard of it, but had never really engaged with the issues or the risks. “At first I didn’t really want to admit to having multiple sex partners while I’m away, so I avoided speaking to the project workers who came to the union. But later some of my friends became peer educators and they made a mission of telling us all – there was no escape!”

Tired of life on the road, Mr Singh would like to spend more time at home with his wife, working his smallholding and watching cricket at the tearoom. “The project went to my village as well, telling all the women and the youth about HIV/AIDS. They also encouraged us to get tested. I confessed my sins to my wife... well, I had to really because apart from anything else she had to take medication for an STI I’d passed to her. I think she always knew because all guys sleep around when they’re on the road and she never thought I was an angel. Yes, the project was a good thing for us. I’m especially hopeful that my son won’t face the same risks I have.”

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“The work done was clearly visible. The awareness level of both truck unions and the community was very high.”
FPAI Monitoring Team.

“People have become more cautious when indulging in extra-marital sex since the project started.”
Dhaba owner, Truck Union Ropar.

“You provide appropriate counselling and you give medicines as well as knowledge.”
Dhaba owner, Truck Union Ropar.

“If the project is discontinued, it is our duty to continue the project activities.”
Truck driver.

mass meetings and panel discussions, video shows and street plays, the project used cultural events and World AIDS Day as opportunities to spread awareness. The project profile was increased through ‘health camps’ addressing general health and medicine needs in the communities.

Demand for services grew exponentially as awareness increased, demonstrating that the provision of basic services along with education provides a valuable indicator of the impact of awareness programmes. Other positive impacts have been measured too. Condoms can be found in the first-aid kit of just about any truck; effective counselling of truck drivers by well-trained project outreach workers, contact with peer educators and group awareness sessions all combined to encourage an extremely positive attitude towards safe sexual practices. FPAI believes the project should be extended to other areas and also involve secondary stakeholders such as garage attendants and mechanics, as well as those who aspire to become heavy-duty long-distance drivers like those currently driving small trucks, taxis and rickshaws.
Nepal  
*Increasing awareness among newly recruited police personnel*

<table>
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<td>Adult HIV prevalence (end 2001):</td>
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</tr>
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</table>

Enclosed by the vast ranges of the Himalayas, Nepal is one of the most impoverished nations of South Asia. Although the overall HIV prevalence rate is still low, since the first case was reported in 1988, HIV/AIDS has spread across the mountain kingdom of Nepal from the confines of vulnerable groups to wider society. By 2005, it is estimated that around 20 per cent of adult deaths in the 15–49 age group will be AIDS-related.

Those under the age of 40 are most vulnerable, their infection rate exacerbated by the trafficking of young girls across the border to India to join the sex industry. Young men also travel far from home to work and many bring STI or HIV infection back with them. The Family Planning Association of Nepal (FPAN) considers unsafe sexual behaviour and the urban migration of young rural people to be the most critical factors in the spread of HIV/AIDS in Nepal. Many of the new entrants to the cities find themselves in the garment and carpet-manufacturing industries. Among injecting drug users in Kathmandu the HIV prevalence rate is close to 70 per cent. The extreme risks taken by some groups in Nepal may soon stimulate a drastic escalation of the epidemic there.

**Using a multi-media approach in the police colleges**

Existing **booklets** on STI/HIV/AIDS were printed for distribution.

**Videos** on HIV/AIDS counselling produced by the Planned Parenthood Association of Thailand (PPAT) were dubbed into the Nepali language.

**Film-shows** were organized, followed by lively discussion sessions with the police recruits.

**Folk-song competitions** were organized on the topics of safe sexual behaviour, society’s responsibility towards people living with HIV/AIDS, and the need for young people to engage in sexual and reproductive health education.

Promotional materials including **pens**, **T-shirts** and **towels** with STI/HIV/AIDS messages were produced and distributed.
Two police colleges were selected by FPAN as sites for its 2002 JTF-funded HIV/AIDS initiative. A number of factors were involved in the choice. Firstly, the majority of police recruits come from rural areas of the country which have fewer opportunities for higher education and economic advancement. Prior to this project, there were no HIV/AIDS programmes designed for those with primary school education – most police recruits are at that level, so the police colleges were an ideal place to develop a new model. Furthermore, the police training curriculum did not include an HIV/AIDS component, so it was useful to develop a module that could be included in future training programmes, particularly as the unfamiliar urban environment new police recruits enter is conducive to unsafe sexual practices.

The aim of the project was multi-faceted. It needed to result in a course module for inclusion into police training to raise HIV/AIDS awareness, influence unsafe behaviour and contribute to a reduction in the HIV infection rate of new recruits. The project aimed to provide high-ranking officers of the Nepal Police and the Ministry of Home Affairs with a basic HIV/AIDS orientation with a view to developing the capacity of internal police personnel to run their own HIV prevention programmes. This would provide continuity once the project was completed, enabling HIV/AIDS programmes to be sustained for the benefit of subsequent generations of new police recruits.
Nepal

Key Achievements

APPROVAL IN THE TOP-RANKS
Gaining the approval of the Inspector General of the Nepal Police and other high-ranking officers for the programme to be implemented in the selected training centres. Buy-in at this level was critical for the success of the initiative.

TRAINING ORIENTATION
Two-day orientation programmes were organized with 45 key police personnel responsible for training – these helped increase awareness and knowledge. Orientation programmes were also organized for new police recruits. In all, a total of 1,050 new police recruits were involved in 20 sessions.

TRAINING OF TRAINER PROGRAMMES
Ensuring trainers were equipped to continue delivering HIV/AIDS awareness training helped the police colleges develop their own HIV/AIDS projects.

REVIEW AND REVISION
An intensive review process ensured the problems experienced on the programmes were worked through, and enabled discussion between police headquarters, the training centres and FPAN staffers on future programme collaboration. This had implications for continuity of the project.

Although the programme of activities was interrupted during the course of the year by a State of Emergency resulting from a security crisis, FPAN is confident that the project contributed to a reduction in HIV prevalence rates amongst new police recruits. The education programmes developed during the JTF project will be incorporated into the existing police training curriculum for new recruits. Some of the back-up activities will continue to be conducted from within FPAN’s core programmes.

Lessons Learned

REINFORCEMENT
If awareness programmes on STI/HIV/AIDS were introduced in other organized sectors [such as the Royal Nepal Army] the messages would be reinforced.

FOLLOW-UP
FPAN needs to be able to cater to the needs arising out of awareness programmes by ensuring that a range of HIV/AIDS-related services are fully integrated into its existing programmes of work.

EMPOWERMENT
Equipping sectors to incorporate an HIV/AIDS component to their own training programmes is a key to project sustainability.

“The project was the first of its kind and it was innovative in the sense that its approach was unique and receptive.”
Hari Khanal, ADG, FPAN.

“Despite the country situation (State of Emergency), the project was quite successful in creating awareness of HIV/AIDS among the new police recruits and in seeing that an HIV/AIDS component was incorporated into the police training curriculum.”
Hari Khanal, ADG, FPAN.
Rwanda  Reducing risk and promoting the rights of prisoners

The small, land-locked central African country of Rwanda is one of the most densely populated states on the continent. Devastated by brutal ethnic violence in 1994 which displaced millions, the country’s prisons remain swollen by the incarceration of tens of thousands accused of crimes relating to the genocide. The year 2004 is the 10th anniversary of the Rwandan genocide.

Despite suspicions of high HIV prevalence rates among the huge prison population, there were no HIV/AIDS initiatives in the prison system prior to the inception of a JTF-funded project in 2002. Underpinning the work was the principle that access to HIV/AIDS prevention is a basic and universal human right and that prisoners have this right too.

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Key Achievements

- **PEER EDUCATION**
  More than 1,500 peer educators were trained from the 17 prisons across Rwanda’s 12 provinces.

- **PARTNERSHIPS**
  Relationships developed with prison managers helped facilitate future access.

- **HIV/AIDS CLUBS**
  Special clubs were established in a number of prisons, administered by trained prisoners who coordinated educational talks on HIV/AIDS.

- **PRISONERS REACHED**
  By the end of the project, 87 per cent of the prison population had participated in sensitization modules and HIV/AIDS sensitization had become an integral part of the work of prison medical personnel.

- **MONITORING IMPACT**
  A basic needs assessment and behaviour study on HIV prevention was conducted, which provided HIV/AIDS and SRH workers with valuable information on the specific needs of prisoners. It also allowed the monitoring of behaviour change following the project.

The project’s primary aim was to raise the awareness of inmates on HIV transmission and the methods available to reduce the risk of infection. The key objective was to see up to 50 per cent of inmates using condoms by the end of the project in order to reduce the level of HIV infection in prisons and lessen the HIV risk introduced to the general population once prisoners are eventually released. Since the genocide, HIV prevalence rates in rural areas have risen to almost match that of the cities.

A presidential decree saw the release in 2003 of many inmates who were sick, very old or were minors at the time of the genocide. Arising from the principle ‘justice delayed = justice denied’, a system of traditional courts is now being implemented.
used to speed up the process of trying those detained because of the difficulties of processing such large numbers through the conventional judicial process. The emphasis of these community-based courts is on reconciliation rather than punishment. A large number of releases is anticipated in the near future, with obvious implications for the transmission of HIV into the broader community.

Following a needs assessment to ensure the programme was tailored to the specific requirements of prisoners, ARBEF set about mobilizing and training volunteers and district health workers on the particular prevention challenges presented by the prison environment. Advocacy meetings were held with the senior government officials responsible for prisons. These were followed by seminars and workshops for prison administrators and education and awareness sessions to sensitize prisoners to the realities of HIV/AIDS, and to distribute condoms to help prevent the spread of HIV. The vast majority of prisoners were keen and cooperative and demonstrated a high level of capacity in dealing with the issues at stake. Many expressed an interest in learning more. Demand for voluntary counselling and testing immediately increased after sensitization sessions.

When peer educators are released from prison, others immediately take their places, ensuring continuity. Although the HIV/AIDS sensitization programme established during the project has been fully integrated into the daily activities of the prisons’ medical service, the role peer educators play is a crucial one. Ideally ARBEF would play an ongoing role in the prison project, to ensure that prisoners receive the education and support they need and that the extent that released inmates act as a bridge between a high-risk group and the wider population is checked.

Outcomes

CHANGE IN BEHAVIOUR
It was observed that prisoners adopted more sexually responsible behaviour.

IMPROVEMENT IN HEALTH
The number of prisoners reporting to the medical service with STI declined.

INTEREST
Prisoners expressed genuine interest in building their knowledge and understanding of HIV/AIDS.

Lessons Learned

STRUCTURES HELP
The organization of the internal prison systems provides an environment conducive to education and training programmes.

MATERIAL NEEDS
There is a significant need for new HIV/AIDS publications and other learning materials. Dedicated Information, Education and Communication (IEC) materials need to be made available to prison educators.

HOLISTIC APPROACH AND ACCESS TO TREATMENT
This type of project is difficult when treatment for infections like tuberculosis (TB) is not accessible to prisoners living with HIV/AIDS.
Vietnam

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<td>Adult HIV prevalence (end 2001):</td>
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“Women working in restaurants and hotels are at high risk of becoming sex workers. It is very easy for them to become sex workers because of their working conditions. Almost all the women are involved in sex work – they may be selling sex at their places of work or elsewhere.”

Police officer.

“The sex industry is underground which makes it difficult to monitor. Sex workers are also at risk because of injecting drug use, but most would not be aware of their HIV status anyway because they rarely have access to medical services.”

Police Department spokesperson.

“Provision of condoms to female workers can be a dilemma – if condoms are readily available in hotels and restaurants people may think sex work is actively encouraged. But if they are not accessible HIV/AIDS cannot be prevented.”

Health official.

The HIV/AIDS epidemic in Vietnam, primed largely by injecting drug use, has escalated rapidly since the virus first emerged in 1990. JTF-funded work in Vietnam recently turned the HIV/AIDS services’ spotlight onto the sex industry. The Vietnam Family Planning Association (VINAFPA) managed an initiative geared towards sensitizing policy-makers on the need to develop an approach appropriate to the sex industry. The project not only aimed to generate a greater awareness of HIV/AIDS issues among sex workers, but also to build the capacity of health workers to access this marginalized and vulnerable group.

The project was an important step in promoting the sexual health and rights of sex workers, particularly women, and in building a better understanding of the link between the sex industry and the spread of HIV/AIDS in the broader community. In Vietnam, involvement in the sex industry is illegal – this creates negative public opinion and a hostile policy-making environment. While the health needs of sex workers are substantial, effective means to fulfil these needs have not been developed.

Targeting sex workers at selected urban sites, VINAFPA set out to increase awareness of HIV/AIDS prevention in the sex industry and improve peer support amongst sex workers operating from hotels, restaurants and other public venues in Hanoi, Ho Chi Minh City and Da Nang. The goal of the project was to contribute to achieving the national HIV/AIDS prevention targets, improving health and quality of life for the people – particularly women and children – and to build capacity for VINAFPA key staff.

VINAFPA wanted to improve HIV/AIDS awareness and change the sexual behaviour of sex workers, while heightening awareness of the issues at stake among policy-makers. Another objective of the initiative was to improve the capacity of the implementing body through skills development and practical experience.

The project succeeded in its aim of setting up ‘Female Servers Clubs’ to provide a model of peer education and support that can be introduced in future at other sites. Through the clubs, sex workers were empowered with valuable knowledge on sexual and reproductive health, HIV/AIDS prevention and positive living. Aside from education, the clubs provided a much-needed support base for infected sex workers as well as an access point for a range of support and treatment services. This was especially...
valuable in an environment where sex workers were often afraid to reveal themselves. Members of the clubs were in turn involved in advocacy work with many other sex workers, both as individuals and in group sessions, dramatically extending the reach of the project.

Another priority was to shift awareness of policy-makers towards a greater commitment to devising policy suited to the needs of sex workers in relation to the provision of HIV/AIDS and other health care services. The project reached more than 60 decision-makers in mass organizations and at local authority level. This should go some way to developing a more coherent approach to the problems and needs of a sex industry which, because of its illegal nature, has been largely ignored.

A survey conducted on the current status of the sex industry provided those working in the policy-making, reproductive health and HIV/AIDS arenas with some key information. It was revealed for the first time that while some 90 per cent of sex workers had a high level of HIV/AIDS awareness and understood how vulnerable they were, behaviour had not changed to reduce the risk. Around 60 per cent of sex workers used a condom only sometimes, or not at all. Most bar hostesses in hotels, clubs and restaurants were infected with STI – 100 per cent in some instances.

These are just a few of the facts and figures which came out of the project and now inform a wide range of decision-making affecting the lives of sex workers and their clients in Vietnam. This information helped build the capacity of key VINAFPA staff to work in HIV/AIDS prevention with vulnerable groups, providing them with a basis for making well-targeted and more effectively planned projects. It also built their knowledge of the wider reproductive health needs of sex workers.

Partnerships formed with other organizations were also key for the project’s success and are central to the continuity of its achievements. Experts in youth and in public health from the NGOs Youth House and The Light were, for example, contracted to help select and establish a 500-strong network of peer HIV/AIDS educators in Hanoi involving sex workers and women working in restaurants, hotels and massage parlours.

In March 2004 VINAFPA planned to meet with other NGOs to share its experiences of working with people in the sex industry. A national workshop would follow involving policy-makers, administrators, organizers and peer educators with a view to arriving at a common voice on HIV/AIDS prevention among sex workers. Recommendations will be made to government and international organizations to ensure future support for other projects of this nature, once VINAFPA has the capacity to work on fine-tuning the model developed with the JTF grant.

Key Achievements

**SKILLS DEVELOPMENT**
HIV/AIDS prevention and advocacy skills were shared with 500 people working in hot-spots (key transmission areas) in Hanoi and 100 sex workers in Quang Ninh.

**INFLUENCING POLICY-MAKERS**
Workshops for senior policy-makers reached around 60 participants in two provinces. A consensus was reached on the need for effective HIV/AIDS projects with sex workers.

**PEER EDUCATOR NETWORK**
A peer educator model was development through the establishment of a network of cooperation between the VINAFPA, the Women’s Union and the Youth Union. In Hanoi, three peer educator teams were put into operation after training – they in turn reached 500 commercial sex workers with counselling and advice, and advocated the use of condoms for HIV/AIDS prevention.

**SPECIAL CLINIC**
A dedicated clinic was established in Quang Ninh, with the support of the project, to provide health care to members of clubs.

**VALUABLE DATA**
The status survey provided a valuable situational and needs analysis of HIV/AIDS and the sex industry in Vietnam.

**USING THE MEDIA**
A series of special articles for the VINAFPA’s Family magazine helped develop consciousness among ordinary people of the HIV/AIDS work with the sex industry and promoted awareness of HIV/AIDS prevention methods.
Case Study

Ms Chong, a 27-year-old restaurant hostess, doesn’t think of herself as a ‘sex worker’ and before the project she didn’t like to think about the risks involved in doing the work either. “I take the occasional client – ‘boyfriend’ or ‘sweetheart’ we call them, although most I don’t see again – to a friend’s place after work. We don’t earn very much so we need to make a bit extra. We all have families to support. I had heard of AIDS but I didn’t think about it – I just figured if I got it that would be pretty sad.

“We didn’t have access to condoms before the project. Our bosses at the restaurant didn’t take any interest then, and we certainly didn’t expect them to. Now we have easy access to condoms and, through the clubs, we know about the risks and how to help protect ourselves. We feel much stronger about insisting condoms are used and because we all stand together the clients don’t have much choice but to use them.

“Quite a few of my colleagues know they’re HIV positive because they’ve been tested. It makes HIV/AIDS much more real for all of us. Now it’s more in the open and there is some support, we can go the clinic for regular checks and also to get treatment for STI. The special club is good because we can share information freely with our peers – they bring expertise and information that we can use and can, in turn, share with others who didn’t join the club.”

“It’s difficult to encourage people to join the ‘Female Servers Clubs’ because they don’t want to admit to being sex workers. So if clubs are to be an alternative to direct one-on-one counselling, we need to call the clubs other names like ‘Young Mothers Clubs’ or ‘Female Youth Clubs’ so women won’t feel ashamed and will participate along with others.”

Project leader, Hanoi.

“Periodic health checks for female servers are very good because it provides an opportunity for their health needs to be addressed. Because they are on low salaries, we should provide financial assistance to help attend to their health requirements.”

Hotel owner, Hanoi.

“The clubs play a vital role in educating our female workers. I used to talk to them, but I didn’t have any expertise and they didn’t really respond. The clubs bring knowledge and professional skills.”

Hotel manager, Quang Ninh.

“Our staff are mainly from the countryside so their schooling and HIV/AIDS awareness is at a low level. We’re happy to work with other agencies to deliver leaflets and integrate HIV/AIDS prevention to improve staff awareness.”

Restaurant owner, Quang Ninh.
People aged 15–24 account for almost 60 per cent of reported new HIV infections in developing countries. Young people are also the most productive and are often breadwinners for their families. AIDS is therefore beginning to impact heavily on developing economies, reversing many of the development gains made over the last decades. Life expectancy is dropping while infant mortality is rising, and the strength of the workforce is waning. In much of sub-Saharan Africa, the hardest hit region of the world, 10–20 years of life expectancy has been lost as a direct result of HIV/AIDS.

IPPF has placed a strong emphasis on becoming youth-friendly in recent years. Aside from being one of the most vulnerable groups, youth have the most to gain from improved access to appropriate HIV/AIDS information and services. As the leaders of tomorrow, youth will have to deal with the consequences of many of the HIV/AIDS decisions that are made today. Young people are the very foundation on which future strategies to address the HIV/AIDS pandemic will be built. It is through empowering tomorrow’s generation that appropriate, effective and enduring responses to HIV/AIDS can be established. Youth also have a key role to play in reducing stigma and in reducing gender abuse and inequality, which is crucial if the spread of HIV/AIDS is to be checked.

The provision of integrated preventive education, accurate information, counselling and testing services, and care and support are vital if young people are to stay healthier for longer. Often young people are denied access to sexual and reproductive health services because of fears that this may encourage earlier sexual activity. The resulting lack of information and access to services compounds the other risk factors facing young people.

It is not only unsafe individual behaviour that needs to be addressed, but also the range of social, economic and cultural circumstances that promote it. Some young people are at special risk as a result of poverty and other factors which often force them into unsafe situations. Migrant workers, military recruits, adolescent sex workers and children living on the street are just a few such groups in need of particular attention if their risk is to be reduced.

Youth-targeted projects account for the majority of HIV/AIDS projects supported by the JTF during the 2001 and 2002 funding cycles. Peer education has become a valuable strategy in reaching youth – young people have more respect for other young people when dealing with sensitive topics like sex. Through becoming peer educators, young people are not only able to pass information to others but also become role models for safer behaviour in their youth communities. The participation of families, parents, teachers and community and religious leaders is often sought to help reinforce youth programmes. All the projects featured here place a heavy emphasis on the active participation of young people in developing as well as implementing HIV/AIDS projects.
**Cameroon**

**Breaking the silence about sex and eradicating the taboos associated with open discussion was a primary goal in 2002 for the Cameroon National Association for Family Welfare (CAMNAFAW).** Like many of its African counterparts, the CAMNAFAW used JTF support for youth-centred HIV/AIDS activities. In 2002 sex education and broad media campaigns aimed to increase the awareness of HIV/AIDS prevention methods among youth aged 11–24, and psycho-medical support was provided to those already infected with HIV. The Youth AIDS Media ("YAM") Project promoted responsible sexual behaviour among youth in four health districts – Deido, Dibombari, Bamenda and Biyen-Assi.

In partnership with other local NGOs, CAMNAFAW invited 30 public schools and 30 youth associations to actively participate in the project and succeeded in establishing 30 STI/HIV/AIDS health clubs. Peer educators were trained in the schools and youth associations in partnership with local NGO Femme, Sante et Developpement, educational materials including T-shirts, caps, leaflets, radio programmes and a video documentary were produced and distributed, and a laboratory was set up in each of the youth centres for diagnosis of STI/HIV/AIDS, as well as for treatment of some infections. In all, 50 groups of young men and women were reached by the project and good community and parental participation was reported.

**Lessons Learned**

**ENHANCED SERVICE PROVISION**
Boosting the capacity of service providers through specialized training is essential if youth needs and interests are to be understood, and youth-friendly services provided.

**PEER EDUCATION**
Young people discuss sensitive issues with their peers far more readily than with anyone else – peer education must therefore be encouraged.

**CREATIVE MESSAGING**
The messages developed, and the mechanisms used to deliver them, must reflect youth interests. Use of popular media can also help break taboos.

**STAKEHOLDER PARTICIPATION**
Community groups must be involved in projects if they are to gain broad acceptance.

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**Côte d'Ivoire**

**Developing imaginary role models**

The second of two projects enabled by JTF funding in the Côte d'Ivoire over the two-year period was given the name ‘Fidel & Abstinia’. The project draws on imaginary characters to provide role models of positive behaviour towards sex, STI/HIV/AIDS and responsible parenthood. Implemented by the Association Ivoirienne Pour le Bien-Etre Familial (AIBEF), the project developed a range of informational materials including a comic strip, an album of songs and a website as part of a multimedia awareness campaign. **Festivals were organized and clubs established to improve the knowledge base of adolescents between the ages of 10–18, in the hope that healthy lifestyles would be adopted and involvement in sexual activity might be delayed.**
The HIV/AIDS work of the Family Planning Association of Kenya (FPAK) focused special attention on youth between the ages of 15–24 in 2003 in an effort to promote positive sexual behaviour change. The organization used JTF funding to establish youth-friendly voluntary counselling and testing services in the areas of Thika and Nkubu in Kenya’s central and eastern provinces; to train service providers in the use of antiretroviral drugs; to develop the skills of peer educators to promote positive behaviour change; to purchase drugs and other supplies, and to improve collaboration and linkages between agencies in the field. The organization also ran an advocacy project with Ministry of Education officials and parents to support HIV/AIDS education in upper primary schools.

FPAK held a series of inter-agency collaborator meetings which were attended by a total of 56 representatives from community-based organizations (CBOs), NGOs and community members. This type of cooperation resulted in additional human and material resources being made available. Partner organizations assisted with the training of peer educators and with the training of trainers. Four schools were identified for the recruitment of peer counsellors nominated by fellow students. Overall, 40 peer youth educators and 24 teachers and PTA representatives received training to work in their own and neighbouring schools. Almost 5,000 young Kenyans were reached through the project’s activities, including nearly 1,000 out-of-school youth. The skills of Member Association staff were also developed through the project.

Lessons Learned

FLEXIBLE APPROACH
There is a need to plan project activities with reference to the schools’ calendar of events to prevent conflicting demands on the time of students and teachers, rather than pursuing a pre-set programme.

EDUCATION AUTHORITY SUPPORT
The participation and support of the education authorities was essential. With a high turnover of staff, there is a need to train a far greater number of trainers.

SLOW PROCESS
Behaviour change does not happen quickly – the project duration of one year is constraining for this type of evolutionary project.

SITE LOCATION
The two pilot sites should have been closer together to facilitate ease of movement between them.

India Promoting knowledge for out-of-school youth

In addition to the truck drivers featured in the previous section, India used JTF funding to improve awareness and knowledge about HIV/AIDS among out-of-school youth. Youth Information Counselling Corners were established, also under the aegis of the Family Planning Association of India. Aiming to reach 5,000 out-of-school youth in Hyderabad and Trivandrum, the information centres provided group and individual counselling to increase knowledge and awareness about sexuality and prevention of STI/HIV/AIDS. A key objective was to generate support among the religious leaders and other major stakeholders in each project area, including government agencies, NGOs and – perhaps most crucially – parents. Advocacy leaders and peer educators received training to develop their communication and counselling skills.
Mongolia

<table>
<thead>
<tr>
<th>Population (2001):</th>
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<tr>
<td>Urban population (2000):</td>
<td>65%</td>
</tr>
<tr>
<td>Main language/s:</td>
<td>Mongolian</td>
</tr>
<tr>
<td>Main religion/s:</td>
<td>Lamaist Buddhism</td>
</tr>
<tr>
<td>Literacy level (1997):</td>
<td>99%</td>
</tr>
<tr>
<td>Infant mortality (1995–2000):</td>
<td>66 per 1,000 live births</td>
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<tr>
<td>GNI per capita (1999):</td>
<td>US$390</td>
</tr>
<tr>
<td>Adult HIV prevalence (end 2001):</td>
<td>&lt;0.1%</td>
</tr>
</tbody>
</table>

Mongolia has had only a handful of reported HIV infections to date. Regular sero-prevalence surveys are conducted, although vulnerable groups make up a small percentage of those tested.

The year 2002 was ‘Student Year’ in Mongolia which led to greater government recognition and appreciation of youth-focused projects. Coincidentally, student needs were the focus of the JTF-assisted project in 2002, conducted under the aegis of the Mongolian Family Welfare Association (MFWA). To help fill a serious gap in accurate information on STI/HIV/AIDS and prevention methods, the MFWA developed a project specifically geared to the needs of university students.

The project, based in the country’s capital and largest city Ulaanbataar, centred around interactive training sessions which included lively discussion, role-playing and video showings covering the topics of family planning, unwanted pregnancy, alcohol abuse, safer sex, modes of transmission and prevention of STI/HIV/AIDS and family violence. Questionnaires completed before and after the one-day workshops indicated that knowledge of students at the Mongolian State University improved by an average of 24 per cent as a result of the project.

The cooperation of tutors and social workers attached to university dormitories was secured and this greatly assisted in disseminating information to students. A good network was developed and the social workers used materials from the project in their work at other schools. Dormitory administrators provided venues and in some cases equipment for use in the training.

“Most of our workers come from rural areas where there is limited access to information, especially on sexual and reproductive health. Our workforce is 86 per cent women and comprises mostly young people aged 16–25. They arrive in the city after finishing secondary school in rural areas. The disparity between city youth and those in the provinces is like day and night. Many of the workers heard about STI/HIV/AIDS for the first time through the JTF project.”

Factory manager, Armano.
Mongolia

Workshops were attended by 140 students. A further 40 young factory workers and unemployed youth between the ages of 16–25 also took part. Teachers and social workers were trained as leaders with the help of the Youth Development Centre of Ulaanbataar. The new peer educators reported passing information on to more than 2,500 young people across the city as well as in other provinces. They also made the others aware of the availability of the MFWA as a source of information and support for HIV/AIDS as well as for broader sexual and reproductive health issues affecting youth.

The students disseminated HIV/AIDS prevention education materials in university dormitories together with condoms and information on their proper use. Oral contraceptives were also distributed to female students to prevent unwanted pregnancy. Some of the peer educators reported a lack of confidence in discussing the topics with more senior students, fearing they would be ignored. A poll was conducted to measure the impact of the project on the student community and it was found that as much as 50–60 per cent of the broader university population was aware of the activities conducted by the peer educators.

The MFWA would like to expand the project into the Chinese border area where a high number of girls turn to sex work because of extreme financial hardship. Implementation there would be relatively straightforward with the cooperation of public sector health affiliates and the MFWA’s own centres in that province which enjoy a high level of buy-in and support from other NGOs.

Lessons Learned

UNEVEN COMMITMENT
Peer educators were not all able to give enough time to the project because of the multiple pressures of student life.

FREE SUPPLIES
Providing free contraception and condoms to cash-strapped young people is very important.

NEED MORE PEER EDUCATORS
Because youth are highly mobile, it is necessary to train greater numbers on sexual reproductive health issues.

BENEFICIARY PARTICIPATION
The contributions of youth in project design and their participation in project implementation leads to greater success.

PARTNERSHIP DEVELOPMENT
Collaboration between NGOs and government organizations is beneficial.

“Before the project we received practically no information on sexual and reproductive health, including STI/HIV/AIDS and unwanted pregnancy. Because as students we have limited free time and a low income, we don’t have much access to TV or to newspapers and magazines. It is very important – I know girls who have fallen pregnant just because they have no money for contraceptives.”

Student,
Mongolian State University.

“The JTF project was successfully implemented in our college. Many of the trained students have since graduated – we’ll gladly cooperate with the training of more trainers on STI/HIV/AIDS. There is a serious need for information and services, especially in our college as most of our students are girls and they also need to avoid unplanned pregnancies.”

Social worker,
Pedagogical College.
Namibian youth and women of child-bearing age were the focus of JTF-enabled activities in Namibia during 2002/2003. The Namibia Planned Parenthood Association (NAPPA) ran a project aimed at enhancing awareness and understanding of sexuality and building the capacity of the target group to make the kind of informed choices that would help reduce the spread of HIV/AIDS. Anticipated results included the development of women’s skills to negotiate safer sex with their partners and an increased assertiveness by young people of their rights regarding sexual and reproductive health. The project also hoped its youth advocacy activities would galvanize political decision-makers to develop policies to help protect girls from unwanted teenage pregnancies and HIV infection.

Namibia

Peer education: key to asserting the sexual rights of women

Lessons Learned

**PEER EDUCATION**
The use of peers was very effective, particularly in promoting and distributing male and female condoms.

**COMMUNITY LEADER SUPPORT**
Sensitizing community leaders adds weight to sexual and reproductive health initiatives for young people and improves communication with their parents.

**PEER EDUCATOR INCENTIVES**
The high turnover of peer educators can in part be addressed by careful selection, good support, reinforcement and compensation or incentives like bicycles and T-shirts.

**DEVELOPING LEADERSHIP POTENTIAL**
The experience of a peer educator can lead to long-term benefits including self-growth and the development of leadership potential.
Pakistan is considered to have a moderate level of HIV infection and most of the cases are concentrated among injecting drug users. Nonetheless, a number of factors combine to make HIV/AIDS a matter of serious concern in the Islamic Republic of Pakistan. Risk factors include increased mobility, low levels of literacy, growing poverty (40 per cent live below the breadline), and unsafe behaviour among the poor. Most reported HIV infections are in the 20–40-year age group. Stigma surrounding HIV/AIDS is a country-wide problem – as is the case in most parts of the world, people living with HIV/AIDS in Pakistan experience isolation, discrimination and abuse.

In pursuit of its goal to promote HIV/AIDS awareness and prevention among vulnerable groups in Pakistan, the Family Planning Association of Pakistan (FPAP) decided to make youth a focus of its activities. The JTF grant enabled a small ‘pilot’ project developed by FPAP staff at the Bangkok South-South Initiative who had observed that without access to appropriate quality information, mythologies and misconceptions dominate youth understanding of sexual and reproductive health issues. Aside from increasing STI/HIV/AIDS knowledge among youth, the project’s objective was to enhance community support for the rights of youth in respect of quality information as well as STI/HIV/AIDS services.

School-going and out-of-school youth were targeted, along with their teachers and parents to ensure ease of access and coherence. In general, there is little serious interaction between youth and older people. The project also promoted networking with religious leaders as well as government and non-governmental organizations. Teachers and religious leaders became the ‘master trainers’, conducting training for school-going and out-of-school youth as peer educators.

Two schools (for boys and girls) in each of three locations in marginalized rural areas of Pakistan – Peshawar, Northern Areas and Chakwal – were selected for the programme’s operations. At the outset, sensitization meetings were held with education authorities, teachers and community religious leaders and these were followed by open sessions with parents.

Although initially reluctant, education authorities granted permission for teachers to participate in the programme and for school premises to be used. The JTF-funded youth project linked with other FPAP programmes of work including the Girl Child Programme, the Male Youth Programme and the Islam and Family Planning Project. An action plan was drafted that clearly recognized the responsibilities of each in respect of the new project.
The first task facing the project coordinators was to put together a package of informational messages to help garner support in the broad community for working with youth in HIV/AIDS prevention. This was followed by the development of training manuals and teaching aids for master trainers, teachers, community functionaries and youths. The manuals cover features of the disease, referral, prevention, treatment, home care, support, counselling, interpersonal communication, peer education and life-skills.

A series of open sessions with parents was then conducted, with a view to highlighting the need to educate students on HIV/AIDS prevention. Men and women were addressed in separate sessions. A training programme was developed for teachers and religious leaders, half of whom were male and half female. Once the youth training sessions were in progress, peer groups were formed, youths were selected for training and peer counselling commenced.

Responses to the project varied from one community to another. In some of the more conservative areas – particularly those governed by religious political parties – there was initial resistance to the idea of providing youth with information on sexual and reproductive health and HIV/AIDS. However, the support of the education authorities, teachers, parents, religious leaders and public representatives helped to dilute the misgivings. Religious leaders already trained by FPAP in HIV/AIDS advocacy were a key asset.

Engaging with the parents, teachers and religious leaders was a critical factor in the project’s success. This made sure the project was embedded socially in a way that was acceptable to most, it enabled the youth to be fully involved and, perhaps most importantly, it was key to ensuring that the HIV/AIDS messages developed were not in conflict with those coming from other influential sources in their lives.

**Key Achievements**

**PARENT PARTICIPATION**
1,200 parents participated in open sessions; feedback was that information should be provided within the socio-cultural context and that parents and teachers should be kept informed.

**MASTER TRAINERS**
24 teachers and 24 religious leaders, half of whom were women, were selected to go to Islamabad to become master trainers.

**PEER EDUCATION**
72 school youths, half male and half female, were trained as peer educators; 1,800 youth were accessed through 144 peer education sessions and 48 group sessions.

**MATERIALS DEVELOPMENT**
A user-friendly, culturally sensitive package of materials suitable for youth was designed, including print materials, videos, audio-cassettes and street theatre.

**Risk Factors for Pakistani Youth**

**ILLITERACY**
Youth illiteracy stands at 46.05 per cent overall and 61.85 per cent in females, a factor that dramatically increases the vulnerability of 15–24-year-olds to STI/HIV/AIDS.

**EXPERIMENTATION**
Adolescents are curious about sex and drugs and prone to experimentation.

**MISINFORMATION**
Lack of authoritative information and reproductive health services creates reliance on quackery and inaccurate information provided by peers.

**MOBILITY**
Youth in Pakistan commonly travel away from home in search of work, resulting in isolation and loneliness which makes them vulnerable to unsafe sexual practices.

**TOURISM RISK**
Opportunities for tourism-related work are common, especially in the Northern Areas region. Youth often work as guides and porters and provide other related services to foreign visitors. Extreme poverty and the attraction of sex make youth vulnerable in this environment.

**ACCESS TO QUALITY INFORMATION**
It is commonly believed that discussion of reproductive health issues leads youth to engage in sex earlier – combined with the low value placed on youth in the family hierarchy, this means access to quality SRH information is limited.

**MARGINALIZATION**
Other factors often associated with youth are social exclusion or marginalization, unemployment, drug use, physical and/or mental abuse including sexual exploitation, and gender-based discrimination.
Pakistan

Lessons Learned

SCHOOL-BASED ACTIVITIES
Activities at school level provide a basis for social interaction and cohesion. The active participation of institutions like schools dramatically increases the impact of a project like this.

STAKEHOLDER PARTICIPATION
The participation of parents and religious leaders is central to the success of this type of project in Pakistani society.

MATERIALS/MESSAGE DEVELOPMENT
Optimal use of human and financial resources is achieved through careful design and development of messages, behaviour change communication materials and training programmes.

PEER EDUCATION
Provided appropriate training and equipment is supplied, peer education is without doubt the best methodology to access youth.

BUILDING YOUTH CAPACITY
Through capacity-building programmes youth can realize their enormous potential to become the leaders of the future.

SENSITIVE APPROACH
With confidentiality, privacy and due respect for socio-cultural practices assured, youth take great interest in sexual and reproductive health information and HIV/AIDS-related services.

Case Study

His own school in Peshawar was the last place 15-year-old Mr Mohammad expected to be talking about sex. "I never talked about reproductive health or HIV/AIDS in classes particularly with my teachers and it was the same with the Moulanas (religious scholars) who teach me how to read the Qur’an. Discussion with parents was also totally unthinkable. I have now come to know that this attitude and practice restricted me from helping many needy people and even exploring my own self."

Selected as a peer educator, Mr Mohammad found that he learned volumes about himself in the process of understanding how he could influence others. "Before the project we all knew little bits and pieces about reproductive health issues, some of it useful, but lots of it nonsense! I never really understood about viral transmission and how it could be prevented, for example. The training has made me much more responsible. What I’ve learned I’ll take through life with me now, and I’ll always be in a position to pass life-saving information on to others. That’s really something."

“Such projects not only generate youth awareness of their health status, but also of their rights and hidden potential. They promote youth self-esteem and an understanding of the pivotal role they can play in the development of their families and country at large.”
Mr Muhammad Asharaf Chatha, Chief Executive Officer, FPAP.

“Reproductive health for youth is a very sensitive issue in Pakistan and against this backdrop authentic information on sexual and reproductive health and HIV/AIDS has assumed great significance, particularly in high school settings. This project not only enhanced the understanding of the students but also improved the knowledge and attitude of teachers towards the disease.”
Schoolteacher, Peshawar.

“We always feared providing such information to our children, especially our daughters. We used to think that sexual and reproductive health information and services are not important to children of school age and that their exposure to such information may result in their early debut in sexual activity. But because of the understanding developed through this project we have come to realize that children have full rights to any information including sexual and reproductive health that could today or later affect their lives.”
Mother, Chakwal.

“The education department would be very grateful to the Family Planning Association of Pakistan if it could replicate the same model in other high schools. We are impressed that the Association planned the project implementation carefully, giving high regard to the social and cultural values of the people and maybe this was the reason the project turned out to be a great success.”
Government education officer, Chakwal.
Lessons Learned

REACHING OUT
Young people are often embarrassed to seek information and must be approached directly – projects must be ‘by the youth, for the youth’ if they are to be successful.

EMPHASIZING OUT-OF-SCHOOL YOUTH
Out-of-school youth are especially vulnerable and their needs must be prioritized, particularly those of the unemployed.

FOCUSING ON ADOLESCENTS
Youth in a period of sexual awakening and experimentation are in need of special attention if they are to make constructive use of their new-found sexual powers.

MULTIPLE PRESSURES
Time commitments and difficulties with travel distances and cost are an issue for youth volunteers.

COMPLEX RELATIONSHIPS
Commitments made are not always respected by all partners. Bringing other organizations in as stakeholders helps develop ownership of the project and helps with implementation.

Seychelles

Around 50 per cent of the Seychelles population is under the age of 20. The government position on the provision of sexual and reproductive health services to youth is not well defined and the needs of youth are consequently marginalized. According to a 1997 study nearly three-quarters of teenagers who became pregnant had never used contraception. In 2002 the Alliance of Solidarity for the Family (ASFF) extended and developed the provision of reproductive health services for youth, including those dedicated to STI/HIV/AIDS.

In particular, gender-balanced, youth-friendly services were promoted with the establishment of a second health centre on the island of Mahe, staffed with service providers specially sensitized to youth needs and interests. An additional 22 counsellors and 20 community-based educators were recruited, trained and equipped with the necessary informational materials. ASFF also conducted a study to establish the level of knowledge and existing attitudes and practices relating to STI/HIV/AIDS, contributing new insights to a growing bank of local HIV/AIDS knowledge in the Seychelles.

Taking an holistic approach to youth sexual and reproductive health

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The HIV prevalence rate in Tanzania rises steadily and AIDS is now officially recognized as the leading cause of death among adults, according to the National Multi-sectoral Strategic Framework on HIV/AIDS 2003–2007. This document estimated that two million people were living with HIV/AIDS in 2002 and drew a strong link between sexual reproductive health and HIV/AIDS prevalence. UNAIDS estimated in 2002 that more than 15 per cent of 15–49-year-old Tanzanians were HIV positive. Far more women than men are infected with the virus and gender disparities are increasing. It is in response to these realities that the attention of health workers turned to the development of youth-centred projects in Tanzania.

Finance from JTF made two youth-focused projects possible in Tanzania during 2002. The first of these aimed to develop behaviour change communication for young people, while the second centred around advocacy for VCT for HIV among youth. The behaviour change project was implemented by the Mwanza City Branch of the Member Association in Tanzania, Uzazi Na Malezi Bora Tanzania (UMATI), while the counselling and testing project was conducted by the Temeke Youth Centre in Dar es Salaam. Both had the support and guidance of the Central Office of UMATI.

Both initiatives aim to reduce the incidence of HIV infection among young people aged 10–25. The specific objective of the first was to influence the behaviour of youth in Mwanza City through communicating the risks of multiple sexual partners, while the second focused on increasing the numbers of youth accessing voluntary counselling and testing services in the Temeke District of Dar es Salaam. Both initiatives align well with two of the priority areas of the UMATI’s strategic plan - adolescent services and HIV/AIDS.

Social and cultural practices and beliefs affect the level of HIV/AIDS exposure for youth. In Mwanza City, for example, it is reported that young people become sexually active very early. The practice of having multiple sexual partners is socially accepted; older men seek out young girls and many subscribe to the belief that sex with a virgin will cure them of HIV/AIDS. These factors are compounded by cultural practices such as the custom governing widows’ inheritance which further exacerbate the vulnerability of young people.

The Mwanza City project situational analysis found that 40 per cent of youth were not using condoms. It also came to light that girls feared unplanned pregnancy more than HIV/AIDS, which was seen as a more
distant threat. Young people said they first had sex at around eight or nine years old and that the level of HIV/AIDS knowledge and awareness of parents was limited.

The Mwanza City project based at the family planning clinic hoped to work with youth to increase health-seeking behaviour, reduce the number of sexual partners and increase the correct use of condoms. The project strengthened youth-friendly services by building the capacity of 12 service providers from health facilities across Mwanza City and developed the capacity of key collaborators in the community to support and deliver information, education and services. Collaboration with other agencies was strengthened through sharing of best practice on behaviour change communication on HIV/AIDS with young people.

A range of key activities was implemented during the project lifespan. Consultative meetings were held for the district, community authorities, collaborating agencies and UMATI staff. A situational analysis was conducted and a behaviour change communication strategy document was produced through a stakeholder workshop. Youth were then oriented on the strategy and message design and youth-friendly services were developed. This included the training of 20 teachers in 11 schools across the city to provide information on an ongoing basis.

Although another study would be required after the project to assess a qualitative shift in behaviour, the early anecdotal reports suggest that the project led to positive outcomes, including a reduction of teenage pregnancy in some of the schools involved.

During the same year, but this time in Dar es Salaam, the 'Advocacy for Youth Voluntary HIV Counselling and Testing' (VCT) project was implemented by the Temeke Youth Centre under the guidance of the UMATI. Temeke District is one of the poorest areas of Dar es Salaam and the centre is already well connected with the youth as well as the wider community. The project used a JTF grant to extend the centre’s services to include youth-friendly VCT and to increase awareness among young people, policy-makers and the community of the importance of such services for youth. A situational analysis revealed that young people fear VCT because of difficulties in dealing with a positive result (particularly given the lack of available treatment options) and that knowledge of VCT services is low and the cost prohibitive.

Anticipated gains in respect of increasing community awareness were met and the project had strong support from the community and district government. Participation of youth and other community members was strong during all the project’s phases and way exceeded the expectations of project workers. Extending opening hours and the developing of further youth services are, however, hampered by a shortage of HIV/AIDS-trained and experienced staff and physical constraints like space.
With more than one-fifth of its adult population infected and more than half a million AIDS orphans, Zambia ranks among the countries hardest-hit by the HIV/AIDS pandemic. To contribute to the improvement of the sexual and reproductive health of young people in a fun and interactive way, the Planned Parenthood Association of Zambia (PPAZ) came up with a unique advocacy campaign. The main goal and objective of the PPAZ is to increase access to and provide quality sexual and reproductive health information and services for young, vulnerable and underserved communities.

The PPAZ developed a small awareness programme that drew on the popularity of sporting events among young people. Together with drama, the idea was to bring safer sex and other HIV/AIDS awareness messages to school-going and out-of-school youth aged 10–24 in Lusaka and Kabwe. Using a JTF grant, the project recruited and trained 30 young people to form an ‘Edu-Sport’ team which would work in peer education at specially organized events. A coach was trained for the team on HIV prevention and advocacy. A second youth group was trained to communicate HIV/AIDS messages to other young people using the arts of music and drama.
The diversity of experiences outlined so briefly here clearly demonstrates that no single route exists for dealing with the multiple challenges presented by HIV/AIDS in our communities. The approaches and the mechanisms developed need to be as diverse as the environments in which they are utilized.

The HIV/AIDS work made possible by JTF in 2001 and 2002 is perhaps most significant because it consolidates the presence of IPPF as a positive force in the delivery of the continuum of care services in respect of HIV/AIDS. With representation in more than 180 countries, IPPF is in a unique position to make a decisive impact on the spread of HIV/AIDS and to dramatically improve access to appropriate services for counselling, testing, treatment, care and support.

The HIV/AIDS pandemic is dynamic. Countries, organizations and individuals must build on lessons learned in order to strengthen future responses. In a highly charged political environment, accurate, up-to-date information on the magnitude and severity of the epidemic and its prevention and treatment options is an important precursor to action. Raising awareness is an important catalyst for change. Sharing the many valuable lessons recorded here enables others working in the field and planning new projects and programmes to benefit from a diverse array of grassroots experience. In particular, IPPF’s work has emphasized the importance of integrating prevention and care as a meaningful process for the foundation of effective HIV/AIDS programmes. Several common elements emerge from the inputs provided by Member Associations. These are detailed in the paragraphs that follow.

**Participation**

Target beneficiaries must be involved directly in the planning and implementation of HIV/AIDS programmes. The projects included here demonstrate the huge diversity of physical and cultural environments which inform the relationship between people and HIV. Aside from the importance of beneficiary input for the development of appropriate responses, the need for a sense of local ownership over projects was clearly central to short-term success as well as to the prospects for future sustainability.

**PLHA Input**

Often overlooked is the critical participation of people living with HIV/AIDS in programme development.

The inclusion of PLHAs’ perspectives introduces a wealth of experience and knowledge that is essential in demystifying and destigmatizing HIV/AIDS. PLHAs are not simply passive recipients or beneficiaries of services, nor should their inclusion be sought merely as spokespersons of public health campaigns. Meaningful participation means actively involving PLHAs at all levels and stages of policy and programme development, including planning, priority setting, implementation and evaluation.

**Capacity Building**

Building HIV/AIDS capacity and competency is essential to ensure that all stakeholders, especially those most affected by HIV/AIDS, have the skills, abilities and opportunities to meaningfully participate in the decisions that affect their sexual and reproductive lives. Many of the projects included in this report included skills-development components. The capacity of peer educators, teachers, community and political leaders and Member Association staff and volunteers was built to improve their sensitization to HIV/AIDS issues and to enable them to participate more effectively in the delivery of education, support and HIV/AIDS-related reproductive health services. In particular, more work is needed to challenge the stigma that exists towards PLHAs within the health services through greater investment in training. The need becomes all the more pressing given the urgency of up-scaling capacity to deliver a complex range of treatment and care options.
**Stakeholder Support**

Generating the support of key community stakeholders such as religious and political leaders is essential for message reinforcement as well as for drawing in a broader pool of resources. Tapping into valuable community networks like faith-based organizations extends a project’s reach and lends greater legitimacy. The participation of parents and teachers in youth initiatives, for example, developed an awareness among a generation other than the intended beneficiary, while ensuring the support of community sectors that heavily influence the lives of youth. A number of the projects found faith leaders to be willing partners, realizing that – often contrary to their expectations – the faith-based organizations proved to be valuable networking resources, or simply provided convenient venues for their activities.

But stakeholder participation not only secured partners for the projects, it defined the shape they took and the mechanisms they used to deliver the messages and to improve the HIV/AIDS services provided. The most effective faith-based responses to HIV/AIDS are the ones that are owned, directed and sustained by spiritual leaders. Situated within communities and building on relationships of trust and respect, faith-based organizations in partnership with Member Associations have the ability to influence the attitudes and behaviour of their fellow community members.

**Partnerships**

Networking with spiritual leaders and other community structures, especially those involved with HIV/AIDS service delivery, is a critical element of a comprehensive and integrated response. The development of partnerships enables resources to be pooled and maximizes impact. Generally there are a number of organizations involved in the delivery of HIV/AIDS-related services and each has some area of speciality or knowledge to contribute. Partnerships lead to more effective use of resources; they pool expertise and reduce duplication. Combined, these factors improve the synergy of the HIV/AIDS response which results in greater impact. Working with other NGOs and with state departments and the private sector also helps organizations to build networks of contacts which can be used to develop future collaborative projects and programmes.

**Peer Education**

All the projects that involved the development of peer educators found them invaluable in reaching vulnerable groups. This was particularly the case with youth who respond more openly and enthusiastically in their interaction with friends and peers than with others. Many of those involved gained leadership skills through the projects. In other settings the value of shared experience in communicating sensitive HIV/AIDS messages was also clear. Equipped with training, appropriate targeted messaging and IEC materials, people in diverse circumstances took HIV/AIDS awareness to their peers and reported their efforts successful.

**Treatment**

In many of the integrated prevention projects, the lack of access to treatment for opportunistic infections and to the prevention of mother-to-child transmission as options in a VCT setting were limiting factors. Rather than operating on a ‘know your status’ philosophy, VCT centres need to develop the skill and expertise to manage all aspects of an HIV-positive diagnosis. The health needs of the HIV-positive community cannot be ignored.

Aside from the basic human rights priorities, meeting the needs of PLHAs is central to the success of the HIV/AIDS response. Prolonging the health and well-being of HIV-positive mothers, for example, is by far the best strategy for addressing the needs of vulnerable children. An integrated service approach will encourage more to learn their status, opening the door to reducing unsafe behaviour and promoting positive living for those who are infected. Access to antiretrovirals must be addressed if the needs of the current scale and phase of the pandemic in many countries is to be addressed. The World Health Organization’s ‘3 by 5’ initiative marks the arrival of treatment access as a tangible goal for the global HIV/AIDS community.
An Integrative Approach

With an understanding of the intricate connection between prevention and care comes a responsibility to infuse mainstream programmes with the capacity to draw on the synergies that exist between these elements. The ultimate goal is to develop existing facilities such as VCT centres into comprehensive reproductive health facilities providing a range of services to the local community. This would ideally include prevention information, counselling and testing, antiretroviral and opportunistic infection treatment, treatment literacy and adherence programmes, and improved psycho-social support. An effective and integrated HIV/AIDS prevention response rests securely on the foundation of a human rights approach. Integration is key to ensuring that HIV/AIDS becomes so seamless a part of the complex of mainstream reproductive health services that stigma is effectively eliminated.

Addressing Stigma and Discrimination

Stigma and discrimination at the level of society as well as the individual are inherent to all integrated prevention initiatives. HIV/AIDS projects cannot stand isolated – approaches to address stigma and discrimination must be integrated, cohesively, into each and every HIV/AIDS programme along the care continuum. Simply embracing the values of reducing stigma and discrimination or empowering PLHAs is not enough. Because stigmatizing attitudes often arise from deeply entrenched social norms and systems, efforts to reduce stigma and discrimination should become a stronger part of the global agenda.

References

Statistical data included in this report is largely drawn from country profiles produced by UNAIDS, United Nations Educational, Scientific and Cultural Organization (Unesco) and the World Health Organization (WHO) which were updated in 2002. The Epidemiological Fact Sheets on STI/HIV/AIDS use a range of data from United Nations Department of Economic and Social Affairs Population Division (UNPOP), the World Bank, WHO and Unesco. While some of the figures may be disputed by organizations working in the countries concerned, they have been used for the purpose of consistency. UNAIDS has just completed the process of updating the figures – these have been revised downwards in 2003 because data and understanding has improved to allow for more accurate estimates. Unfortunately the data for individual countries was not readily available at the time of writing this report.

In addition to the numerous progress reports, evaluation papers and final report-back documents on individual projects provided by IPPF and national MAs, the following references were drawn upon:


‘JTF Grant Project Selection Committee Report 2003’

‘Learning from the Field – Experiences in HIV prevention from family planning associations worldwide’, IPPF, 2002

‘Encarta Encyclopedia 2000’, Microsoft

‘Middle East and North Africa Fact Sheet’, UNAIDS, December 2003
# List of HIV/AIDS Projects


<table>
<thead>
<tr>
<th>NO</th>
<th>M A / R O</th>
<th>PROJECT TITLE</th>
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<tbody>
<tr>
<td>1</td>
<td>Africa Regional Office</td>
<td>Capacity building for effective response to HIV/AIDS pandemic</td>
</tr>
<tr>
<td>2</td>
<td>Lesotho (LPPA)</td>
<td>Women fighting HIV/AIDS: promoting the female condom</td>
</tr>
<tr>
<td>3</td>
<td>Malawi (FPAM)</td>
<td>Preventing STI/HIV/AIDS among the youth in Lilongwe city, Ta Chiseka and Ta Tsabango</td>
</tr>
<tr>
<td>4</td>
<td>Zambia (PPAZ)</td>
<td>HIV/AIDS prevention among Zambian youth</td>
</tr>
<tr>
<td>5</td>
<td>East and South East Asia and Oceania Regional Office</td>
<td>Prevention and management of sexually transmitted infections including HIV/AIDS among sex workers</td>
</tr>
<tr>
<td>6</td>
<td>China (CFPA)</td>
<td>HIV prevention education for rural young adults</td>
</tr>
<tr>
<td>7</td>
<td>India (FPAI)</td>
<td>Education, counselling and control of STI/HIV/AIDS for truck drivers and IV drug users</td>
</tr>
<tr>
<td>8</td>
<td>Nepal (FPAN)</td>
<td>Integration of STI services into FPAN clinics</td>
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**Advocacy Action Plan**

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<tr>
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<tbody>
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<td>9</td>
<td>Botswana (BOFWA)</td>
<td>Advocacy directed towards education authorities and community leaders for incorporating HIV/AIDS prevention activities for schools in Kanye</td>
</tr>
<tr>
<td>10</td>
<td>Nigeria (PPFN)</td>
<td>Private sector initiative for HIV/AIDS prevention</td>
</tr>
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<td>11</td>
<td>Uganda (FPAU)</td>
<td>Advocacy for supportive attitude towards condom use for STI/HIV/AIDS prevention from religious leaders in Mityana</td>
</tr>
<tr>
<td>12</td>
<td>Cambodia (RHAC)</td>
<td>Reaching indirect commercial sex workers (beer-promoting girls) to reduce the spread of HIV/AIDS in Phnom Penh</td>
</tr>
<tr>
<td>13</td>
<td>Myanmar (MMCWA)</td>
<td>Advocacy directed towards decision-making bodies/authorities on HIV/AIDS prevention in Tamu township, Sagaing Division</td>
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<tr>
<td>14</td>
<td>India (FPAI)</td>
<td>Advocacy for creating an enabling environment for implementing sexuality education in schools with special emphasis on STI/HIV/AIDS prevention</td>
</tr>
</tbody>
</table>
## List of HIV/AIDS Projects


<table>
<thead>
<tr>
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<tr>
<td>1</td>
<td>Botswana (BOFWA)</td>
<td>Botshelo Ke Mpho (Life is a Gift) – video production for IEC material</td>
</tr>
<tr>
<td>2</td>
<td>Burundi (ABUBEF)</td>
<td>Reduction of the transmission of HIV and other sexually transmitted diseases in Bujumbura, Gitega and Ngozi</td>
</tr>
<tr>
<td>3</td>
<td>Cameroon (CAMNAFAW)</td>
<td>Youth AIDS Media (the ‘YAM’ project)</td>
</tr>
<tr>
<td>4</td>
<td>Côte d’Ivoire (AIEBF)</td>
<td>Fidel &amp; Abstinia: fidelity and abstinence among youths</td>
</tr>
<tr>
<td>5</td>
<td>Seychelles (ASFF)</td>
<td>STI/HIV/AIDS prevention and control among the youth in Mahe</td>
</tr>
<tr>
<td>6</td>
<td>Tanzania (UMATI)</td>
<td>Behaviour change communication for HIV/AIDS prevention among young people</td>
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<tr>
<td>7</td>
<td>Uganda (FPAU)</td>
<td>Care and support for STI/HIV/AIDS-infected and affected youths involved in transient trade in Mbarara Municipality</td>
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<td>8</td>
<td>Cambodia (RHAC)</td>
<td>Extension to program for reaching indirect sex workers (IDSWs) in Phnom Penh</td>
</tr>
<tr>
<td>9</td>
<td>China (CFPA)</td>
<td>Rural educational movement on HIV prevention by Utilizing FPA’s network</td>
</tr>
<tr>
<td>10</td>
<td>India (FPAN)</td>
<td>Project on education, counselling and control of STI/HIV/AIDS for truck drivers and IDUs</td>
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<tr>
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<td>Eritrea (FRHAE)</td>
<td>Advocacy for HIV/AIDS prevention for Ground Force Commanders at the Sawa National Service Training Center</td>
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<tr>
<td>12</td>
<td>Gambia (GFPA)</td>
<td>Advocacy for HIV/AIDS prevention for bank employees</td>
</tr>
<tr>
<td>13</td>
<td>Liberia (FPAL)</td>
<td>Advocacy initiative for policy makers and opinion leaders on HIV/AIDS prevention and control</td>
</tr>
<tr>
<td>14</td>
<td>Rwanda (ARBEF)</td>
<td>HIV/AIDS prevention in/from Rwanda prisoners</td>
</tr>
<tr>
<td>15</td>
<td>South Africa (SMMEs)</td>
<td>Implementation and advocacy plan for small, medium and micro enterprises in the Gauteng and KwaZulu-Natal provinces</td>
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<tr>
<td>16</td>
<td>Tanzania (UMATI)</td>
<td>Advocacy for youth HIV voluntary counselling and testing</td>
</tr>
<tr>
<td>17</td>
<td>Mongolia (MFWA)</td>
<td>HIV/AIDS education for dormitory university students in Ulaanbaatar</td>
</tr>
<tr>
<td>18</td>
<td>Bangladesh (FPAB)</td>
<td>Advocacy among garment factory owners and management to initiate programme on reduction of STI and prevention of HIV/AIDS among factory workers</td>
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<td>19</td>
<td>Nepal (FPAN)</td>
<td>Prevention of HIV/AIDS Program for newly recruited police personnel through advocacy</td>
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<td>2</td>
<td>China (CFPA)</td>
<td>HIV prevention life skills training for rural out-of-school adolescents</td>
</tr>
<tr>
<td>3</td>
<td>Ghana (PPAG)</td>
<td>Strengthening HIV/AIDS voluntary, counselling and testing services (VCT) within PPAG</td>
</tr>
<tr>
<td>4</td>
<td>Kenya (FPAP)</td>
<td>Promotion of positive behaviour change among the youth</td>
</tr>
<tr>
<td>5</td>
<td>Malawi (FPAM)</td>
<td>Promoting STI treatment – seeking behaviour among youth aged 15-24 in Lilongwe, Chisembe, Tsabango, Malili and Chitukula</td>
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<td>6</td>
<td>Namibia (NAPPA)</td>
<td>Prevention of STI/HIV/AIDS among youth in and out of school and women of childbearing age in Amusati region</td>
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<td>7</td>
<td>Pakistan (FPAP)</td>
<td>Strengthening FPAP system for STI/HIV/AIDS awareness and prevention among high-risk groups</td>
</tr>
<tr>
<td>8</td>
<td>Vietnam (VINAFPA)</td>
<td>Capacity building for the VINAFPA on AIDS prevention among commercial sex workers (CSWs)</td>
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<td>Advocacy for STI/HIV/AIDS prevention among taxi-drivers in Abobo Communes</td>
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<tr>
<td>10</td>
<td>Ethiopia (FGAE)</td>
<td>Advocacy for HIV/AIDS prevention among factory workers in Nazareth</td>
</tr>
<tr>
<td>11</td>
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<td>Advocacy on youth HIV/AIDS information counselling corners</td>
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<td>Kenya (FPAP)</td>
<td>Advocacy directed towards Ministry of Education officials and parents to support peer youth education on HIV/AIDS in upper primary schools in Nakuru</td>
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<td>Zambia (PPAZ)</td>
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FPAP: pages 3, 18, 20, 21, 22 | JTF: pages 6, 41, 42, cover (2nd right) | GFPA: page 13 | PPAZ: page 43 | FPAU: pages 15, 17 | IPPF: pages 8 (top), 9, 4 (bottom)

* Some names have been changed to protect the identities of interviewees.