Techniques and Practices for Local Responses to HIV/AIDS

Part 2: Practices

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This Toolkit is a joint publication between the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Royal Tropical Institute.

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Preface

It is people who must respond to HIV/AIDS. For their responses to be effective, they need commodities, information and money. However, these can only support — and not substitute for — a people-driven response. Individuals, households and communities that respond effectively to HIV/AIDS take ownership both of the issue and of its solution. To progress towards AIDS competence, they forge partnerships with local sources of support, with individual and peers and also with local government, social service departments, community-based and non-governmental organizations or the private sector. This is, briefly, what we have learned from effective local responses, the responses by people where they live and work. How can one foster such effective responses at large scale?

This toolkit represents a new and excellent resource for the many committed to this goal. The techniques and practices presented here have been "distilled" from local responses around the globe. This toolkit offers the techniques and practices for others to adapt to their own context. To the extent possible, it includes a contact address so that various actors can contact each other to share their experience with the various techniques and practices, and make a synthesis of lessons learnt from their use.

We wish that the publication of their Toolkit would stimulate new connections for more effective Local Responses. UNAIDS is looking forward to learn more from those new connections.

Michel Sidibé
Director of Country and Regional Support Division
UNAIDS, Geneva

Acknowledgements

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Madeleen Wegelin and Georges Tiendrebéogo from KIT brought together the techniques and practices contributed and adapted them to the framework, initially assisted by Carolien Aantjes. After sending them back to the various sources for comments, they were reviewed by a group of colleagues from KIT. We like to thank the many individuals and organisations for taking time to talk and write to the KIT consultants about their programmes and for the frank analysis of the impact and challenges of these programmes. We are also grateful for suggestions from many people working in HIV/AIDS around the world on organisations that could contribute to the documentation of techniques and practices for Local Responses.

A special word of thanks goes to Luc Barriere-Constantin of the Africa Division of the Country and Regional Support Department, UNAIDS and Jean Louis Lamboray of the UNAIDS/UNITAR AIDS Competence Team for their continuous guidance, advice and support as well as their comments on the draft practices and techniques and the links with the Self Assessment for AIDS Competence.

Finally, without financial support, the toolkit would never have been possible. For this, we therefore thank the Japanese government, the government of The Netherlands and the UNAIDS departments of Technical Network Development (TND) and Information Centre (IRC).

Introduction

In 2001 UNAIDS initiated the development of a toolkit with techniques and practices for Local Responses to HIV and AIDS in consultation with the UNAIDS Secretariat, with the UN Theme Groups in different countries and members of the UNAIDS Technical Network on Local Responses to HIV/AIDS. The toolkit aims to further strengthen the capacity and competence of different actors to address HIV/AIDS at local level. Experiences worldwide contributed to the identification and selection of practices and techniques for the toolkit and they are meant for all with an interest in furthering local responses to HIV/AIDS. The Royal Tropical Institute (KIT) in the Netherlands manages the project for UNAIDS.

This document presents the practices that have been contributed to the toolkit. They are available in hard copy in English and on CD-rom. In addition, they are posted on the Local Response e-workspace (LR_toolkit@ews.unaids.org) for further discussion and are available on the UNAIDS website (www.unaids.org) and the KIT website www.kit.nl/health/html/aids.asp. A practice describes a process that has been carried out by an organisation/ institution/ community to address one or more specific problems, indicating in a practical way the whole process of implementation as it has taken place. The techniques, that also form a part of the toolkit, are presented in a separate document and are available in English, French and Portugese in hard copy, on the CD-rom, the e-workspace and the websites. Techniques help a facilitator to support an audience to analyse their own situation and to establish their needs and priorities, in order to plan interventions.

In this document we first describe the reasons for developing the toolkit and the process that was followed for the collection of techniques and practices. It continues with a description of how you can contribute and/or access the practices and techniques and how to use them. The last part of the introduction describes the link with the framework for Self Assessment of AIDS Competence and concludes with an overview of the practices. The rest of the document consists of fifty practices. Annex 1 provides guidelines on how to write a practice enabling readers to contribute to the toolkit and expand the common knowledge base. Annexes 2, 3 and 4 respectively give the index of the practices by category of practice, by domains of the Self Assessment Framework and by country. A list of abbreviations is given in annex 5.

Why a toolkit for local responses

Local Responses to HIV/AIDS imply the involvement of people where they live - in their homes, their neighbourhoods and their work places. For HIV/AIDS prevention and impact mitigation, each individual, family, community and organisation needs to deal effectively with HIV/AIDS, in other words, needs to become “AIDS-competent”. AIDS competent societies acknowledge the reality of HIV/AIDS and assess how HIV/AIDS affects different aspects of life and organisations. Based on this assessment, AIDS-competent societies build their capacity to respond and take concrete measures to reduce vulnerability and risk. Learning and sharing experiences with others is an important aspect of building capacity and avoids time and energy spent on re-inventing the wheel.

Crucial in a strategy for learning and sharing across communities, organisations and countries, is the documentation of experiences that have proven to work in a specific context. Often, such experiences tend to remain local and are rarely documented. Even if they are, these are often lengthy case studies and not very accessible. The toolkit and the discussion on the e-workspace provides a platform where experiences are available in a short, concise format in which the source for further information is given to facilitate practical application and adaptation to another local context. The development and implementation of a strategy for learning and sharing in each country will help to get the experiences to those that can use them best.

The process followed to collect the practices and techniques

Partners that already collaborated in the UNAIDS local response network, developed a format for the practices and techniques that form the backbone of the toolkit, during a start-up workshop (held in Uganda in May 2002). In addition, the strategy for the project was discussed as well as approaches for a knowledge exchange strategy within and between countries.

Subsequently, KIT finalised guidelines for writing practices and techniques (see annex 1). Organisations in the local response network, partners that participated in the workshop and contacts made at international conferences, played an important role in identifying practices and techniques for the toolkit. In addition, KIT staff visited six countries (Brazil, Burkina Faso, Trinidad and Tobago, Thailand, Uganda and Zambia) to document practices and techniques. In the countries, practices and techniques already available in the toolkit were shared and in-country knowledge exchange strategies were discussed. In three countries this was also linked to workshops on self-assessment.

A total of 50 practices are included in the toolkit, taken from twelve countries across the world. The majority of the practices are documented as a result of visits by KIT staff to the organisations implementing the practice. Usually interviews were conducted following the format of the practice. KIT prepared the document and sent it back for comments and approval. In Burkina Faso and Trinidad and Tobago, a workshop was held after which the participants wrote their own practices, to be commented and reviewed by KIT. The same approach was used for the practices that were contributed by organisations through email. The practices of some of the organisations visited, turned out to be impossible to capture in the practice format for a variety of reasons. For instance, in Brazil and Kenya, the operation of the Documentation and Resource Centres of ABIA and KANCO is too specialised and complicated to describe in a short document. The same applies to the orphanages Viva Cazuza in Brazil and Mercy Centre in Bangkok, Thailand. Other practices, such as the approach for mobilisation of communities in Bangkok (BMA) and the newsletter for MSM communities in Trinidad (Free Forum), are still evolving and too new to properly analyse the impact and sustainability. Some practices that were documented are not included because we never received feed-back and comments from the organisations. All practices documented, were assessed on clarity, consistency, focus and practical use by a team of external reviewers.

Who contributes to the toolkit, who uses it and how can it be accessed

The organisations that contributed to the toolkit are diverse, some of these organisations function as umbrella organisations for local NGOs, such as AIDSNet in Thailand, UNASO in Uganda, CHAZ in Zambia and ABIA in Brazil. They helped to contact their participating NGOs to share their practices and techniques and will also be instrumental in disseminating and using the tools. Other inputs result from NGOs implementing the Local Responses agenda in the six selected countries with the support of the World Bank (MAP) and other UNAIDS co-sponsors, such as UNICEF, UNDP and WHO or from NGOs that are linked to international NGOs such as Save the Children, Action AID, International HIV/AIDS Alliance, Oxfam and international faith based organisations.

National facilitators for Local Responses, district support teams or umbrella organisations are a key audience for the use and further development of the toolkit because their task it is to motivate, facilitate and support communities in planning their own responses. They make use of participatory techniques in this work and the tools in the toolkit give them additional options. The practices describe what (often common) problems are addressed, what the purpose of the intervention is and what steps the organisation has taken to implement the practice. In addition, an analysis is given on the impact of the intervention and on the critical issues and lessons learnt. This is meant to facilitate adaptation by other organisations and to build on both positive and negative aspects of the practice. It is hoped that by making these practices available on a wide scale, both within countries and internationally, effective responses can be fed back to the policy level (National AIDS Councils or Programmes), to sector ministries for possible integration in national policies and to national and international NGOs.

The practices and techniques in the toolkit, are presented and discussed in the Technical Network on Local Responses to HIV/AIDS with about 700 members working in all continents and at all levels of the response. The members of this network meet virtually in the Local Responses to HIV/AIDS e-Workspace. They exchange lessons with regard to their work in e-mail discussions and contribute to the collective learning on responses to HIV/AIDS.
The Local Responses e-Workspace hosts three e-mail discussion forums. One on the City-Aids programme (LR_City-Aids@ews.unaids.org) focussing on responses to HIV/AIDS in cities, one on the Toolkit for Local Responses (LR_Toolkit@ews.unaids.org) where new practices and techniques related to Local Responses are discussed, and one on general information related to Local Responses (Localresponse@ews.unaids.org). The Local Responses e-workspace further accommodates document libraries, an event calendar, a contact list and links to related websites.

It is expected that with a substantive initial collection of practices and techniques in the toolkit, organisations are motivated to share their experiences in using and adapting the practices and techniques and thus enhance global learning. We ask the users of the toolkit to contribute to this discussion by sending a response to the e-workspace on the following questions:

- For what purpose have you used the practice/technique
- What adaptations have you made
- What is the outcome of the use of the practice/technique

In addition all users are invited to contribute new practices and techniques so the content can evolve continuously and a platform for exchange is established on the website and in the e-workspace. The facilitator of the toolkit will give support in documenting the practices and techniques in the common framework.

What are practices and techniques

A practice describes a process that is carried out by an organisation/ institution/ community to address one or more specific problems. It can serve as an example and/or inspiration for others that are confronted with a similar problem. The practice describes in a practical way the whole process of implementation as it has taken place and gives an analysis of critical issues and lessons learnt. The source of information is included to ensure that more details of the process can be obtained if necessary. A practice usually has a longer time frame and it must be sustainable in the context in which it is applied.

A technique is a procedure that is used for a specific purpose at a certain stage during a process of intervention, described in a practical step-by-step fashion. Many of the techniques are applied in development programmes that aim at community mobilisation and empowerment and are adapted for use in HIV/AIDS programming. Although some techniques and practices are for use specifically at community level, others are applied at sub-district, district, regional and international levels by government staff and by NGOs. Because most organisations have experience with participatory techniques, the toolkit does not include a specific training manual but is a collection of techniques that can be adopted in an existing approach.

The framework for Self Assessment of AIDS competence

Since the formulation of the toolkit project, UNAIDS has formed a partnership with UNITAR to create and share knowledge from effective responses to the HIV/AIDS epidemic. As a starting point, a self-assessment process is designed in which people (groups and organisations at various levels) assess where they are already performing good practice, where they might improve, what gaps in knowledge and experience exist and how these can be overcome. This process helps to guide sharing of knowledge and interaction between organisations and groups of people and can be seen as a technique in itself. The self-assessment framework is described in annex 2 of the Techniques of the toolkit. The toolkit is complementary to the self-assessment process as it provides a framework for documenting practices and techniques and a common source of practical examples that can help organisations to advance from one level of competence to another. In annex 3, the practices are listed for each ‘domain’ of the self-assessment framework. Some of the practices are listed in more than one domain. The listing has to be regarded as an indication and illustration of interventions that can help people and organisations to improve their AIDS competence.

Overview of the practices presented in this document

There are 50 practices in this document. We have divided these in four categories: Prevention, Care and treatment, Support and mitigation, and Partnerships and coordination and within these categories have listed them in alphabetical order. The categories are not mutually exclusive, but the key words indicate the activities, target group and location of the practice. In the table below, an overview is given of the practices by category of intervention. In annex 2 the same table is given, but including key words. Annexes 3 and 4, give the index by domains of the Self Assessment Framework and by country.

No.	Practice
	Prevention
1	Buddhist approach to prevention and care
2	Club Cool
3	Community Art vs. AIDS
4	Community Centre for IDUs
5	Condom 'Krew'
6	Cross Border project
7	'De Living Room'
8	Drop-in centre for sex workers
9	Each one, teach one
10	'Jus Once', an interactive HIV/AIDS awareness production
11	Life skills education in a poor suburb in São Paulo
12	Meakaotom Youth Group
13	Migrant workers prevention and care
14	Mobile VCT clinic
15	Prison setting prevention and care
16	Protection of young male prostitutes against HIV/AIDS
17	Rap against silence
18	Resource centre for youth
19	Sang Phan Wan Mai Youth Group
20	Sex industry outreach
21	Toco Youth Sexuality Project
22	VCT at MSM saunas
23	Voucher scheme
24	Wear to care
25	Young people's movement
26	Youth learning to take care in a poor neighbourhood in São Paulo
27	Video Documentary of HIV/AIDS Projects, 'Choice or Chance'
	Care and Treatment
28	Group Therapy, 'Show you care, Take care of yourself and others'
29	Macha mission home based care and prevention
30	Maramba home based care and prevention
31	Masaka ARV provision
32	Mpigi home based care
33	Nursery for Orphans and Children affected by AIDS
34	Psycho-social and home care for PLWHA
35	Sai Samphan management of ARV treatment by PLWHA group
	Support and mitigation
36	Access integrated child support
37	Balcão de direitos (Rights Corner)
38	'Child is Life' project
39	PLWHA Health and Income generating activities
40	Co-operative of PLWHA for producing school uniforms
41	Farm school for orphans
42	Counselling and skills training in Kara Hope House
43	Support to orphan girls in Kara Umoyo
44	Orphan feeding scheme
45	Support from monks to HIV positive women group
	Partnership and coordination
46	NGO and Local Government cooperation
47	People Living with HIV/AIDS Coming Together in the Caribbean
48	Networking and training of MSM NGOs: Projeto Somos
49	SEPO Centre, district coordination
50	Soroti Network of AIDS Service Organisations (SONASO)

1 A Buddhist approach to HIV/AIDS prevention and care, Thailand

Developed by: Sangha Metta Project, Chiangmai, Thailand
Key words: Faith based organisations, community, training, prevention, care, Thailand

Section	Content
1 Summary of the practice	A programme that trains and supports monks to expand their traditional role to include HIV/AIDS education, prevention, care and outreach
2 Level of intervention	Community level for implementation, local, national and regional level for training
3 Prospective users of the practice	Faith based organisations, NGOs, communities
4 Problem addressed	• PLWHA face stigma and discrimination in their communities • PLWHA and their families need spiritual, social and economic support from the communities in which they live • Monks are traditionally teaching communities but do not have the knowledge to include HIV/AIDS in their teaching; they support communities in their development activities, but not do not address HIV/AIDS in a structured way
5 Purpose of intervention	1 To provide Buddhist monks with an opportunity to take part in HIV/AIDS prevention and care 2 To establish a network of Buddhist monks capable of working in HIV/AIDS prevention and care 3 To help Buddhist monks identify roles they can play in HIV/AIDS prevention and care 4 To provide Buddhist monks with accurate and up-to-date information on HIV/AIDS prevention, transmission and care 5 To organize seminars, workshops and training programs for Buddhist monks, nuns and novices 6 To equip Buddhist monks, nuns and novices with participatory social management skills to enable them to work more effectively in HIV/AIDS prevention and care 7 To serve as a resource centre providing information and materials on HIV/AIDS 8 To promote and support the role of Buddhist monks, nuns and novices in HIV/AIDS prevention and care 9 To cooperate and coordinate with other organizations working in HIV/AIDS prevention and care
6 Context	94% of the Thai population is Buddhist. The temple and the monks, nuns and novices who live in the temple are the centre of spiritual and social well being in all communities. Because of their faith in Buddhism and the respect that they have for monks, community members listen to what monks have to say and uphold their teachings as truth. At the end of 2001 there were more than 1 million PLWHA in Thailand and there is hardly a community in Thailand that has not been affected by HIV/AIDS, in one way or another. A multi-sectoral approach that involves government, religious organisations, NGOs and the community is needed to address impacts and develop effective approaches for prevention. If the HIV/AIDS problem is to be solved it should be dealt with locally. To enable this to happen, all communities need to be made aware of the problem, its impact on their community and the need for their cooperation in solving it. Once awareness has been raised, the community has to be given assistance in identifying ways to solve the problem and in developing plans and strategies.
7 History and process	The Sanga-metta project was initiated by monks themselves in 1997 in response to the need for monks to have a more active role in HIV/AIDS prevention and care. Taking the Buddhist teachings as their inspiration, they concluded that a core aspect of HIV/AIDS was ignorance about the condition both among those infected and the general public. In line with their traditional role as teachers, they decided they could teach both groups about its realities. Within this basic framework, the project teaches monks, nuns and novices about HIV/AIDS, taking as a starting point the Four Noble Truths of Buddhism – Dukkha (Suffering); Samudaya (the origin of suffering); Nirodha (the cessation of suffering); and Magga (the path leading to the cessation of suffering) and replacing dukkha (suffering) with HIV/AIDS. The Buddhist way to overcome suffering is by following the Noble Eight-fold Path that includes right understanding, right thought, right speech, right action, right livelihood, right effort, right mindfulness, right

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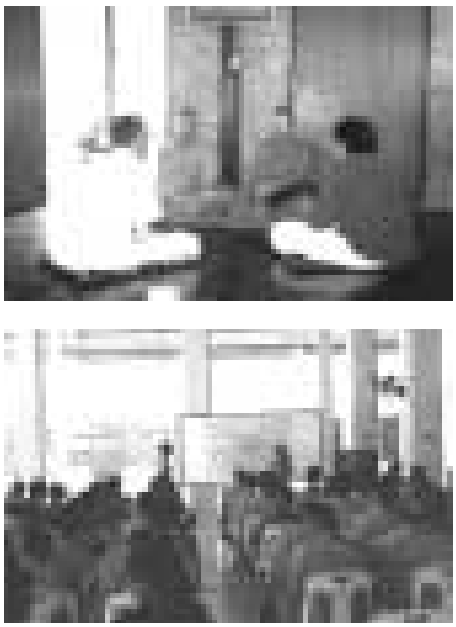
	concentration. These can also be applied to HIV/AIDS. It also equips the monks with modern participatory social management skills and tools so that they can in turn work effectively in their communities both to prevent further HIV transmission and to help people living with HIV/AIDS and their families. One of the most important developments is that, in contrast with their traditional formal roles (where the monks wait for the community to come to them), the project trains monks to have a more active role in community work. Using Buddhist ethics as their guideline, they now teach villagers how to avoid high-risk behaviour, help to set up support groups, train people with HIV/AIDS in handicrafts, donate their alms and take care of AIDS orphans. Because local people are accustomed to telling monks their troubles, the latter have become a conduit for identifying many secret HIV+ people who, once identified, can be referred to support groups and public assistance programs. 'HIV-friendly' temples encourage these people to participate in community activities. They also provide training in meditation as well as grow and dispense herbal medicines in collaboration with local hospitals. This more active role among monks is strengthening trust between them and the people. It is also developing community potential and encouraging greater grass roots participation in solving problem at the local level. Because the project has given monks a way to become actively involved in their communities, something they have always wanted, it is spreading rapidly into other regions of Thailand and in neighbouring countries such as Cambodia, Laos, Myanmar, Vietnam, Bhutan, Mongolia and China.
8 Steps in implementation	1 Conduct training seminars with monks, nuns and novices. Topics covered are basic knowledge on HIV/AIDS, the impact on the community and development and its socio-economic impacts. This is then applied to Buddhist teachings to increase understanding. Monks and lay people engaged in community development work are invited to talk and also this is applied to Buddhist teachings. Also PLWHA are invited to talk about their experiences, their needs and wants from the monks and the community. In addition, the training covers participatory skills, life skills education and social management skills. At the end of the seminar they realise that HIV/AIDS prevention and care are an integral part of community development work 2 Trainees return to their temples and conduct 3-5 day seminars similar to those they attended for other monks and lay community leaders (including village headmen, members of the village development committees and representatives of the local government council) to ensure participation of people responsible for the development and well being of the community. The monks and lay community leaders work in groups to draft action plans and devise strategies for managing HIV/AIDS related problems at the community level. They also identify potential problems and obstacles and work out ways to solve or avoid them 3 In the community HIV/AIDS action groups are set up and community members are collaborating with the monks, existing NGOs and local government staff to develop their work 4 As an ongoing activity, monks carry out home visits for advice and spiritual support, give counselling, give health care and refer to health services 5 They give seminars on HIV/AIDS related topics and especially prevention topics (awareness raising, narcotics and substance abuse, Buddhist values and the five precepts of Buddhism) to special target groups such as youth, orphans, schools, PLWHA. In this they make use of participatory and life skills approaches 6 They promote and support community initiatives such as income generating activities, orphan care, herbal gardens and network with supporting organisations 7 The Sangha Metta project organises specialised seminars on topics such as child and adult counselling, facilitation skills, media at different levels (district, provincial, regional) to further train the monks. It also gives technical advice for projects set up by monks in the communities 8 The project is involved in other activities such as youth camps, vocational training, an information resource centre, education fund, a milk bank, a medicine bank, an alms offering bank, a funeral robes bank
9 Duration	From 1997 onwards and expanding to neighbouring Buddhist countries
10 Resources required	• Staff (5) • Skilled facilitators to conduct the seminars • Resource persons for the seminars (doctors, public health officials, PLWHA) • Transport • Office equipment

Section	Content
	• Funds for rent of space for the seminars, food and accommodation • Funds to support special activities (see under 8)
11 Indicators for monitoring	• Number of monks trained (over 5000) • Evaluations at the end of the training seminars • Number of seminars conducted at local level by trained monks • Number of communities that have initiated action plans with support of the monks • Activities carried out in the communities
12 Impact	• Raised awareness with monks, nuns and novices on HIV/AIDS and its impact and ability to teach this in the community • Ability with the monks to integrate HIV/AIDS in their Buddhist teachings and to have a greater and more influential role in community development and social welfare • Greater cooperation between monks, communities, local government administration, public health sector, schools and other relevant sectors • Monks promote and support many activities in the communities, resulting in increased awareness, decreased stigma, greater solidarity and hence increased care and support for PLWHA and their families • Behaviour changes are taking place in the communities where monks are active and people are involved less in risk behaviour (visiting sex workers, substance abuse) • PLWHA receive counselling, spiritual guidance, care and support from the temple
13 Challenges and pitfalls	• Organisation of resource persons for the seminars is not very easy as they are paid only a small incentive • Often monks ask for support of their community activities, but the project feels quite strongly that such activities need to be financed from the temple donations in order to be sustainable • Initially the attitude of the higher Buddhist officials was not very supportive, but this has changed with the success of the project
14 Critical issues and lessons learnt	Through this approach, those trained have become aware that HIV/AIDS is a serious socio-economic issue with potentially devastating impacts on future development. It is something that affects everyone and everyone must unite to respond to the crisis if they are to ensure a peaceful, happy future. Participants recognize that all the resources needed to confront this crisis are already available in their own community. They learn how to identify those resources and how to mobilize them in the fight against AIDS. When people unite, it is the community working together for the benefit of the community. When they don't unite, it is the community who suffers.
15 Source of practice and dialogue	Sangha Metta Project (Project manager: Laurie Maund), Wat Sri Suphan, 100 Wualai Road, Soi 2 Tambon Haiya, Muang District, Chiang Mai, Thailand 50100 laurie@cm.ksc.co.th www.buddhanet.net/sangha-metta/project.html
16 Editor's note for learning	This is an exceptional good project because it builds capacity in a target group that reaches the majority of the population in Thailand (or any Buddhist country). It not only enables the monks, nuns and novices to integrate HIV/AIDS in their Buddhist teaching, but also equips them with methods to reach out effectively to different groups in the community through participatory approaches and life skills. The approach moreover is highly sustainable because the trained monks in turn train others and community initiatives are funded by temple donations, private donations and by linking to funded government activities.

Picture: Monks give meditation instruction to people living with HIV/AIDS



2 Club Cool Project, Haiti

Developed by: Population Service International (PSI), Haiti
Key words: Youth, sexual and reproductive health, income generating activities, Haiti

Section	Content
1 Summary of the practice	A total of 24 youth clubs, called Club Cools, were set up to run educational and entertainment activities in schools and communities. A magazine was developed, *Journal Jenn Yo*, to reach Haitian youth with entertaining information on reproductive and sexual health issues.
2 Level of intervention	Community level
3 Prospective users of the practice	NGO's, local government authorities who want to start up initiatives to reach youth
4 Problem addressed	• Young people in Haiti are at high risk of contracting HIV but harbour many misconceptions about their personal risk • Half of all youth aged 15-24 reports they have never used condoms with their regular partners. Lots of rumours and misconceptions circulate about HIV/STI prevention through condom use
5 Purpose of intervention	• To educate and train Haitian youth in HIV/AIDS and STI prevention, family planning, sexual awareness, condom negotiation and other skills • To provide entertainment and income generating opportunities for adolescents through local community organisations (Club Cools)
6 Context	• Haiti has the highest rate of HIV/AIDS in the Americas. In addition, it is estimated that 48% of all Haitians has at least one STI • Young people in Haiti begin sexual activity at a very early age: a national survey found that 67% of adolescents interviewed had sex before they were 15 years old, and 43% said they had had more than four partners • Ninety percent of Haitians who are HIV positive acquired the infection during adolescence or early adulthood • Due to the socio-economic situation, and security problems, there is a lack of parks, sport fields and other places for adolescents to meet and entertain themselves • Unemployment rates in young people are high. This places young people at a particular risk for early sexual activity. At the same time, Haitian adolescents are looking for ways to entertain themselves and become involved in community activities
7 History and process	• The first Club Cool was developed in Port-au-Prince out of a focus group organised by PSI/Haiti to test messages for a youth magazine *Journal Jenn Yo*. Adolescents in the focus group came from various parts of Port-au-Prince, and represented diverse socio-economic backgrounds. There was a general sense of excitement to become part of AIDS prevention work, and after a second focus group, the participants decided to form a youth club • They approached PSI/Haiti for training in peer education, and to help them become involved in community HIV/AIDS prevention work. This group became the first Club Cool • Subsequently, interested adolescents in each of Haiti's nine regions were identified by PSI to form their own local Club Cool. They proved their commitment and motivation by identifying and securing the facilities. PSI/Haiti then assisted in developing the organisational structure of each Club Cool
8 Steps in implementation	1 **Membership and recruitment**: Club Cools are initiated when a core group of young people is able to identity 25 potential club members and petitions PSI/Haiti to establish a club in their area. PSI/Haiti then provides assistance with the development of goals, objectives and implementation strategies including income generation activities 2 **Club Cool development**: Each Club Cool elects a board, comprised of a President, Vice President, Secretary, and Treasurer, and develops a management structure based on an established Club Cool constitution. The Board is responsible for identifying a facility adequate for meetings and activities, supervising the implementation of the strategies and for meeting the Club mandate. Club members are responsible for implementing the activities

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	3 **Peer Education Training**: Board members receive training to assist them with management and leadership responsibilities. PSI/Haiti staff also provide training and technical assistance in HIV/AIDS and STI prevention, sexual and reproductive health, peer education techniques, and counselling skills 4 **Further Technical Training**: Adolescents who are interested in learning sales skills are trained as Club Cool vendors that sell condoms directly to consumers. The three-day training includes information on reproductive health, social marketing goals and strategies, interpersonal communication, sales techniques, condom use and demonstration, and field practice **Activities of Club Cool members:** 1 **Peer Education**: Club Cool members organise various educational and entertainment activities designed to convey messages about reproductive and sexual health. A wide variety of activities, such as theatre and dance presentations, movies and sporting events, are used to capture the attention of youth and provide a medium for conveying information in an exciting and interactive manner 2 **Contribution to the Journal Jenn Yo**: Ideas and contributions from Club Cools are featured in PSI/Haiti's monthly youth magazine, *Journal Jenn Yo, which* serves as a forum to advertise Club Cool activities and to present entertaining information on reproductive health to youth. Each Club Cool sells *Journal Jenn Yo*, which enables wide dissemination of the magazine across Haiti and also provides a source of income generation for the Clubs, thereby improving overall sustainability 3 **National Club Cool Festival**: PSI/Haiti organises an annual workshop to exchange ideas amongst the various Club Cools. The workshops also serve to bring together peer educators who provide training and presentations to young people and show locally produced videos that feature youth celebrities
9 Duration	The Club Cool program began in 1997. Now in its 5th year of operation, the network has expanded from the initial ten clubs to 24 clubs throughout the country in 2002
10 Resources required	To get started, the Club Cool program secured $ 75,000 in funding from UNFPA and the Dutch Embassy in Haiti. Considerable investments were needed for the training of peer educators. Additional resources went to club sponsorship, the development of educational materials, promotional activities and AIDS day and Carnival workshops. Monthly sales from the *Journal Jenn Yo* also provide local Club Cools with revenues
11 Indicators for monitoring	• Number of Clubs established • Type of activities initiated • Number of members • Achieved outputs • Type of training completed, with number of participants, achieved training plans and follow up of trainees • Revenue, sales and distribution data are collected monthly and compared with objectives. Data include the number of male and female condoms sold by Club, by sales outlet, by geographic location, by sales agent, and the rates of re-stocking • Distribution of the *Journal Jenn Yo* is monitored for each Club and geographic location
12 Impact	• As a result of the Club Cools, hundreds of peer educators have been trained and provide ongoing community education on HIV/AIDS prevention • Myths and rumours about HIV/AIDS prevention have been dispelled • Entertainment and educational activities, using innovative techniques including a local mobile van with video equipment, are likely to have reached thousands of Haitian adolescents • Through their involvement as members of Club Cool, numerous youth have developed important leadership skills as well as gained valuable experience in project planning, budgeting and organisation • Five issues of *Journal Jenn Yo* are produced each year, with 25,000 copies of each issue being printed and distributed around the country. Over 90% of all issues are sold via Club Cools and other partner organisations
13 Challenges and pitfalls	• Over 50% of Haitians are under the age of 18. Due to these demographics, every year, a number of new Club Cool members arrive and older members depart. This rapid turnover of the youth in the various clubs causes occasional disruptions in specific club operations due to lack of consistent leadership. Therefore Club Cools require frequent refresher training's as new leaders are identified and new members are incorporated

Section	Content
14 Critical issues and lessons learnt	• Income generating activities afford a measure of cost recovery, but the Club Cools are not fully sustainable and require continued, albeit minimal, outside financial support
	• Adolescents must be empowered to train and educate each other on reproductive and sexual health issues. To this end, peer educators from each club were involved and encouraged to take the lead in message development, to ensure that activities are entertaining and appealing to their peers. Club Cools have their own elected Board and self established goals and objectives • Club Cools, while primarily designed to convey messages on adolescent sexual and reproductive health, also provide youth with experience in other areas such as democratic governance, micro-credit management and community mobilisation. It would therefore be important to have these Clubs tap into the expertise of other local institutions that could provide expertise and training in these fields
15 Source of practice and dialogue	Moussa Abbo, Country Representative PSI/Haiti C/o USAID/PSI Rue Theodule # 1, Bourdon, Port-au-Prince, Haiti Email: mabbo@hainet.net Jim Malster or Julie Fine at PSI/Washington: 1120 19th St. N.W., Suite 600 Washington, DC 20036, USA E-mail: jmalster@psi.org or jfine@psi.org www.psi.org
16 Editor's note for learning	Similar programmes could be initiated in many countries. PSI has many offices or affiliations in the world and can be approached for funding. The management and leadership training and sales skills training are useful to manage the club cools, and may at the same time enhance future perspectives for employment for the trained youth

3 Community Art versus AIDS project, Togo

Developed by: Focal Point HIV/AIDS, UNDP Office, Lomé, Togo
Key words: Youth, community, contest, awareness raising, prevention, care and support, arts, Togo

Section	Content
1 Summary of the practice	Youth are involved in the creation of a mural which carries a message on HIV/AIDS to their own community and serves as a discussion starter among youth and other community members
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs, Youth organisations, villages, workplaces, any community
4 Problem addressed	• Lack of targeted information on HIV/AIDS for rural youth on specific issues such as living positively with HIV/AIDS and prevention of mother to child transmission • Insufficient opportunities for rural youth to express their creativity
5 Purpose of intervention	• To create open and creative ways of expression and communication for rural youth • Provision of information on risk behavior leading to an understanding of the relationship between behavior and transmission of HIV/AIDS • To create 40 messages on positive living with HIV/AIDS targeting rural youth in a public space • To promote the rights of people living with HIV/AIDS and their families • Creation of awareness on vertical transmission as one of the three modes of transmission of HIV
6 Context	• Prevalence of HIV in Togo according to latest surveillance in 1999 is 6% • A national multi-sectoral institutional framework, Conseil National de Lutte contre le SIDA (CNLS) was created by presidential decree in October 2001 and there is an increasing awareness and interest HIV/AIDS issues among governmental and non-governmental organisations • Information and awareness campaigns on HIV/AIDS have been carried out throughout Togo, but have mostly been concentrated in the urban areas, in particular in Lomé and the Maritime region • The prevalence of HIV is high amongst young people; however, their perception of risk is still relatively low • Youth in rural communities are more difficult to reach due to a number of factors, including low school attendance rates, and relative geographic isolation of villages
7 History and process	The project is a collaboration between UNDP, UNICEF, and the Peace Corps Volunteers and the communities in which the Peace Corps Volunteers are located. Peace Corps volunteers facilitate a public discussion within their communities on a specific AIDS-related theme, assist in the creation and selection of a drawn message for the community, and organize the painted visualization of this message in a public space. A jury of representatives from various organizations, including people living with HIV/AIDS, selects the village with the most effective and powerful message answering one of the following questions: • How can we support persons living with HIV/AIDS and their families, both emotionally and practically? • How will our community support HIV-positive pregnant women, their newborns, and their partners? • How can we prevent HIV/AIDS as individuals and as members of our community? On the World AIDS Day, an award ceremony with festivities is held in the winning village
8 Steps in implementation	**1 Identify and assemble a team.** Think about youth groups and out of school youth, take gender balance into account. Start with a large enough groups to allow for the normal drop-out rates, core team of 8-15 people. It may be a good idea to establish some group membership rules, especially in communication and attendance

Section	Content
	2 Assess knowledge and attitudes. This has to be the basis of the messages and also provides an indicator to assess change as a result of the murals. The project used a questionnaire that measures knowledge and attitudes about HIV/AIDS among the participants **3 Identify topic**. The mural can answer any of the questions mentioned in section 7. Help the group brainstorm their ideas and their visualisation through art. Give the team members a few days to come up with designs, and then reassemble to collectively choose a design for the wall (anonymous voting is encouraged). At this time also discussions can take place on HIV modes of transmission, and on myths and facts, to make sure that everyone is on the same knowledge level **4 Identify an appropriate wall with the group and seek permission from the appropriate authority.** Identify a wall with little direct sunlight and rain. If the mural is to be painted on a school wall, ensure permission of school and village authorities. Show the final project design for approval **5 Choose approach**. Decide if other types of behaviour change interventions should also be developed during the process or an exclusive focus on awareness raising. Factors to take into consideration include: the level of knowledge of HIV/AIDS transmission and prevention among target population, time available for team meetings, and the possibilities for linking it with other ongoing work **6 Set a timeline.** Set up a schedule with the team for the prevention/behaviour change activities, as well as the drawing and painting. Painting usually takes three days for paid professionals- it may take longer for the team, depending on the motivation and organization of the group **7 Sketch designs and lesson plan.** Individual members of the group make a sketch of the mural based on the theme identified. There are certain basic art skills such as colour mixing, line, and proportion that may need to be covered to help the team better express their ideas. Create an encouraging atmosphere to allow expression of creativity and feelings. Display all the drawings at the end of the session and talk about art skills, and then use the themes of the drawings in the next session to talk about the topic **8 Select a design.** A team can either select one drawing democratically, or combine elements of the separate drawings into one group mural painting. The mural has to have an overall coherent style that can be understood by its audience. Make a group draft before the final painting; test the design on target group members to see if they understand the basic message **9 Paint the mural.** Keep an overview of the whole mural- to ensure coherence. Ensure equal participation in creating the mural by creating alternative tasks to keep dominant members occupied **10 Village opening ceremony.** Mobilize the whole community and let the youth speak out and present themselves in a positive manner as a vital asset in the fight against HIV/AIDS Optional: **11 Jury visit & Village celebrations.** A jury composed of representatives from various organizations working on HIV/AIDS visits each completed mural site and selects one mural as the winner. The winning village holds celebrations, hereby press can be invited, as well as high level representatives of the government and donor community **12 Evaluation** with the group on the process. Assess and compare knowledge and attitudes on HIV/AIDS with assessment at the start
9 Duration	The duration of the activity depends on the amount of awareness raising that is taking place in the process, on the size of the group and the size of the wall
10 Resources required	• Paint, brushes • Preparatory drawing materials • Transport • Finances for village party • Per diem jury • Total budget for 40 village murals U$ 4900 (UNDP/UNICEF)
11 Indicators for monitoring	• Number of murals created • % of participants who can list the three modes of transmission of HIV/AIDS • % of participants who can list the three methods of HIV/AIDS prevention
12 Impact	• Art versus AIDS has elicited a tremendous response from the Togolese public – As one market woman put it: 'You can bring your boy or girl here to teach them how to stay healthy, how to live longer' • While the activity takes place at community level, the scope of the project was regional and national. The nation wide competitive element stimulated local youth to do their very best • Nationwide and local visibility of key problems of the HIV/AIDS epidemic

Section	Content
	• For host villages and their volunteers this project left a concrete memory of the volunteer after his/her departure • Mobilisation of a wide range of village leaders and youth • Mobilisation of regional AIDS activists as they work together as jury members • Facilitation of networking between regional experts and rural youth
13 Challenges and pitfalls	• It is crucial to assure the logistics are well taken care of. Every village, even the most remote one, should receive information, paint and tools at the same time The Peace Corps has a weekly mail delivery system by road, which was used to reach volunteers • All jury's should use the same criteria for which this project used a standardized jury form • A coordinating and facilitating body is crucial and needs people experienced in art and with basic understanding of the issues surrounding HIV/AIDS
14 Critical issues and lessons learnt	• Even though murals are visual, it remains difficult to reach illiterate unorganised poor people. One stops to watch the murals but needs strong encouragement to ask questions about the themes • More follow up activities, such as informative talks and sketches could be undertaken at these new murals to keep the discussion on HIV/AIDS going
15 Source of practice and dialogue	Focal Point HIV/AIDS, UNDP Office, Lomé, Togo. fo.tgo@undp.org or For pictures see http://www.pnud.tg/artvsaids/
16 Editor's note for learning	• This approach is a very interesting way to raise HIV/AIDS in a manner that is accessible not only for youth, but for communities as a whole. It would be interesting to find out the impact of the murals on the general public: does it lead to a more open discussion on HIV/AIDS, does it increase levels of knowledge and can it be used to mobilize youth on further AIDS awareness activities or as the start of a process of making action plans to address the topic of the mural (e.g. organizing care and support activities) • The questions that are raised in section 7 can be adapted to any other problem to be addressed • This type of intervention could also be used in a workplace environment

Picture: An example of a mural

4 Community Centre for IDUs, Ukraine

Developed by: 'Eney' Club with the support of the International HIV/AIDS Alliance in Ukraine and International Renaissance Foundation, Ukraine
Key words: IDU, self-help, syringe exchange, counselling, Ukraine

Section	Content
1 Summary of the practice	A community centre for Intravenous Drug Users (IDU) provides counselling, referral to other services, syringe exchange, self-help as well as information and preventive messages to IDUs in Kiev
2 Level of intervention	Community/municipal level
3 Prospective users of the practice	Active groups of IDUs, AIDS service organisations, health care providers, governments and NGOs/CBOs
4 Problem addressed	• The risk for HIV infection in IDUs is very high • IDUs need information on HIV prevention and on support mechanisms to IDUs with HIV • IDUs need peer psychological support • IDUs have poor understanding and knowledge of Ukrainian legislature on drug use and human rights • IDUs face numerous social problems
5 Purpose of intervention	• To provide support to active and former IDUs and PLWHA by conducting self-help groups every other day • To identify and involve new IDUs into the programme of 'Eney' Club • To minimise the risk of HIV transmission and to dispel myths and misconceptions about HIV/AIDS in the community of IDUs of this district of Kiev through syringe exchange, counselling on medical issues and referral to relevant services • To improve the life of IDUs and to help them solve legal, medical and social problems via counselling on legal issues, referral to relevant medical and social services
6 Context	• HIV epidemic in Ukraine is IDU-driven with 72% of adults with HIV having been infected via injecting drug use (official data as for October 1, 2003) • There are about 75 thousand officially registered IDUs in Ukraine; recent research by the Centre 'Social Monitoring' estimate there are about 560 thousand IDUs in the country; the same research says that about 15% of IDUs in Ukraine are being reached by the work of HIV-service NGOs • Total population of Kiev is 2.6 million • Official data for IDUs in Kiev is 7300; estimated number is about 30 thousand, with average age of 26-30 years • Services for IDUs are provided by government services such as substance abuse clinics, STI clinics, TB clinics and other medical institutions, centres for AIDS prevention, centres of social services for youths and rehabilitation centres. Services are also provided by NGOs and these are most friendly and most efficient • Free of charge condoms and syringes remain to be the most efficient mode of HIV prevention among IDUs • There still remains great need in information on HIV/AIDS, various legal and social aspects in IDUs in the country • Drug use is indirectly criminalized in Ukraine (there is no punishment for using drugs, but it is prohibited to carry certain doses of drug substances, to cook drugs and to sell them), nevertheless harm reduction is recognised as an effective measure of HIV prevention and supported by the relevant ministry decree
7 History and process	• Club 'Eney' started as a self-help group for IDUs in 1993 in Kiev but they didn't get officially registered until 2000. They had 7 members at that time • In 2001 they developed with members and with the support of the International HIV/AIDS Alliance in Ukraine, a proposal for a HIV prevention project among IDUs of Kiev and suburbs. This proposal entailed a needle exchange programme, self-help groups, provision of counselling on HIV/AIDS, legal counselling, solving questions in dealing with police, and referrals to other relevant services

Section	Content
	• From the very beginning of its activity 'Eney' managed to establish friendly relations with local authorities of Kiev • In 2002 'Eney' concluded a 3-side agreement with Centre for Social Services for Youth and AIDS-Centre in Kiev on mutual support of activities • In the Autumn of 2002 they started needle exchange in one of the buildings on the grounds of the city AIDS-Centre and Hepatitis Hospital. This is actually the place where many IDUs from all around Kiev gather to have their diseases treated. There is a drug dealing spot located right near the hospital and it was especially important to organise a needle exchange right beside the drug selling and using point • 'Eney' started repairs of this building by the efforts of their own members and finished the work in the spring of 2003 • Since this time they are carrying out all activities as proposed in the plan from this centre. Self-help groups follow the 12 steps programme using the method of group therapy. The main task of a self-help group is to help those who want to quit using drugs. Therefore it gathers former and active drug users to discuss problems under the facilitation of one of the group's members. The group elects the facilitator for 6 months or a year to facilitate once a week. So there are several facilitators every week and a different facilitator every day • Every month 25 new IDUs and about 4 newcomers are entering self-help groups • Within a year of operation Eney reaches about 15% of the IDUs of the district of Kiev in which they are working
8 Steps in implementation	1 Getting registered as an HIV-service organisation 2 Establish among the members priorities for activities 3 Establish good working relations with local authorities (possibly concluding an agreement on mutual assistance) 4 Identify partners to support a community centre and write a project proposal 5 Carry out a situation analysis and assess the most appropriate place for such a centre taking into account the local drug scene 6 Organise all the agreements and permissions needed for operation 7 Find an organisation to manage disposal of used syringes and make up a contract 8 Get the premises and arrange the necessary renovation 9 Buy syringes and start the syringe exchange, meanwhile give information about the future programs of the centre 10 Acquire, develop, print booklets on HIV and other social issues to distribute in the centre 11 Identify staff members to work in the centre. All 'Eney' staff are former drug users and have no problem getting access to IDUs (self-help can hardly be organised by an outsider) and specialists to counsel on relevant topics, and identifying friendly services for drug users for referrals 12 Implementation of syringe exchange, outreach work to attract more people into the 'Eney' programme and facilitation of self-help group and counselling 13 Implementation of needle disposal
9 Duration	The project started in October 2002 and is ongoing
10 Resources required	• Syringes, condoms, containers for the used syringes • Premises and some minimal furniture for the centre • Tea, coffee supply for the visitors of the centre • Leaflets on HIV, legal questions and other relevant issues with information on other activities of the organisation • Funds for staff salaries and operational management • Trained staff and counsellors for relevant issues
11 Indicators for monitoring	• Number of people making use of the syringe exchange (newcomers and regular visitors) • Number of consultations and people served • Number of self-help group members (newcomers and regular visitors) • Number of casual visitors • Documentation distributed • Number of syringes and condoms distributed and syringes exchanged • Number of people that visit the head office of 'Eney' and become involved in the main activities of the club • Number of people starting to volunteer for the club • Feedback book for the visitors of the community centre • Reports of consultants and facilitators of the self-help groups

Section	Content
12 Impact	• IDUs have access to clean syringes and condoms, information, education, communication, counselling and referral • IDUs provide peer support in self-help groups • 'Eney' is organising disposal of the used needles that used to lie all around the place so now the place is clean and is less dangerous for passers-by • Doctors in the hospital and AIDS-Centre are aware of the programme, highly appreciate its work and refer their patient IDUs to 'Eney' • The centre facilitated behaviour change in many IDUs, several of them have quitted using drugs and started volunteering for 'Eney', taking pride in managing to live without drugs • The programme was accepted by the authorities in the country's capital which serves as an example for other regions
13 Challenges and pitfalls	• Problems exist because drugs are sold and used right besides where the centre is located and many syringes may lie around the place causing negative reaction to the centre's activity. This problem is easily sold via organisation of utilization of the disposed syringes • As drugs are used right besides the point, staff working in the centre have to be very familiar with and ready to work with people being high • Syringe exchange has to be regular as breach for even a day's functioning can lead to dangerous outcomes for the clients. So there have to be at least 2 staff members responsible for the exchange • It is difficult to motivate IDUs for safer behaviour
14 Critical issues and lessons learnt	• It is extremely important to establish good working relations with local authorities, including the police, and the organisation providing the premises. Drawing up a written agreement is a good idea • The syringe exchange point should be located near the places of drug use • It is very important to continuously involve new and young IDUs in the programme • Self-help group should be carried out as often as possible (ideally every day) • Members have to develop a sense of ownership and collective responsibility to make the programme work
15 Source of practice and dialogue	International HIV/AIDS Alliance in Ukraine Victor Isakov, NGO Support Officer Dimitrova 5, building 10 A, 6th floor Kiev 03150 Tel: +38 044 490 54 86, 490 54 87, 490 54 88 E-mail: deshko@aidsalliance.kiev.ua, isakov@aidsalliance.kiev.ua Website: www.aidsalliance.kiev.ua
16 Editor's note for learning	At the present stage of the HIV/AIDS epidemic in Ukraine it is necessary to reach large numbers of IDUs. Although needles and syringes are freely available in Ukraine and not very expensive, it is the change in attitude that is most important. By offering comprehensive services in the community centre, catering for various needs of various groups of clients, more drug users are attracted and can eventually be motivated for safer behaviour

Picture: Participants of a self-help group at the Eney club

5 The Condom 'Krew', Trinidad and Tobago

Developed by: YMCA, Outreach Department. Trinidad
Key words: Youth, sexual and reproductive health, STI/HIV, condom promotion, Carnival, Trinidad, The Caribbean

Section	Content
1 Summary of the practice	'The Condom Krew' is an intervention focussing on the provision of condoms and information on their procurement, storage and use. The 'krew' has as its main strategy the infiltration of social events such as parties and public premises where people socialize. The bulk of its work is done during the carnival season, a time when it has been shown that there is an increase in sexual activity
2 Level of intervention	National and community levels
3 Prospective users of the practice	NGO's, CBO's and Peer education groups who target especially urban youth
4 Problem addressed	• Increased sexual activities during the carnival season • The spread of sexually transmitted infections (STI) and HIV through unprotected sexual contact • Inaccurate information about condoms
5 Purpose of intervention	Inform and provide condoms to sexually active groups especially in places / events where sex is negotiated.
6 Context	Trinidad is well known for its annual carnival that gathers the population and tourists from different parts of the country and the world. National statistics and the Caribbean Epidemiology Centre (CAREC) year 2000 record of people living with HIV/AIDS in Trinidad and Tobago indicate that: • Rate of pregnancies increases during the post carnival period. • Young people between the ages of 15 –24 are engaging in unsafe sexual practices, noting a 45% increase in the rate of HIV infection amongst youth • An increase in the number of persons aged 15-27 treated for sexually transmitted infections
7 History and process	• Noticing these trends, YMCA worked with a group of key young people (the 'Krew') representing various agencies working on HIV/AIDS awareness in Trinidad and Tobago to come together to provide and promote the use of condoms. Different stakeholders such as condom promoters, condom manufacturers, UNAIDS, CAREC and the National AIDS Programme (NAP) each saw the advantage of the intervention (for instance manufacturers saw the potential to have their brand marketed without them spending large sums on an advertisement campaign) • The Carnival season was selected as the point of introduction for this activity, Carnival being the most sexually charged cultural season in Trinidad and Tobago • The 'Krew' is now focused on expanding its outreach to include a community-based approach throughout the year during other cultural and entertainment events, and sporting events
8 Steps in implementation	1 **Planning**: YMCA contacted organisations and groups involved in HIV/AIDS related work or in the field of sexual and reproductive health and rights. On the basis of existing activities of the organisations, relevance, comparative advantage and barriers to cooperation were discussed 2 **Organisation**: The 'Krew' secured storage space for condoms at the store rooms of the Rapport/NAP. Main sources of condoms were the NAP and condom manufacturers and distributors. In addition procurement of cloth for the making of the condom 'krew' flag and plain t-shirts for printing; identification of a printer for the flag and t-shirts for the 'krew'; transport for the conveyance of the 'krew' members, condoms and flag; planning for 'krew' members attendance at events 3 **Advocacy**: Contacts with party promoters to secure entrance to their events and with possible sponsors to bear the cost of entrance fees to parties, t-shirt and flag cost, transport cost and condoms if they have to be bought. Coordination with ongoing awareness raising activities on condom promotion and on promotion of the event

Section	Content
	4 **Implementation**: The locations are selected for their attendance of young people and their history as a meeting place (incidence of sexual activity during or after parties)
9 Duration	2000 to present (every carnival season)
10 Resources required	• Crew members (at least 10 members per event) • Condoms (from Rapport/NAP, the NGO ASPIRE, Durex and was approached by the manufacturers of SLAM condoms) • T-shirts, flags • Transport • Condom pamphlets • Entrance fees to parties • Storage space for condoms
11 Indicators for monitoring	• The number of condoms distributed at one event • The number of condoms (intact) seen strewn on the floor of the event. This is done by surveying the premises after the event is over to get a brief account of what lies intact or used in and around the premises • The number of condoms (used) seen strewn in and around the premises of the event assessed in the same way as above • The number of condoms distributed over a stated period • Number of cases of STI's post season and in general. The Krew acquired results of treated and reported STI cases from the Queens park clinic and the Monitoring department of the Ministry of Health public labs • Number of people seeking condoms at the various organizations from which they are available • The duplication of the condom 'Krews' methodology of distribution at parties and other social hot spots
12 Impact	• The Condom Krew has successfully distributed approximately 5,000 condoms per carnival event for the year 2000. Over the past 3 years the 'krew' has successfully sustained its efforts without funding, distributing an average of 30,000 condoms per carnival season • An increase in condom use among the youth population aged 15 – 25. The evidence for this is the increase in distribution at the Rapport and Family Planning Association drop in centres. The Krew has also done its on-the-spot surveys at the events and has detected an increase in the number of people who would say yes rather than no. In addition the Krew keeps track of distribution figures from its own stock of condoms • The popularity of the phenomenon of the Party Krew and heightened awareness of condoms by the public as evidenced by an increase in the number of public condom debates (television and radio segments, symposia on contraception). Attribution to the Krew's activities are ascertained during these public debates by questions in relation to the Krew's activities or distribution material and often involve Krew members as panellists. One of the Krew member groups AYSHR (Advocates for Youth Sexual and Reproductive Health and Rights) has been responsible for sparking a great deal of debate • Stimulation of research to ascertain patterns of condom use by sex, age, sexual orientation etc. in Trinidad and Tobago
13 Challenges and pitfalls	• Securing a consistent supply of condoms • Condoms provided by the NAP, which were close to expiration on one occasion • Securing access to a brand of condoms trusted by the public • The willingness of some promoters to allow only small numbers of the 'krew' into the party free of charge • No consistent sponsorship to help defer operational costs • Cultural association of condoms with infidelity, which made some people self-conscious about the idea of taking condoms publicly • Limited human resource i.e. the same people having to attend all events every night during the carnival period and then work by day can be very exhausting
14 Critical issues and lessons learnt	• Access to a brand of condoms trusted by the public is key to a good starting response • The maintenance of good relationships with promotional organizations rather than just individuals is important • Membership should consist of individuals capable of answering any question asked and able to do a proper condom use demonstration

Section	Content
	• The securing of a sponsor for a long-term period like 3 years will eliminate the need to be constantly searching for means of covering of operational costs • If the Condom 'Krew' is to consist of several groups, there should be intermittent meetings to assess needs and issues arising • While there may be members who work tirelessly in the field of HIV/AIDS, there may be religious and value related issues to hinder participation in the activities of the intervention
15 Source of practice and dialogue	YMCA, Outreach Department Benbow Road, Off Wrightson Road, Pot-Of-Spain Trinidad, W.I. Contact – Gregory Sloane-Seale, Outreach Director, sloaneseale@yahoo.com; Svenn Grant, Community Outreach Coordinator, svenngrant@hotmail.com, Tel: +1 (868) 627-7835, Fax-1 (868) 627-8764
16 Editor's note for learning	• It is not clear if distributing condoms will enhance their actual and consistent use. However, this rather 'aggressive' way of condom demonstration and promotion does provide condoms – in a timely manner – to those in need, especially during carnival seasons and in places where sexual activities are known to be negotiated and performed • The practice highlights collaboration rather than competition of several organizations in an attempt to spread information on condoms in places where sexual activities are negotiated and to promote the use of condoms. At present the Krew membership includes ASPIRE, YMCA, THE RAPPORT, AYSHR, with support of UNAIDS

6 Outreach Program targeting Hong Kong China cross-border travellers

Developed by: AIDS Concern, Hong Kong
Key words: Truck drivers, awareness raising, prevention, condoms, Hong Kong

Section	Content
1 Summary of the practice	A community-based outreach programme targeting cross-border drivers and other frequent Hong Kong-China travellers
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs, government services
4 Problem addressed	The number of cross-border drivers who pass through the busiest border access points range from 7,000 to 25,000 round trips per day. Local research has shown that many of these drivers visit sex workers in China often without using condoms
5 Purpose of intervention	This project aims to increase HIV/AIDS and safer sex knowledge and condom use among cross-border travellers and drivers through outreach efforts at border access points
6 Context	• The Hong Kong Department of Health STD/AIDS statistics revealed that for the period April 2001 to March 2002, HIV transmission through heterosexual contact comprises over 50% of all new cases. Cumulative HIV cases in Hong Kong now stand at 1798 persons • A report recently released by UNAIDS (2002), estimates that mainland China now has approximately 850,000 to 1,500,000 cases of HIV infection, which could rise to 10 million by the year 2010 • As the volume of travel between Hong Kong and its neighbouring cities such as Shenzhen and Guangzhou increases, a low prevalence zone (Hong Kong) becomes connected to a high prevalence (mainland) area, and HIV can spread further and faster • The building of transport and other infrastructure brings about mobility of workers and communities, and people's vulnerability to HIV transmission in turn rises. Prevention efforts to target a highly mobile population is therefore important
7 History and process	• A safe-sex kit distribution campaign and survey on HIV/AIDS knowledge targeting cross-border travelers was conducted in 1996 • This was followed by the design of a strategic plan to conduct a mass continuous promotion and education program targeting not only cross-border drivers but other cross-border travelers who travel to China by public transportation (i.e. bus and train) as well • Outreach workers for this project were recruited from the target population of current or ex-cross border drivers. At present, half of the staff members for this project are enlisted from this community • In 1999, a large-scale distribution of safe sex kits and leaflets was carried out at two locations including a train station and a bus station • Contact was established with truck drivers' unions, police, cafe owners, and other border access points administrators to ensure support of the project and to obtain permits to operate safer sex booths at the border access points • After travelers became familiar with AIDS Concern's presence, safer sex booths were established for enquiries and direct dialogue with the travelers in order to further influence their safer sex practices
8 Steps in implementation	1 The Project coordinator consults with respective authorities (e.g. vehicle terminal administrators, police) and schedules weekly outreach sessions at border access points 2 Development of materials for distribution 3 The primary outreach activities involve activities-booths set up at Hong Kong-China border locations with a high volume of vehicle traffic ('border access points'). These 'access points' include bus and train stations, vehicle holding areas, container terminals and cafes where cross-border travellers congregate 4 Each outreach session involves 2 workers who interact with cross-border travellers through condom demonstrations, giving out safer sex materials, and answering STD or HIV/AIDS questions raised by the contacts

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	5 During each outreach occasion, cross-border travellers are invited to take part in the condom demonstration activity and if correctly demonstrating the necessary steps to accurate condom use, a small souvenir will be given to them as a token of appreciation and encouragement 6 Following each session, workers record on report forms safer sex items that were handed out and issues being raised during their conversations with the travellers 7 An educational safer-sex video is also shown once a week at border access points to drive home HIV prevention messages
9 Duration	Ongoing, the project formally started in 1999
10 Resources required	1 **Human Resources:** The project requires one full-time coordinator to plan, coordinate, and implement program as well as oversee the design and production of safer sex materials. The project coordinator conducts weekly outreach visits with three additional workers (one full-time and two part-time). Since the project's main focus is on-site outreach, which requires that workers travel to border access points far away from the city centre and interact with a large mobile population, a large labour pool is necessary to prevent worker fatigue and burn out 2 **Safer sex kits, condom instruction cards, HIV/AIDS and STD booklets:** large quantities are produced each year to meet the high border traffic 3 **Volunteers:** their primary responsibility is to pack the high number of safer sex kits 4 **Funding:** Funding came mainly from the government trust fund (The Hong Kong AIDS Trust Fund), and international donors (Levi Strauss Foundation and Japanese Foundation of AIDS Prevention). The cost last year was HKD 600,000 (app USD 77,120)
11 Indicators for monitoring	• Number of outreach sessions • Number of cross border travellers and drivers approached • % of cross border travellers who show correct knowledge of HIV prevention methods • Number of safer sex material (condoms, leaflets, booklets and video showings) distributed • % of cross border drivers who demonstrate correct condom use
12 Impact	• Two surveys, conducted by the Chinese University of Hong Kong for the cross-border prevention program, show that knowledge about HIV/AIDS has increased with the target group (through leaflets) and so has the willingness to use condoms while having commercial sex • In another survey AIDS Concern conducted, 97% respondents claimed that they understood more about safer sex after watching the safer sex film • Of the number of drivers who participated in our HIV oral-fluid antibody test pilot project, 95% of drivers who filled out the post-service evaluation questionnaire felt that the counselling provided increased their understanding of HIV/AIDS, their knowledge on safer sex and of the testing
13 Challenges and pitfalls	• Building a trustful relationship with a highly mobile population is very difficult as they have little time to stay at one location and to interact with outreach workers • It is difficult to discuss safer sex with commercial sex workers clients if people are not willing to admit that they visit these workers • Since they are an extremely diverse group of people, counselling styles and messages have to be tailored to the different types of people who constitute the target group • The success of this project is highly dependent on the receptiveness and support of administrators and other gatekeepers who manage the bus and train stations, vehicle holding areas, as well as legal authorities. For AIDS Concern, maintaining a trusting relationship with these people, can at times be quite a challenge
14 Critical issues and lessons learnt	• Persistence, regularity and the establishment of trust are crucial. Clients are more inclined to disclose personal details such as their safer sex practices if a trusting relationship has been built. Behavioural and attitudinal changes among the target groups increase with regular communication • Trusted relationships lead drivers to offer help with outreach activities, such as recruiting other drivers to participate in the condom demonstrations. This may lead to recruitment of peer educators from among the target group • Condom demonstration activities have shown that a lot of drivers could not properly put on a condom. There was a general assumption among drivers that since they were male, they should naturally know these things • It is important to use different channels of communication. AIDS Concern produced a safer sex video specifically with cross-border drivers in mind. This is shown weekly at border vehicle terminals, where drivers have to wait for instructions. The response to this

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	video has been very positive because the drivers can easily identify with the video's characters (truck drivers) and language used • A pilot HIV oral-fluid antibody test was provided to cross-border drivers during ten weeks. The high response rate for testing showed demand, but many did not return to get their results. This may in part be due to the intensely mobile nature of this population and their highly unpredictable work schedules that make returning after a week for test results difficult. Therefore, other testing processes that may be more suitable such as rapid testing methods will be assessed
15 Source of practice and dialogue	AIDS Concern Margaret Pang, Prevention Officer 17B, Block F, 3 Lok Man Road, Chai Wan, Hong Kong. Tel: +852 2898 4411 Fax: +852 2505 1682 E-mail: Margaretpang@aidsconcern.org.hk Website: www.aidsconcern.org.hk
16 Editor's note for learning	• This is a highly relevant project because truck drivers are at high risk • Because they usually have to wait for a long time at border crossings, they may be more inclined to spend some time on information activities relating to HIV/AIDS • It is also conceivable that sex workers could be reached with information, as they often operate at these crossings

Picture 1: An enquiry booth set up in Lo Wu KCR station. Outreach worker (right) talking to a cross border traveller, giving him a safer sex almanac

Picture 2: Outreach worker discusses HIV/AIDS with some cross border truck drivers in a café in Lok Ma Chau

7 'De Living Room', Trinidad and Tobago

Developed by: Family Planning Association of Trinidad and Tobago (FPATT)
Key words: Youth friendly clinic, sexual and reproductive health, Trinidad, The Caribbean

Section	Content
1 Summary of the practice	Provision of comprehensive sexual and reproductive health services (SRH) in a Multipurpose Youth Centre. 'De Living Room' is a youth-friendly clinic in which young people 25 and under access SRH clinical, educational and counselling services
2 Level of intervention	Community level with focus on Trinidad's capital Port of Spain and its environs
3 Prospective users of the practice	Youth organizations, NGOs, CBOs, Governmental and International agencies
4 Problem addressed	Low use of SRH services among young people
5 Purpose of intervention	To reduce physical and psychological barriers to access of SRH services faced by young people by creating a separate facility, that provides services in a non-threatening environment, with non-judgmental staff, enhanced comfort, privacy and confidentiality
6 Context	• Despite the existence of SRH services, the unmet need among young people is high. This is evidenced by teenage live birth rate (14.1%), extensive HIV/AIDS and STI transmission rates among youth • The fastest growing rate of HIV transmission has been reported among young women between the ages of 14 and 19 • The percentage of females infected with HIV rose from 0% in 1983, to 42% in 1999. Females between the ages of 15 and 45 represent 82% of those cases (UNAIDS, 2000) • Both Ministry of Health and PAHO/WHO are interested in the establishment of a model centre for young people
7 History and process	• FPATT participated in the Adolescent Wellness Initiative, a programme spearheaded by Ministry of Health in collaboration with PAHO/WHO and joined the national delegation on a trip to the Bahamas to learn from their best practices • FPATT conducted Operations Research funded by International Planned Parenthood Federation's I3 (Innovate, Indicate and Inform) Project to identify barriers to the use of its services by youth and to implement interventions to increase the use of these services among males and females under 25 years old • The research involved young people recruited to administer a Client Satisfaction survey to young clients of FPATTs existing Port of Spain clinic and Community surveys to youth who lived within communities in the catchment's area of the clinic. Focus groups with the target population were also conducted • Findings were translated into practical strategies by FPATT and young people involved in the process, and with support of various stakeholders working with youth, such as the YMCA and RAPPORT
8 Steps in implementation	1 **Operations Research - Diagnostic Phase**: Tested the service delivery systems of FPATT with respect to its youth friendliness as well as socio-cultural and economic barriers to utilization. To test the hypothesis that utilisation of the sexual and reproductive health services (i.e. the number of young people 15-24 who seek and receive information, counselling, contraceptives, condoms, pap smears, pregnancy tests from the FPATT) varies with the quality of its service delivery system. Quality is assessed against the variable included in section 11 below 2 **Operations Research – Intervention Phase**: To empower young people to take greater responsibility for their sexual and reproductive health. 'De Living Room' Multipurpose Youth Centre is established. Youth were called upon to assist in the design of the planned dedicated multi-purpose centre, in relation to layout and structure as well as development of the services offered. They were also involved in the naming of the clinic and the official launch, and continue to be involved to this day with regard to the general running of the clinic and other activities of the FPATT, which are youth-centric. A doctor, two nurses and a social worker assist the core group of young people

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	3 **Programme Evaluation** – 'De Living Room' is monitored by a team comprising the Youth Co-ordinator, the Director of Operations and the Programme and Evaluation Officer. The YMCA also have a role to play in the ongoing monitoring of the Centre for they provide the critical youth perspective which helps the Association to gauge its performance with respect to standards for the delivery of youth friendly services
9 Duration	The diagnostic phase of the intervention lasted approximately one month. 'De Living' room was established based on the findings in May 2001 and continues to operate
10 Resources required	**Personnel, cost per Year in US$** • 1 Centre Manager/Youth Co-ordinator - 10,400 • 1 Social Worker (part time) - 3,466 • 1 Doctor (part time) - 4,333 • 2 Nurses (part time) -17,333 • 1 Clinic Clerk - 4,333 • Benefits 12% - 4,983 **Total:** US$ 44,848 **Material resources:** Corporate citizens donated furniture with a total value of US$ 10,333 to 'De Living Room'. These items included: three computers, three computer desks and chairs, VCR, television, refrigerator, two coffee tables, one Living Room Set and one Dining Room set. Other material resources such as medical equipment and filing cabinets valued at US$ 6,450, were purchased with designated project funding
11 Indicators for monitoring	**Qualitative Indicators** • Provider-client interpersonal relations • The youth friendliness of the physical set-up of the service areas • Client comfort with the level of privacy and confidentiality and the competence of the providers • Client satisfaction with the range of services provided • The extent to which FPATT reaches out to youth in marketing its services **Quantitative indicators** • The number of young people who see and receive a) information b) counselling c) contraceptives d) condoms e) pap smears f) pregnancy tests from the FPATT
12 Impact	• 'De Living Room' – first of its kind in Trinidad and Tobago to offer comprehensive sexual and reproductive health services to young people 15-24 • Phenomenal increase in client visits. In the month before its opening in May 2001 approximately 80 visits were recorded. In the first twelve months since the Centre has been in operation, young people have visited the Centre on average 355 times per month – with the highest – 561 – in April, 2002 • Sustainability: As a model-programme it has the potential to attract long-term government support as it demonstrates ongoing success in addressing the unmet sexual and reproductive health needs of young people. FPATT will continue to seek corporate sponsorship. FPATT's Healthlink programme for corporate clients will help to subsidize 'De Living Room'. FPATT's standardized clinic fees are charged. 86% of clients who attended the clinic between January and March 2002 were employed and are in the 19-25 age range
13 Challenges and pitfalls	• Initial defensiveness of older staff on the need to institutionalise youth-friendly services • Some pre-existing youth organizations felt threatened by the opening of 'De Living Room' despite their involvement in the designing of it
14 Critical issues and lessons learnt	• The Operations Research has acted as a catalyst for institutional change within FPATT, which has had an impact upon all FPATT programmes and staff • There is a need for the continual management of these internal processes of change to ensure continuity of quality and approaches to serving young people across FPATT's services • There is a need for continual management of relations and networking with youth advocacy and community groups to strengthen collaboration and referral networks • As demand increases, there will be a need to manage the disjunction between the quality of FPATT's youth services and the quality of its existing clinical services • Efforts to encourage the corporate sector and others to support Centres such as 'De Living Room' should be ongoing

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	• It is imperative that mechanisms be put in place to ensure the youth involved as clients and as providers (with respect to the YAM members) are encouraged to form an integral role in the monitoring and continued development of the programme • It is important to engage in ongoing staff sensitisation workshops on the issue of youth friendly service and to ensure that there is enough opportunity for staff to engage in frank and open dialogue re any fears, questions and suggestions they might have about the process
15 Source of practice and dialogue	Family Planning Association of Trinidad and Tobago 79 Oxford Street, Port of Spain, Trinidad W.I. Contact: Donna Da Costa Martinez, Executive Director Tel: +1 (868) 623 5169 E-mail: fpattrep@ttfpa.org Website: www.ttfpa.org
16 Editor's note for learning	• Sexual and Reproductive Health services are not meeting the needs of young people due to unfriendly attitudes of service providers. Some are rather entertainment centres or at best, information centres. Staff is criticised on the lack of confidentiality particularly in relation to STIs • This practice addresses the use of a research and systematic approach to project development. FPATT's approach is characterised by strong client orientation, cost efficiency and high quality standards combined with innovation. The systematic approach to project design, implementation and evaluation ensures that the project meets the needs of beneficiaries (access, affordability, confidentiality, quality services, non-judgemental attitudes, etc) • In a similar way, in Ivory Coast, the Santé Familiale Prevention du SIDA / USAID has designed a youth friendly approach 'Just Smile' following a study, which identified unwelcoming attitudes of staff as the main barrier to use of services

8 A drop-in centre for sex workers, Thailand

Developed by: Empower, Chiangmai, Thailand
Key words: Commercial sex workers, information and education, skills training, social and legal protection

Section	Content
1 Summary of the practice	A drop-in centre that supports commercial sex workers (CSW) by offering counselling services and different types of skills training in a home where they can also come to meet and relax. By being united, the group is able to fight for the rights of sex workers and to advocate for improved policies at different levels.
2 Level of intervention	Community, municipality
3 Prospective users of the practice	Organisations of commercial sex workers, women's rights organisations, NGOs
4 Problem addressed	• CSW have insufficient access to information that enables them to protect themselves physically and to defend their rights • Poverty and lack of education keeps the women trapped in a situation they find difficult to control and from which it is hard to escape • CSW are being discriminated by employers, public services and legal policies, lacking social security provisions that apply to other types of employment
5 Purpose of intervention	• To increase access to information on general health, sexually transmitted diseases including HIV/AIDS, and safer sex methods for CSW • To increase self confidence and self esteem through counselling and to give CSW opportunities to improve their living conditions through education and skills training • To provide a place where CSW can meet for friendship and to share their daily experiences and ideas about working and improving their living conditions • To unite CSW to strive for better working conditions, improved health sector services, improved legal status and adherence to human rights principles
6 Context	• Prostitution is still illegal in Thailand, but this is not enforced for women over 18. An Act that will give prostitution a legal status including social benefits is being drawn up at present • The economic situation in Thailand has been difficult over the past years after the Asian financial crisis and this has increased poverty and migration from rural areas, including from ethnic communities. The more difficult economic situation in neighbouring countries has resulted in a large number of sex workers from these countries • CSWs work for employers such as bars, karaoke clubs and bar-brothels for a regular salary. If they engage in sex work with clients picked up in the bar, they have to hand over a percentage of their earnings. As part of this agreement they have to have medical check-ups, including a test for HIV, every three months. There is only post test counselling if found HIV positive • There is a government drive for 100% condom use for sex workers, but not all sex workers are adequately informed and educated to adhere to this all the time or in all their sexual contacts • Discrimination and harassment of sex workers is common
7 History and process	• When HIV prevalence started to increase in Thailand, the sex workers were the first to be blamed. In 1990 women activists came together with sex workers and decided to establish the organisation Empower (stands for: **e**ducation **m**eans **p**rotection **o**f **w**omen **e**ngaged in **r**ecreation) to protect their human rights and to enable sex workers to meet and to have better access to social counselling, education and skills training • Subsequently, the group developed plans, wrote proposals for funding and obtained funding • The drop-in centre in Chiangmai was established in 1990. All staff in the centre are ex CWS, trained in social and health counselling. The centre provides documentation on sexual and reproductive health and on other topics of interest. There are a number of computers that members can use • Classes are offered in Thai language, English language, typing and computer skills, non-formal adult education, sewing, batik, art and martial art. It is possible for the women to

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	obtain a certificate (primary and high school) of the non-formal education programme (community school) that is accredited by the Thai Ministry of Education. The classes are conducted by the staff of Empower or by someone from outside if staff does not have the required skills. The selection of subjects for training is based on demand from the members • Empower staff has established relations with social workers, health centres and organisations relevant for support to CSWs with regard to social security and legal aspects of their profession
8 Steps in implementation	1 Establishment of a drop in centre that is open daily with at least 20 visitors a day 2 Ongoing health and social counselling, referral if needed 3 Ongoing networking with social workers, the public health system and NGOs active in related fields 4 Regular visits to the health centre with new members to ensure proper treatment by health workers 5 Ongoing membership registration (0.5 $ fee for life) with about 300-500 new members a year and fluctuating active members 6 Selection of subjects for training by members, subjects change over time. Recruitment of teachers if needed 7 Registration for subject classes by payment of a 1$ fee for 20 lessons (signed off by the teacher) 8 Twice a month a meeting with feed back on general issues (such as the development of the Act on prostitution) and a special focus, topic decided on demand or issues of importance (trafficking of women, women's rights, PLWHA networks, STIs and HIV, rights of children, abuse and violence). Resource persons for the topic are identified from the network 9 Once a year a three day camp with 40-60 members organised by different community based organisations with the objective to: 1) have fun, learn to give and take and unite as a group 2) to get special knowledge from resource persons and to visit other community based organisations 10 The staff conducts daily awareness raising activities in different institutions in the community (on invitation from schools, temples) and visits places where sex workers are for awareness raising and education and to invite sex workers to visit the centre 11 Ongoing advocacy and liaison with women activists in Bangkok with feed back from and to members
9 Duration	The centre in Chiangmai opened in 1990 and is ongoing
10 Resources required	• Human resources: 3 full time staff (education, information, health) trained in counselling who are ex sex workers, 2 part time staff, 2 volunteers, one consultant advisor (nurse) • House (rented), 3 computers, gasoline for transport (own motorbikes) • Total funding for two centres (Chiangmai and Mae Sai) 1.3 million baht/year (1 Thai Baht = 0.03 US$)
11 Indicators for monitoring	• Number of members (active and inactive) • Number of visitors (members) at the drop-in centre • Type of information and counselling given • Referral and liaison with health centres • Number of classes held, number of participants • Number of certificates obtained by members • Special sessions organised and attendance at these sessions • Number of visits to schools and other institutions for awareness raising activities • Number of liaison visits to employers of CSW
12 Impact	• Sex workers feel supported and more protected • Increased self esteem and determination • Increased income (by speaking English, they can get foreign clients who pay more) • Increased possibilities to start up their own business and quit working as sex workers • Better treatment by health workers (attitude and medical) and employers (less exploitation)
13 Challenges and pitfalls	• Some employers are not co-operative because they expect Empower to motivate sex workers for other employment, which will affect their business • Other sectors that are involved with sex workers always want them to stop their work and do not agree with the support given by Empower which does not question the type of employment

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14 Critical issues and lessons learnt	• It is important to consider all women related issues and not to focus only on the health aspects of sex work • Respect for/by staff and members is critical in order to enhance confidence and self esteem and to be able to unite as an organisation
15 Source of practice and dialogue	Empower Chiangmai (Ms. Pornpit Puckmai) 72/2 Raming Nives Village, Tippanet Hiya district, Chiangmai 50100, Thailand. Tel: 66-53-282504 E-mail: empower@cm.ksc.co.th
16 Editor's note for learning	• Commercial sex workers are subjected to continuous discrimination. The drop-in centre functions as a home where the CSWs give each other mutual support and at the same time can get information and skills to improve their life, be it as sex worker or in another profession • The fact that Empower staff has also worked as CSW makes counselling much more effective • Operating as a group enables the CSW to promote their rights better, to influence the attitudes of health workers, to better avoid exploitation and to strive for a better legal position.

Picture: Members of Empower in the drop-in centre

9 Each one Teach one, Hong Kong

Developed by: AIDS Concern, Hong Kong
Key words: MSM, awareness raising, safer sex practices, Hong Kong

Section	Content
1 Summary of the practice	Peer HIV and STI education project, targeting younger men who have sex with men (MSM) in public places, where men pick up sexual partners
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs targeting young MSM, Public Health services
4 Problem addressed	HIV disproportionately affects gay men, with gay and bisexual men comprising close to one fourth of new cases of HIV infection through sexual contact
5 Purpose of intervention	• To increase HIV and STI knowledge among MSM who frequent PCE. • To increase their condom use
6 Context	The MSM population in Hong Kong remains a highly stigmatised and invisible community. They are invisible because of a complete absence of public policies that protect their personal and working lives and because of the cultural values that favour Confucian ideology and emphasise family over individual rights. As a result, there is a proliferation of 'underground' venues where MSM find each other. Public Cruising Environments (PCE) such as gay saunas, health clubs, beaches, and public toilets become popular meeting places where MSM find sex partners. AIDS Concern's MSM outreach project is developed in reaction to this phenomenon. It seeks to bring HIV and STI information to MSM who are unconnected to existing gay resources and untouched by general public HIV education.
7 History and process	• Recruitment of Project Staff: 6 peer educators are recruited from the MSM community to conduct weekly outreach sessions at PCE. They are recruited with diversity in age, occupation and personalities to maximize opportunities to reach out to an equally diverse population of MSM. In addition, peer guides – volunteers are recruited for PCE to assist in expanding the coverage of the program. They affect change when and where paid workers leave off, given the limited work hours and clearly defined work boundaries that workers have to abide by • Geographical and Social Mapping: to uncover and document a variety of public cruising venues where MSM congregate, MSM publications, electronic message bulletin boards on gay websites, anecdotal information provided by outreach contacts are used • Scheduled outreach visits: based on data gathered from the geographical and social mapping, outreach visits are scheduled at sites where there is a high MSM traffic • Annual revisions and updates: Due to the dynamic nature of PCE (mobility of MSM, closure of public cruising sites, gang influences, etc.), the PCE geographical mapping is revised each year so that the outreach team can maximize its contact rate • Design and production of outreach materials: safer sex kits (each containing a condom and lubricant sachet as well as a condom instruction card) and pamphlets designed specifically with MSM in mind (and especially younger MSM) are produced to support the contacts' safer sex practice. These pamphlets focus on topics such as sexually transmitted diseases, ways to negotiate safer sex with partners and community resources (i.e. gay information/crisis lines, social groups, HIV/STD clinics) • Police Liaison: Meetings with the police were conducted to discuss the programme and its objectives with the police and gain their support. Monthly outreach schedules are faxed to police stations to inform them of the outreach activities. This is to protect our staff from being apprehended by police during their outreach work • Pre and Post Intervention Assessment of Selected PCE baseline and follow-up studies are conducted at selected outreach sites to monitor the effectiveness of this programme
8 Steps in implementation	1 Three outreach sessions are scheduled per week; two outreach workers will partner at each outreach site

Section	Content
	2 Direct face-to-face dialogue at PCE. Each contact with an individual is approximately 30 to 45 minutes long, involving a risk assessment of contact's sexual behaviour, exchange of safer sex and HIV transmission information, and referrals (e.g. HIV antibody testing or gay community groups). Safer sex kits and STD booklets are also given out 3 After face-to-face conversations in which contacts are made, workers will fill in contact reports and debrief with each other after they have left the outreach venue
9 Duration	The project commenced since 1999 and still ongoing
10 Resources required	1 **Human Resources***:* One project coordinator to manage a public cruising environment outreach team of four part time team members and volunteers 2 **Equipment***:* Target population specific safer sex kits (condoms, lubricant, and condom instruction cards), safer sex pamphlets 3 **Transport:** vehicles 4 **Funding:** HKD350,000 (appr. USD 44,987) per year (includes salary, condoms, lubricant, production of other safer sex materials, stationary and travel costs) (1 Hong Kong Dollar (HKD) = 0.13 USD)
11 Indicators for monitoring	• Number of MSM contacted in PCE outreach sites • Number of MSM contacted who are within the ages of late teens and twenties • Number of MSM counselled on HIV and STIs • % of MSM who show correct knowledge of HIV prevention methods • Number of MSM who report unprotected anal sex in the last 12 months • % of MSM who used a condom for last episode of anal sex • Number of peer educators • Number of MSM reached through contact with volunteer peer guides
12 Impact	• Outreach workers now have opportunities for direct face-to-face dialogue with MSM. This allows for greater influence on behavioural change, i.e. more accurate risks assessment, correction of misconceptions on how HIV is transmitted, as well as peer role modelling to encourage and support contacts in adopting safer sex practices • The outreach prevention program that targets MSM in PCE brings information to a highly closeted population that may have no knowledge of MSM community resources, i.e. gay information/crisis lines, social groups, HIV/STD clinics • A variety of positive changes have been witnessed among the target population. Repeated contacts with whom we have built a solid rapport would voluntarily approach our workers to report increases in condom use. Younger MSM we have counselled also report greater usage of community resources (e.g. access to gay groups) as well as successes in safer sex negotiation. Even contacts we have approached years ago would later recall our name and select our HIV antibody testing service as their first experience in testing
13 Challenges and pitfalls	• The closure/renovation of toilets: the layout of older toilets has been conducive of MSM cruising. As the police become more aware of sexual activities at these venues and as traditional toilets deteriorate and become run down, complete renovation of such toilets forces regular users to disperse to other PCE • Gangs, who might pose as MSM, extort money from innocent victims who fell prey to their sham and this stops many MSM from visiting these sites. There is no legal recourse for victims to strike back • There has been a diversification of PCE environment in the last few years, making traditional PCE sites such as toilets no longer the only way MSM meet their sexual partners. MSM sex is now common at certain beaches, health clubs, and gay saunas. With the popularisation of ICQ and gay specific bulletin board systems (BBS), finding sex partners has become increasingly instant and easier with less opportunity for outreach • Under current Hong Kong law, the age of consent for homosexual sex is 21. This contrasts with the age of consent for heterosexual sex set at 16. To complicate things further, sex with multiple partners at one time or at public places such public toilets, bathhouses is considered illegal activity. However, staff in fiduciary relationships such as that of social workers and their clients, are not required by law to report if they suspect any illegal or dangerous activities. To avoid staff from getting apprehended by the police, monthly outreach schedules to public toilets are faxed to the relevant police stations • Mainstream funding sources usually reflect the public moral climate, and in Hong Kong public sex in saunas or toilets is considered immoral. At times our program proposals are rejected because funders side with public sentiment

Section	Content
14 Critical issues and lessons learnt	• Who the Messenger is Matters: Mainstream HIV prevention services either avoids the issue of sexual diversity altogether or assumes everyone is heterosexual. This situation keeps many MSM from seeking services from such service providers (e.g. STD clinics that show a discriminatory attitude towards MSM). AIDS Concern ensures that the peer educators it employs are not only recruited from the MSM population but that they hold non-judgmental attitudes towards the community they serve. This promotes the likelihood that rapport is built between worker and client and that trust is established • Worker versus Participant approaches: This project utilizes two outreach approaches: Worker Approach and Participant-Observer Approach. The former approach requires that the outreach worker introduce himself as an AIDS Concern staff. This method clarifies the role of the worker. However, under this approach, honest conversations about sexual behaviours may not always be possible. Contacts may feel that they are being scrutinized and are more likely to exaggerate their safer sex behaviours. As for the latter method (Participant-observer approach), outreach workers are not required to immediately disclose their agency affiliation. Instead, they act as one of the participants, with the apparent exception that they do not take part in any sexual acts. This approach places the worker and client on more equal footing and an accurate risk assessment of the contact behaviour can be achieved • Repeat Contacts: It has been formerly assumed that the high mobility of our target population would make it difficult for any follow-up contact to occur. At the initial stage of the project, AIDS Concern mainly focused on new contacts and reached out to as many individuals as possible. But with regular visits to the venues, it became apparent to all of our workers that there are a good number of toilet users who are regular users. The project then took on the emphasis of building up a stronger relationship with these users in order to establish a greater influence on their sexual behaviour. Our outreach workers have repeatedly reported how the quality of their conversations with contacts have greatly improved and risk assessments have become more complete and in-depth
15 Source of practice and dialogue	AIDS Concern, Paul Louey 17B, Block F, 3 Lok Man Road, Chai Wan, Hong Kong. Tel: +852 2898 4411 Fax: +852 2505 1682 E-mail: paul@aidsconcern.org.hk Website: www.aidsconcern.org.hk
16 Editor's note for learning	• This is a very strategic approach to reach a population that is almost impossible to reach. The fact that the outreach workers themselves are MSM clearly facilitates the work. The cooperation of the police is crucial but this may be quite difficult to obtain in other countries • We wonder about actual adoption of safer sex practices. Research has shown that knowledge in itself does not lead to behaviour change, as this is an individual asset while the social environment in which the behaviour occurs largely determines behaviour. The self reported change by repeated contacts may be biased • It would be good to develop indicators for behaviour change resulting from the intervention, but we do realise it will be quite difficult with this target group

Picture: MSM outreach - Safer sex kits distributed during outreach work in public cruising environment

10 *Jus' Once*, an interactive HIV/AIDS awareness production

Developed by: Arts-in-Action/Centre for Creative & Festival Arts. University of the West Indies
Key words: Community, awareness raising, prevention, myths, sexuality, drama and arts, Trinidad, The Caribbean

Section	Content
1 Summary of the practice	*Jus' Once* is an interactive participatory HIV/AIDS programme for young people and the community, which invites the participating audience to address the concerns in their community in order to alleviate the spread and stigmas surrounding HIV/AIDS epidemic
2 Level of intervention	Community, schools, Government ministries, corporate bodies, NGOs throughout Trinidad & Tobago, and the wider Caribbean
3 Prospective users of the practice	Government's institutions, youth organisations, NGOs, communities, schools
4 Problem addressed	Misinformation, stigma and denial associated with HIV/AIDS prevention, care, and support found in the Caribbean
5 Purpose of intervention	The Centre for Creative and Festival Arts and Arts-in-Action (Theatre-in-Education outreach unit), a group of artists working within the Centre at The University of the West Indies aims to: • Present interactive and participative performances which seek to explore the reasons and the forces behind the continuing growth of HIV/AIDS (especially in the Caribbean) • Encourage people of different age groups in the community to look inside themselves and their environment for answers and strategies to reduce and control the growth of all sexually transmitted diseases • Form links and support with the community as an effective means of disseminating ongoing information on HIV and AIDS
6 Context	• The Caribbean Epidemiology Centre (CAREC) reported that young girls and women are among the highest numbers of persons infected with HIV in Trinidad & Tobago • Research in Trinidad & Tobago has revealed that there are number of myths associated with the disease • National statistics suggest a continuing and increasing problem of HIV/AIDS, and the need to explore the societal impact of this situation is critical • Education through lectures and brochures has been shown not to be especially effective due to the educational levels of certain sectors (i.e., low income areas) of the society • Interactive productions which encourage participants to openly address the situation and 'practice' informed responses within hypothetical dramatic situations, is now statistically proven to be highly effective in curtailing the forces behind the growth of HIV/AIDS
7 History and process	• The Centre for Creative and Festival Arts has established its outreach programme, 'Arts-in-Action', since 1994. The basis of the work of Arts-in-Action is that art has an indispensable role to play in the process of social and attitudinal change and development. Arts-in-Action is the most experienced and professionally trained group of actor-teachers/facilitators in the Caribbean. In 1998, HIV/AIDS was identified as the main issue to be dealt with • Working together with its Director, Arts-in-Action actors/facilitators researched, devised, rehearsed and prepared a series of interactive scenarios/monologues for interactive performance-workshops. The scenarios all focus on HIV/AIDS prevention amongst young adults (see Section 8 below) • Specific venues and areas are chosen in order to reach groups of young adults (approximately 50 to 150 at any given time) in easily accessible locations where they 'lime' and/or congregate in their free or formal time (i.e. in and outside of school /office hours) • Links are established with and in the proposed local areas or venues where the productions are being offered. These include the community elders, mentors, shop keepers, etc. and/or school administrations, as well as NGOs associated with HIV/AIDS dissemination and awareness programmes (e.g. AIDS Foundations, community hospitals, clinics, resource persons) • The actor-facilitators perform *Jus' Once*. The issues of the production, based on seven or eight monologues and linked by original Caribbean music and song, are then opened up

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	for discussion from the participating audience by facilitators who *hot seat* and *role-play* the characters. This causes the participating audience to empathize, question, condone, or support the actions and experiences they witness. They face their own perceptions and experience actual feelings about their sense of self and how to deal with, for example, their own sexuality, gender issues, and peer relationships (male and female), thereby raising their awareness of self and others and their self-esteem to maximize their potential. The interactive facilitation techniques cause the viewers to offer and try out alternative solutions and options, empowering and evoking a positive change in attitude and behaviour, as well as a heightened sensibility to be more highly attuned to their surroundings
8 Steps in implementation	1 **Training**: Five to eight actors are trained in interactive techniques by the actor-facilitator. (i.e. Forum Theatre, facilitation, etc.) 2 **Research**: Research and rehearsals for the process-drama are carried out by the group and the Director 3 **Planning**: Administrative personnel locate venues, educative links and transportation facilities 4 **Performance Preparation**: Production staff (director, designer) design and identify costume and set requirements. These minimalist elements include stock 'uniforms' for the performers, colour coordinated, symbolic costume pieces and props, black cubes or blocks for the set, a heavy-duty circular carpet (for the performing arena), and an advertising sandwich board 5 **Implementation**: Performances-workshops are performed. At each venue, 'an ambassador' is identified to monitor local needs and distribute further educative materials. Characters used in workshops: • **Cassandra**: Vengeance is the solution to getting rid of all promiscuous men; life ends with an HIV/AIDS diagnosis; class, education level, professional status aid in determining who would be infected • **Stanton**: Only skinny people are HIV/AIDS infected; once a person looks healthy they are not infected; a good 'sweat' (workout) could solve any illness; selective use of condoms only with new clients • **Susan:** Pulling out of the penis before ejaculation is safe sex; sleeping with only one person is a guarantee that safe sex is being practiced; the need to be tested only once if sexually active • **Taye:** The denial of a loss of a friend to an AIDS related death (renal failure); the unsafe practice of 'parrying' otherwise known as orgies; the need for testing for HIV once sexually active; the risk of promiscuity • **Derek:** Pleasure vs. safety; decision to break up the relationship because lack of condom use is an issue; stigmas attached to condom use • **Judy:** How it feels to be an AIDS patient; what you REALLY can and cannot do with someone who has AIDS; the world does not end with a positive HIV result • **Simon**: immediate reactions to being tested HIV positive; risky sexual behaviours coming back to haunt a person living with HIV/AIDS; best way to deal with being tested HIV positive 6 **Evaluation**: Evaluations before and after each intervention are assessed and where necessary adjustments are made to the interactive performance
9 Duration	Ongoing. In Trinidad & Tobago, the first productions began in 1998
10 Resources required	• 5 to 8 actor-facilitators, one who can drive • Funding for performers, facilitator, and director's stipends/fees • Transportation & fuel • An administrative base and person to arrange production timetable, dates, and venues; fund-raising and payments • Research assistant to document pre and post questionnaires and/or videotape interventions for record keeping purposes and assessment
11 Indicators for monitoring	• Pre and post performance evaluation forms are developed, distributed to audiences and collected by the actor-facilitators at each venue • On site, the actor-facilitators record oral questions and their answers, or comments and further suggestions after each performance-workshop • Links with local 'ambassadors' are identified and contact maintained • Follow-up productions are created and community awareness is assessed • Quarterly reports are written and disseminated to sponsors

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12 Impact	• Reports are available to show the positive impact of this intervention (Canada Fund Reports May 2001, November 2002, March 2003) • The project reaches and speaks to the youth and the community on their own turf/ground through animated interactive presentations and increases the number of youths with first-hand knowledge as to how to prevent sexual transmission of HIV/AIDS • Involvement of the participating community directly with options and ways to protect themselves from HIV/AIDS • Requests for training youth organisations in Trinidad and Tobago and from other countries in the Caribbean
13 Challenges and pitfalls	• Challenges and pitfalls Weather conditions may prevent consistent outdoor performances • Large venues may require amplification • Sponsorship for performers, and transportation to and from venues is essential in order to facilitate the process • A home base with administrative & rehearsals facilities is necessary
14 Critical issues and lessons learnt	• A well-trained and committed team is essential • Monetary reimbursements for the hours of preparation and performance times are necessary to maintain a high level of professionalism • Participating audiences are generally aware of the HIV/AIDS epidemic, and consequently affirm their commitments to adjust their lifestyles, remove the stigmas and understand the myths surrounding the disease. But the need to continually re-educate, remind, reinforce this information to the ever-growing younger generations is never-ending, even in a population of only 1.3 million people
15 Source of practice and dialogue	Arts-in-Action c/o Centre for Creative & Festival Arts The University of the West Indies St. Augustine, Trinidad (West Indies) Contact person: Dani Lyndersay Tel: +1(868) 663 0327 or 662 2002 ext 2510, 3539 dlyndersay@fhe.uwi.tt, artsinaction@tstt.net.tt, festival@tstt.net.tt, www.festival.uwi.tt
16 Editor's note for learning	Arts-in-Action is also involved in training NGO and CBO members and teachers in Trinidad and Tobago. The institution hosts students from various countries and has the potential for becoming the Regional/International Training and Resource Centre for promoting the use of participatory approaches to social problems, especially for HIV/AIDS

11 Life skills education in a poor suburb in São Paulo, Brazil

Developed by: ECOS – Communication and Sexuality, Brazil
Key words: Life skills education, teacher training, Brazil

Section	Content
1 Summary of the practice	A Training of Teachers project to strengthen life skills amongst adolescents to handle the danger of AIDS and drugs in a marginalized suburb of São Paulo
2 Level of intervention	Secondary schools in marginalized suburbs
3 Prospective users of the practice	Secondary school teachers
4 Problem addressed	• High vulnerability for HIV infection of adolescents through high risk sexual behaviour in which male adolescents are afraid not to be able to give up to their macho role and female adolescents are afraid to be rejected • Both attitudes provoke fear to negotiate or even to suggest the use of condoms • Inadequate attitudes and lack of skills to negotiate for safer sex with sexual partners contribute to this problem
5 Purpose of intervention	To promote a 'natural attitude' in the communication and negotiation between adolescent partners in the use of condoms by emphasising sexual pleasure
6 Context	The Project is situated in Vila Brasilândia, one of the poorest suburbs of São Paulo. The suburb has the following characteristics: • Low level of income • High level of male unemployment • High consumption of alcohol, resulting in violence en sexual abuse • High level of use and traffic of drugs • Social vulnerability • Limited access to public education
7 History and process	• Concerned with the problem of HIV/AIDS in this marginalised suburb of São Paulo, the National AIDS programme wrote out a tender that was won by ECOS, an NGO with a strong reputation in communication projects with adolescents • ECOS is an NGO, based in São Paulo with a focus on sexual and reproductive rights of women and adolescents but covers also areas like participation of youngsters, prevention of drug use and violation against women. For that purpose it developed participatory communication techniques in workshops and by involving target groups in the publication of their own newsletters / bulletins
8 Steps in implementation	**1 Curriculum development** Elaboration of intervention strategies and educational materials. The intervention is aimed to develop skills for safe sexual behaviour of adolescents. Central in its approach is the empowerment of the adolescent that are vulnerable because of lack of natural communication skills in negotiating the use of condoms. The approach emphasises the pleasure of sex, in which distinguishes itself from other programmes that usually emphasise the mandatory use of condoms. The program forms a series of workshops that have the following components: • Information on STI/AIDS • Social and physiological aspects of adolescent sexuality • Skills training to empower adolescents to decide, to communicate, to be more assertive, and to negotiate using condoms. Note: The three components above are not based on gender equality but on role and skills differentiation **2 Manual** The manual produced for the Project has the following content: • Initial considerations (methodology of training, self esteem, empowerment and the acquisition of abilities, gender perspectives)

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	• Workshops (after and pre tests, games, videos, case studies, information about STI/AIDS and drugs) • Supporting texts • Bibliography / Sources of info **3 Identification of the teachers** The teachers that participate in the project are identified through visits at the schools in the neighbourhood. Teachers make themselves available on a voluntary basis **4 Implementation Phase** The implementation of the training of teachers and the organisation of the workshops at school lasted eight months, during which workshops were held of 4 hours, 3 days per month, covering in this way about 300 children per school in different classes. Instead of first completing the training in total, the teachers started to implement the course in their schools, after each workshop. In this way the teachers could exchange the experiences between themselves and the trainers. In order to stimulate the participation of the adolescents and to increase motivation during the process, the following activities were included: • The publication of *Transa Legal* (Save Sex), a bulletin of ECOS Institute for adolescents, produced with contribution of teachers about sexuality, violence and drugs (six editions in total) • A design contest for a poster about AIDS prevention
9 Duration	8 months
10 Resources required	**Infrastructure:** • Room with a capacity of 20-30 persons • Chairs • TV /video set • Flipchart • Other materials **Human resources:** Skills: Competency in relation to contents (Aids, reproductive health), in attitude (didactic methods) and being a good performer on stage Preparation of the course: 2 persons x 100 hours Course: 120 hours x 2 persons Bulletins: 40 hours each x 6 bulletins **Budget:** US$ 10-15 thousand, including the production of bulletins and poster
11 Indicators for monitoring	Process indicators: • Number of teachers trained (38) • Number of adolescents reached (8.750) • Number of schools visited (30) Impact and Quality indicators: • Quality of training: Pre and after testing of teachers • Demand for condoms from distribution outlets in the neighbourhood • Research about changes in skills and attitude of adolescents (not yet implemented)
12 Impact	• Communication between adolescents about sexuality and violence improved • Violence in the schools decreased • Solidarity between students increased • Demand for condoms increased • Communication about sexuality within the family improved (Source: personal observations of trained teachers to ECOS)
13 Challenges and pitfalls	• One of the major challenges is the establishment of good operational relations with the public (health) services for health (that not necessarily exist in these suburbs) • The continuity of the project depends on the awareness of the director of the school. This requires that the project is carried out as a school activity and not just as a project of one of the teachers • There is a risk that the project is not regarded as an integrated part of the standard curriculum of the school, which could threaten its continuity • The social position and low salaries of the teachers affects their motivation in general negatively

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	• The project also meets opposition in these suburbs from religious and cultural groups, and from the families of adolescents
14 Critical issues and lessons learnt	What to do: • Keep always a professional attitude (which means always a certain distance towards local context) • Focus always on the professional capacity in training of teacher, which implicates to always actualise the knowledge and attitude in relation to reproductive health and AIDS • Establish partnerships with public health services and community leaders and get sponsors What not to do: • Do not mix age groups (i.e. join young people of 13 years with adults of 20 years) • Do not mix adolescent and parents • Do not keep on with the theory, but discuss the day to day reality
15 Source of practice and dialogue	ECOS – Communication and Sexuality Rua Araújo, 124, 2º andar – Vila Buarque 01220-020 – São Paulo – SP, Brasil José Roberto Simonetti (Director) E-mail: zeroberto.ecos@uol.com.br Sylvia Cavasin (Director)
16 Editor's note for learning	ECOS has a highly professional approach towards involving adolescents in these underprivileged suburban areas

12 Peer education among youth in a rural district in Thailand

Developed by: Maekaotom AIDS Coordinating Centre, Chiangrai, Thailand
Key words: Youth, peer education, awareness raising, prevention, Thailand

Section	Content
1 Summary of the practice	Education by trained youth volunteers among in and out of school youth and other groups in the community for HIV/AIDS awareness, acceptance and prevention
2 Level of intervention	Community
3 Prospective users of the practice	Youth groups, community based organisations
4 Problem addressed	• HIV/AIDS is not perceived to be a problem that affects everyone in the community • People in the community do not have the knowledge and skills to avoid becoming infected • Discrimination of PLWHA and their families, especially children
5 Purpose of intervention	• To enhance knowledge on HIV/AIDS prevention in the community at large • To increase acceptance and community involvement of PLWHA and their families so they can be part of community development efforts, happy and with dignity like the others • To enhance the capacity of children and youth that are affected by HIV/AIDS to come to terms with HIV/AIDS with concern for their physical, social and emotional development in a creative way and facilitate them to develop their own plans for prevention • To enhance the capacity of youth volunteers to effectively work with youth and other groups at community level and to improve adult understanding and appreciation of the potential of youth
6 Context	• Communities in the North saw the incidence of AIDS grow in the early 90s, but apart from the general government information and awareness raising campaign, no targeted activities were taking place to enable people to deal with HIV/AIDS in their own environment and to develop their own plans. Discrimination of PLWHA and their families was high in all sectors of society • Most villagers are poor and male and female migration is common. Girls/women often end up working in the entertainment sector as sex workers in the large cities. Youth who want to continue their studies also have to leave the village for their education, often staying in dormitories, which increases their vulnerability to infection
7 History and process	• In 1994 a teacher in the village realised that her pupils and other youth in the village did not understand that they were vulnerable to become infected with HIV. With another teacher and a number of young people, she decided to launch a campaign for HIV/AIDS awareness raising. This led to the establishment of the Maekaotom AIDS Co-ordinating Centre, based in the house of the teacher • She trained the youth volunteers in PRA activities (mapping, AIDS trend appraisal, ranking of risk behaviour, Venn diagramme – see techniques in the toolkit) and these volunteers started to work with different youth groups in the village. This was so successful that the volunteers were asked to organise PRA in schools, at festivals etc. and also with groups other than youth. This then expanded to other villages • Because not all people like PRA activities, other methods of awareness raising were developed such as puppet shows, drama, a painting exhibition, sports events, music • The awareness raising activities are followed by AIC (Appreciate, influence, control) workshops in which during 2-3 days community groups are facilitated to develop a common vision, explore interventions to reach this vision, prioritise interventions and develop an action plan. The process is documented and after three months a review workshop is organised • The activities of the Coordinating Centre have now reached over 20 communities in the district and outside and also include saving and loan schemes in the communities
8 Steps in implementation	1 Identification and training of youth volunteers (10 in total, but changing over time, presently 8 girls and 2 boys, age 14 and up – most are still schooling) in HIV/AIDS knowledge, in PRA, and in counselling

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	2 Identification of youth group leaders to work with (there are 'gangs' in most communities and to get these interested it is important to persuade the gang leader first) 3 Identification of other groups such as migrants going away for work, children whose parents are away, children in- and affected by HIV/AIDS and their guardians 4 Mobilizing interest in these different groups to participate in the HIV/AIDS awareness activities by talking to the leaders first, by showing them the PRA activities and by discussing the vulnerability of all to HIV infection 5 Division and coordination of activities between group members (each has their own target group, but due to shortage of volunteers, often events cannot take place on the same day) 6 Planning for activities to be done – this depends on the type of target group that is being addressed (activities such as working/playing with the children and counselling support to PLWHA are ongoing) and is done in a meeting once or twice per week 7 Implementation of activities (one member responsible, others may assist) followed by evaluation 8 Networking with community level institutions (schools, health centre, local government administration, community leaders, PLWHA groups) to promote involvement and support of the activities – expansion to 27 other communities 9 AIC workshops have led to the establishment of PLWHA networks, counselling services, development of alternative care systems, interventions for community development issues and the establishment of a community saving and loan scheme that incorporates a welfare fund (part of the interest). Such saving and loan funds are being promoted by the Thai government in rural areas (Social Investment Fund) 10 Training of health volunteers and PLWHA family members and guardians in counselling
9 Duration	Since 1994 and ongoing
10 Resources required	• A skilled PRA and AIC facilitator and trainer • Trained and motivated volunteers • Pick-up truck (donation) • Computer • Funding from variety of donors (including UNICEF, Aidsnet, Save the Children) for different activities (when there is no funding, the groups savings fund is used and activities further away may be scaled down) • Volunteers are paid if they are involved in a funded activity
11 Indicators for monitoring	• Number of youth volunteers in a community • Number of plans for activities developed and implemented • Recognition in the community that youth are capable/able to play a key part in working on HIV/AIDS by involving them in the development of HIV/AIDS action planning • Linkages for collaboration/coordination developed by youth groups with other community sectors
12 Impact	• Community understands AIDS facts and problems of PLWHA and their families and discrimination has reduced • PLWHA have been integrated in community development work and live with dignity • Care in the community for PLWHA and their families has increased • The saving funds (24 with a total of 208 members) that have been started in the community give part (25%)of the profit for a fund for Orphans and Other Vulnerable Children that is being organised by a CBO • The (ex) volunteers have acquired skills to work with groups, have increased self confidence and are recognised in the community
13 Challenges and pitfalls	• Youth is highly mobile and not interested for a very long time so turnover of volunteers is high • School teachers do not understand the value of the involvement of their pupils as volunteers and do not support the empowerment that is taken place as it clashes with their approach to learning • Since most volunteers are still in school, most activities have to take place in the weekends. This reduces the number of activities that can be carried out • The development of the saving and loan groups was a slow process because much time was needed to raise understanding of the concept. The amounts saved are small and hence contribution to the Fund for OVC is also small

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14 Critical issues and lessons learnt	• It is more difficult to get male volunteers than female volunteers: boys can spend time away from home easily while girls are expected to do household chores. For them the youth group activities provide a chance to be outside the house • The volunteers who are being empowered in their volunteer work, making use of participatory methods of learning find it difficult to get motivated in school where the traditional way of teaching is adopted. Ways have to be found how the volunteers can combine what they learn in school with what they learn as volunteers • AIDS is a problem that challenges the moral, ethical, economic and social responsibilities of people in the community. To make people in the community feel the problem is theirs, the power of traditional culture needs to be combined with the power of thinking and analysing using new (participatory) techniques that give equal importance to all involved • Youth have to be supported to become change agents as they are open to combine new approaches with traditional wisdom • The saving groups have become the motor for community development
15 Source of practice and dialogue	Ms. Sumalee Wanarat, Maekaotom AIDS coordinating Centre, 138 Moo2, Tambon Maekaotom, Muang district, Chaingrai 57100, Thailand. Tel. 66-53-607026 Fax. 66-53-742143 E-mail: s_wanarat@hotmail.com
16 Editor's note for learning	• The enthusiasm with which the peer educators work, has a very positive impact on the youth who enjoy the PRA activities. The peer educators do not suggest youth to change their activities but rather discuss how to avoid taking risks (like always having a condom with you when you go out to a party). Not being told what to do, but being facilitated to develop their own plans is much more effective than 'lecturing' • This empowerment however, clashes with the traditional education system and the traditional social environment of Thai rural society where adults instruct youth how to behave and do not recognise the strength of youth themselves. It will take longer to develop this recognition, but in the end it will be one of the positive spin-offs of the programmes. The same experience is described in the practice of the Sang Fan Wan Mai youth group • The high turnover of volunteers affects both these programmes and requires a constant identification and training of new volunteers

Picture: A Venn diagramme made by youth to list places of recreation and the relative risks

13 Prevention and care for migrant workers, Brazil

Developed by: GRUPO GIV – Grupo de Incentivo à Vida
Key words: Migrant workers, prevention, care, Brazil

Section	Content
1 Summary of the practice	Prevention, care and support activities for Brazilian migrant workers in Japan are organized in a cooperation between a Brazilian and a Japanese NGO
2 Level of intervention	Community of migrant workers
3 Prospective users of the practice	Organizations of migrant workers
4 Problem addressed	• Migrant workers as such usually form a high-risk group for becoming infected with HIV/AIDS • Brazilians in Japan are faced with all kind of cultural and other barriers to integrate in the Japanese society. This makes them even more vulnerable • Once infected with HIV/AIDS, they don't know as foreigners how to find their way to get treatment, due to language problems and misunderstanding / discrimination by Japanese society
5 Purpose of intervention	• To promote safe sex practices with migrant workers prior to departure • To reduce problems of access once they become infected in Japan • To assist them to return to Brazil to receive antiretroviral treatment
6 Context	• About 80 thousand Brazilians come for temporary migrant work to Japan and 250 thousand Brazilians (*dekasseguis)* are resident in Japan (women and men) Many of the migrant workers are in the age group of 25-40 years (predominantly male adults). They are working in the big industries in the provinces of Shizuoka (30.000 Brazilian residents), Kanagawa (20.000 Brazilian residents), Aichi (35.000 Brazilian residents) and some in Tokyo, where the main Brazilian representations are located • The migrant workers usually come for two years to Japan and do in such a short period not integrate in the closed Japanese society with strong cultural identity. They do not speak the language and Portuguese is not understood in Japan • The migrant workers, many of them from Japanese origin, feel discriminated. Once they suspect being infected, they get insecure because of fear of being expulsed from work • In many cases the workers are illegal and do not receive information about the health system in Japan and therefore stay outside the system
7 History and process	• GIV was founded on the 8 of February 1990 by a group of seropositive people, lead by the psychologist José Roberto Peruzzo, and is the first NGO in Brazil functioning as a self-help group and a centre of care, managed by people infected with HIV/AIDS. GIV organizes meetings with people newly infected with HIV/AIDS, psychotherapeutic workshops, discussions on sexuality, attending infected children, activism, professional courses, discussions with the community and social services • In 1994, José Araújo Lima, a Brazilian HIV/AIDS activist and third president of GIV in São Paulo, met a Japanese who invited him to a Global Conference on AIDS in Yokohama. There he saw the enormous problems that Brazilian migrant workers had when becoming infected with HIV/AIDS, because of cultural barriers and lack of information on where to look for help • Back in Brazil, GIV made contacts with CRIATIVOS, a Japanese NGO that promotes Brazilian culture and sports in Japan to try to set-up a partnership to provide information on prevention of HIV/AIDS and to support Brazilian migrant infected with the virus. This partnership was established in 1996 • Two years later in 1998, the National AIDS programme of the Ministry of Health in Brazil also established contacts with various institutions in Japan, trying to promote preventive practices and assistance for the migrant workers • Because of the lobby of GIV and CRIATIVOS, the two governments signed in the year 2000 an agreement for co-operation in policies regarding HIV/AIDS that aims to improve the lives of Brazilians that are affected by HIV/AIDS in Japan • All was formalized in the year 2001 in a direct partnership between GIV / CRIATIVOS and the National HIV/AIDS programme

Section	Content
8 Steps in implementation	Prior to departure to Japan: **Activities in Brazil by GIV:** 1 Contact recruitment agencies for migrant workers 2 Conduct workshops on prevention of HIV/AIDS in general and information on cultural aspects in Japan with regard to HIV/AIDS (culture of shame!) 3 Develop and distribute educational materials through the recruitment agencies to migrant workers to Japan, including information whom how to get condoms in Japan and how to get access to the health system in Japan and Brazil While in Japan: **Activities in Japan by CRIATIVOS** 1 Identification of concentration areas of Latin American migrant workers in Japan 2 Distribute condoms 3 Develop and conduct periodically (through the general network CRIATIVOS) workshops on prevention of HIV/AIDS, how HIV/AIDS can be recognized and what to do in case of suspecting HIV/AIDS 4 Seven days a week counseling and support in Portuguese and Spanish (to Brazilians and other Latino's) by telephone (roughly 1500 persons are attended every year) When infected: 5 Assistance to infected persons and their families by organizing meetings, support to form self-help groups, translation services (interpreters) in hospitals and other institutions 6 Support to repatriation of Brazilian PLWHA Back in Brazil: **Activities at return by GIV:** 1 Facilitation of arrangement of places for home-based care of PLWHA
9 Duration	The migrant worker project started in 1996 and is ongoing
10 Resources required	In Brazil: • Funds for office costs of GIV • Input by volunteers of GIV • Funds for conducting workshops in Brazil • Funds for producing and distribution of educational materials • Funds for repatriation of PLWHA (Tickets covered by VARIG) • Funds for home-based care • Funds for medical services of PLWHA (including HAART) In Japan: • Input from volunteers of CRIATIVOS • Funds for production and distribution of educational materials • Funds for covering telephone costs for counseling • Funds for organizing coordination meetings and self-help groups
11 Indicators for monitoring	• Number of direct beneficiaries (different categories) • Number of workshops conducted in Brazil and Japan • Number of self help groups established • Number of educational materials distributed • Number of condoms distributed (CRIATIVOS) • Number of migrant workers returned to Brazil and put on treatment
12 Impact	• Access problems to counseling and testing reduced by telephonic VCT services • Lives saved of many migrant workers by assisting them to return to Brazil and receive treatment
13 Challenges and pitfalls	The level of discrimination of HIV/AIDS victims, particularly of ethnic Japanese migrant workers from Brazil remains still very high
14 Critical issues and lessons learnt	• This case shows the important role NGOs play in identifying issues affecting people living with HIV/AIDS. In this case, support of the Brazilian victims in Japan is in fact the responsibility of both governments, but the NGOs took the lead in the process • In Japan, the approach to HIV/AIDS is totally different from that in Brazil. In 'a culture of shame' people are very afraid to talk about AIDS. Initially Japan did not want take responsibility for the Brazilian victims, which however radically changed during the process

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15 Source of practice and dialogue	GRUPO GIV Rua Capitão Cavalcanti, 145 (Vila Mariana, São Paulo - SP) Brasil Gilvane Casimiro da Silva Presidente CEP 04017-000 Phone/Fax (55 11) 5084-0255 / 5084-6397 Website: www.giv.org.br / www.aids.gov.br E-mail: giv@giv.org.br / edugiv@ig.com.br / araujo.l@uol.com.br Connected sites: www.forumaidssp.org.br forumongsp@uol.com.br www.criativos.org araujo.l@uol.com.br / www.araujo.hpg.com.br
16 Editor's note for learning	This practice describes a relevant response to the problem of migrant workers, a group that usually is not first mentioned as a core group for HIV/AIDS prevention or care. The isolated position, in which (illegal) migrant workers operate, makes them vulnerable and the extent of the problem is grossly underestimated. The ILO estimates that worldwide there are roughly 130 million people working as migrants, up from 75 million in 1965. The number of undocumented migrants is estimated at 10 million to 15 million. Economic migrants are seeking work in roughly 67 countries, up from 39 in 1970, and fleeing 55 countries, compared to 29 previously. But in a sign of the complexity of immigration patterns, 15 countries such as Thailand and Malaysia both receive and send a major number of migrant workers The press release summarizing the ILO report is on line at: http://www.ilo.org

14 Mobile VCT Clinic, India

Developed by: Peoples Health Organisation, Mumbai, India and Rajiv Gandhi Foundation, New Delhi, India
Key words: Voluntary counselling and testing, awareness raising, India

Section	Content
1 Summary of the practice	A mobile VCT centre provides same day voluntary counselling and rapid HIV testing as well as information and preventive messages to the population of Mumbai
2 Level of intervention	Community level/District level
3 Prospective users of the practice	AIDS service organisations, health care providers, governments and NGOs/CBOs
4 Problem addressed	• Ignorance, lack of time and fear of breach in confidentiality reduce the use of facility-based HIV testing • Delay in providing test results is common in most facilities (from days to weeks) • Lack of appropriate HIV/AIDS information understandable for illiterate people
5 Purpose of intervention	• To minimise the risk of HIV transmission and dispel myths and misconceptions about HIV/AIDS in the community of Mumbai • To provide information and education on HIV/AIDS through exhibitions, a public address system, participatory group meetings, condom demonstration and distribution • To provide HIV testing using rapid test kits and provide same day results to VCT clients • To provide quality counselling and appropriate referral for people with HIV/AIDS • To identify and network with HIV friendly health care facilities
6 Context	• There are an estimated 250,000 HIV infections and 50,000 AIDS cases in Mumbai (2001). Among the medical in-patients of public hospitals 15% are HIV positive; among the TB patients 35%; in STD patients over 30% are HIV positive. Among healthy blood donors and pregnant women HIV rate is between 1.5 to 2% • Total population of Mumbai 12.4 million • Total of VCT centres in Mumbai: 15 + 1 mobile VCT clinic • The 15 VCTs have been started within the mandate of National AIDS Control Organisation, rather than based on specific needs. While some VCTs exist only on paper, others do provide free services to clients • High stigma attached to HIV/AIDS: This is due to the stigma attached to sex outside marriage and the fact that sexual transmission is the main mode in India. Stigma leads to discrimination at societal, medical and workplace level. Most medical caregivers are apprehensive about caring for HIV/AIDS patients and if they do, they use extra-ordinary precautions that are discriminatory to the patients • Government funding for HIV/AIDS prevention and control is limited, the national annual budget is 45 million US dollars (0.05 of the total annual government budget) for a total population of over a billion people. But this amount is already a 25% increase over the previous year
7 History and process	• People's Health Organisation (PHO) started a Mobile Clinic catering for sex workers in Mumbai in 1989 and in Pune in 1991. With the support of the Rajiv Gandhi Foundation (RGF) this developed into a partnership project to initiate a Mobile HIV Counselling and Testing clinic, incorporating rapid HIV testing and results. Capillus HIV test kits were chosen as they are sensitive and user-friendly and only need one drop of blood • The mobile clinic is manned by medical officer, health educator, peer counsellor, helper and driver to carry out counselling and testing as well as public information and condom demonstrations • Every week the clinic covers ten pre-determined locations on rotation basis in South & Central Mumbai, reaching a population of 3 million • Locations selected are in busy strategic places like railway stations, markets, over-crowded slums • Non-reactive results are given instantly with post-test counselling • The link with the formal health care system is maintained through referrals for confirmation of initial reactive tests and for follow-up of people living with HIV/AIDS

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	• The Rajiv Gandhi Foundation sponsored the project from November 1999 to October 2000 and again for one year from April 2002. From Nov.2000 till March 2002, PHO continued the project without any regular grants and thrived on financial assistance collected through small donations, selling IEC material, membership subscription, publication of AIDS ASIA (a bimonthly newsletter) and training fee collected from those trained by and at PHO facilities. PHO pays all the mobile clinic staff salaries from the above funds
8 Steps in implementation	1 Identification of Private Medical Practitioners (PMP) to be responsible for the prevention and control of AIDS and care for PLWHA's 2 Identification of other staff members, like social workers, counsellors and NGO activists to be responsible for raising awareness and the prevention of HIV/AIDS and to carry out intervention programs to halt the spread of HIV/AIDS 3 The staff is trained in sensitively handling HIV/AIDS patients and those at risk of HIV/STDs and this created a mutual understanding and a common goal 4 Proper spots for the locations of Mobile clinic are selected and a time schedule is developed so that adequate follow-up can be maintained 5 Necessary permissions are obtained from Police and local authorities for parking of the vehicle at the scheduled stops, using public-address system, arranging mobile exhibition and for having group meetings 6 A protocol is designed to enable a proper risk assessment done by the staff for each visitor of the clinic and to give appropriate advise for or against taking an HIV test, depending on the risk assessment by the staff 7 The van is covered with slogans in Hindi and English and a public address system is used to air short speeches and important messages. Mobile exhibits on different aspects of HIV are hung on the mobile van once it is parked, hundreds of passer-by come and see the exhibits 8 Group meetings are held outside the van and among other things demonstration on proper condom usage is held, followed by distribution of AIDS leaflets and condoms 9 Visitors are received in the van (one by one) and a proper risk assessment is done by the staff according to a protocol to counsel patients on taking a HIV test or not, this takes about 10-15 minutes 10 For those who wish, the test is done, this takes about 5 minutes 11 The result is given in a post-test counselling session of about 10-15 minutes. For those who have tested positive, referral is given to clinics for confirmation of initial test results and for follow-up (care and support). The clinic serves on an average 10-12 persons per session of 3 hours. Most of them come for counselling. A few take a HIV test. There is not much waiting usually. When one takes to testing enclosure, the other can be taken for counselling. Some times, they do come back after a while. Most people coming for the test come after calling the AIDSLINE run by PHO, which informs the callers the exact location of the Mobile clinic. People from one part of town may go to the Mobile Clinic location in the other part, where they cannot be recognised
9 Duration	The project started in October 1999 and is still ongoing
10 Resources required	• Vehicle, large enough to have facility for counselling enclosure, testing enclosure, carrying literature, exhibition and condoms. It should be preferably with high roof • Public Address system • Mobile Exhibits • Ice-box to carry HIV test kit in the vehicle and refrigerator to preserve the kits in organisation's office • Good-quality spot HIV test kits; which can be used on one drop of blood • Gloves, needles for prick (lancets), spirit swabs etc. • Consent forms, reporting forms, receipt-book, referral forms, information booklets • Condoms • Funds for staff salaries and operational management (like fuel, repairs etc) • Trained staff
11 Indicators for monitoring	• Number of people attending the mobile exhibition, public meetings, counselling, testing, literature distributed, number of condoms distributed • Number of revisits of persons found to be HIV positive who come for supportive counselling, crisis counselling, or reasserting the results from referral centre. They come back to Mobile clinic because of personalised care and excellent rapport that the clinic staff enjoys. In most referral places, they do not get adequate attention as the hospitals are usually busy and there is discrimination from staff of public hospitals • Suggestion book

Section	Content
	• Feedback on Hotline, where people can anonymously provide feedback, critic, suggestions etc.
12 Impact	• The project provides access to information, education, communication, counselling and HIV testing at the doorstep of the people in Mumbai. Information is given in own language and questions can be answered on the spot • Medical consultation is available to people at risk of HIV/AIDS without appointments or queues in private clinics/public hospitals, saving time, money and energy and therefore people feel more free to go for HIV testing • People get an HIV test without much fuss at a reasonable cost: Rs. 100/- (US$ 2/-) with full anonymity and confidentiality • Test reports are given instantly to those who test negative, thus most of them don't have to wait for hours or days for reports and save time to visit to seek a report • The project helped in reducing the stigma about HIV/AIDS, has increased initiative in seeking help and making infected people feel confident in coping up with such a serious problem
13 Challenges and pitfalls	• Resistance of shopkeepers and traffic police when the van operates near them as it affects their work, sometimes forcing to relocating of the clinic • Residents have complained to the police about the 'noise pollution'. However, looking at the laudable goals of the mobile clinic, no action was taken. The project now has official permission to use the public address system till a certain decibel level • When the van breaks down, the staff takes leave or during heavy down pour, the service comes to a halt. Thus the mobile van was grounded almost half the time affecting the regularity of the service. There is no back-up vehicle or back-up staff. Implementation of strategies to overcome this aspect are necessary • Hesitance of people to be seen entering the van is not a big problem because of the anonymity of the large city and the possibility to visit the van in a different part of the city away from the normal living environment • Confirmation of positive results is not possible in the mobile HIV clinic
14 Critical issues and lessons learnt	• Strategies to enhance acceptance of counselling and testing among women need to be devised and implemented, as very few women attend this service • There is a need for three or four mobile clinics, with one spare vehicle for back-up in the event of break-down • Most of the clients tested were not tested for HIV before, indicating that this approach is useful in out-reach and creating a need of testing among the persons practising 'risk' behaviour • Mobile clinic offering voluntary counselling and HIV test are well accepted in a metropolitan city, but may not be suitable in smaller towns
15 Source of practice and dialogue	Peoples Health Organisation (India) Dr. I.S.Gilada, Secretary General Municipal School Building, J.J. Hospital Compound Mumbai-400008 Tel. No. +91-22-23061616; 23719020 E-mail: ihoaids@vsnl.com Website: www.aidsasia.info; www.aidsindia.info
16 Editor's note for learning	• The mobile van is an interesting concept in situations where uptake of VCT in clinics is low for a variety of reasons (staff, equipment, access). But the confidentiality aspects will prevent people to go to the van in their own neighbourhood • In Dakar a different system of mobile service is established by SIDA service. Here the van brings counsellors and equipment to a clinic and service is given in the clinic itself ensuring confidentiality and privacy

Picture: HIV testing in the van

15 Prison Aids prevention and care programme, Zambia

Developed by: HIV/AIDS Project, Prison Fellowship Zambia, Ndola, Zambia
Key words: Prison, care, prevention, Zambia

Section	Content
1 Summary of the practice	A prison based aids care and prevention programme that aims to contain the spread of HIV in prisons and to give care and support to chronically ill prisoners
2 Level of intervention	Prisons
3 Prospective users of the practice	Any individual or organisation that works in prisons
4 Problem addressed	• Prevalence and spread of HIV/AIDS and STIs in prisons is high (20% up to 60%) and access to VCT is lacking • Health care and treatment is not available • Knowledge and awareness on HIV/AIDS basic facts is insufficient • Stigma and discrimination is very high
5 Purpose of intervention	• Mitigate the impact of HIV/AIDS • Create awareness on HIV/AIDS • Promote safe behaviour
6 Context	• Prisons in Zambia are overcrowded and accommodate 10-15 times more people than intended. The conditions in the prisons are terrible with poor hygiene, poor water and sanitation services, poor ventilation, inadequate quantity and quality of food leading to a very bad health status among the inmates (diarrhoea, TB, respiratory diseases, malnutrition, scabies) • The Prisons Act stems from 1959 and sentences people to prison for all offences, including minor ones such as theft of food. Procedures take a long time; so all inmates are in prison for long terms
7 History and process	• The Prison Fellowship Zambia Programme, a faith based interdominational para-church organisation, carried out an assessment on the health conditions of prisoners. Subsequently, consultations were held with prison authorities, government departments such as the judiciary and the high court registrar and prisoners, and a request for intervention was approved • A strategic plan was developed on the basis of experiences with interventions in HIV/AIDS and STI prevention and treatment and peer education in other settings. This plan was successfully used to raise funds from donors. The strategy includes awareness raising and health education, peer education, pre- and post test counselling, STI syndromic treatment, care giving, stigma reduction
8 Steps in implementation	1 Selection of prisons in the programme based on proximity to Prison Fellowship Offices, the gravity of the problems, the (non) availability of health services, interest of prison authorities in the programme and availability of resources such as transport 2 Recruitment of local volunteers from the church community around the prisons 3 The volunteers are male and female (to help male and female prisoners) and have a medical profession (doctors, nurses, para-medics) or are unemployed high school graduates that are trained in health education and counselling 4 The volunteers are not paid but receive training in coordination and decision making processes with a future possibility of promotion into a paid system 5 Development of a training programme, training and orientation of volunteers on HIV/AIDS and STIs, health care and roles and responsibilities 6 Development of an action plan for each prison 7 Development of leaflets and brochures 8 Health education and AIDS awareness training of prisoners in large groups (up to 250 prisoners) with use of participatory methods such as role plays, song and dance, picture codes and story telling. Weekly sessions of two hours following a health education syllabus

Section	Content
	9 Art competition on specific subjects selected with the prisoners (rape, battering) resulting in calendars with art made by prisoners. This years' topic is women's rights and prevention of HIV/AIDS among women and the role of men in this. Country-wide dissemination through churches and shops 10 Peer education. For each cell of about 40 people, 5 peer educators, selected by their cell mates, are trained to do peer counselling in their cells and to refer prisoners for treatment. They receive a kit with stories, a HIV training manual, games and leaflets. As an incentive they get soap and sugar and regular training. They also encourage improvements in hygiene in the cell as many prisoners suffer from water and sanitation related diseases 11 Counselling, pre- and post test counselling carried out by trained volunteers. The blood samples are taken to the nearest testing centre. Demand for testing is high 12 Training of prisoners in care and treatment of common STIs. They give drugs and refer for diagnosis and treatment that they cannot do 13 AIDS care is now piloted in two prisons with 40 clients. Initially trained volunteers from outside did this care, now volunteer inmates are trained and provided with drugs and gloves. There is a referral possibility to the hospital, but possibilities for treatment are not much better there 14 Stigma reduction with the help of PLWHA who visit the prison and give testimonies. They help create support groups for PLWHA in the prisons. In addition, there is a programme in HIV/AIDS awareness raising for prison officials and their families that helps them to become peer educators in their own communities
9 Duration	Started in 1998 and ongoing programme in 11 prisons
10 Resources required	• 3 full time staff trained in counselling and peer education training • 50 outside professional volunteers trained in counselling and HIV/AIDS prevention and care • Trained peer educators in prison • 1 car, public transport • Funding needed is about $ 100.000 per year (last year only $ 41.000 was available)
11 Indicators for monitoring	• Weekly team meeting with volunteers in which lesson plans are assessed and discussed • Weekly assessment of counselling monitoring forms Monitoring of drug use for STI treatment, cure rate • Monitoring of time spent on specific subjects by peer educators and volunteers • Tracing of contacts of prisoners with STIs • Behaviour change after treatment and counselling • Consistent and correct use of condoms
12 Impact	• More openness on HIV/AIDS in the prisons • STIs are being cured and incidence is going down • Self reported behaviour change • A more caring environment in the prisons • Increasing interest in testing
13 Challenges and pitfalls	• Stigma is still an issue, inmates leaving the prison do not disclose • Chronic shortages of drugs and basic health care • No proper link to the health system that is very weak • Access to testing facilities was difficult, but now the programme has received their own testing equipment • Attracting funding is very difficult • Basic environmental hygiene is lacking and very difficult to improve without funding • The hierarchy among prisoners is strict with inmate 'bosses' and 'judges' enforcing security, but also abusing their fellow inmates. The problem of sodomy is often raised during counselling sessions, but it is difficult to address the bosses effectively in a special programme
14 Critical issues and lessons learnt	• An attempt was made to train prison wardens as counsellors but this did not work because of confidentiality issues and unequal power relations • Prison wardens are mobile and therefore at risk, there is a high HIV prevalence among them. Thus programmes need to be developed that target them as well • Prisoners are very receptive to HIV/AIDS interventions both in prevention and care. It is possible to empower them as peer educators and assist their peers to make informed choices

Section	Content
	• A recent behavioural survey showed that the level of awareness has increased, but behaviour change needs to be facilitated not only by the prison management, but also through better training, through activities, recreation and rehabilitation programmes
15 Source of practice and dialogue	Maurice Shakwamba, project manager HIV/AIDS Project. Prison Fellowship Zambia. P.O.Box 240070, Ndola, Zambia. E-mail: prisonf@coppernet.zm or mshakwamba@yahoo.com. Tel: 096-781996
16 Editor's note for learning	• This programme requires a high degree of motivation on the part of staff and volunteers • A major problem is the inability of the programme to change anything about the unhygienic conditions in the prisons – this can easily discourage inmates to become involved • If the programme would get more funding it is also conceivable to that follow-up activities are developed with inmates that leave the prison and could become active in peer education outside the prison

16 Protection of young male prostitutes against HIV infection, Brazil

Developed by: IBISS (Projeto Programa), Rio de Janeiro, Brazil
Key words: Street boys, prevention, Brazil

Section	Content
1 Summary of the practice	Awareness raising, mobilisation and life skills training to reduce the risk of HIV/AIDS infection in street boys who prostitute themselves
2 Level of intervention	Community level
3 Prospective users of the practice	NGO's working with street boys
4 Problem addressed	• Within the macho culture in Brazil most boy prostitutes will not admit that they have sex with men. Therefore these boys have to offer their services in dark, remote places, where they can't be recognised and where they stay anonymous, but where they run an increased risk of being raped. They do not have the skills to negotiate condom use with their clients, particularly if they are put in the passive role • Lack of knowledge on STI/HIV/AIDS and other health issues • Intravenous drug use and sharing of needles in an effort to build up courage for prostitution
5 Purpose of intervention	To empower street boys from urban slums to survive in a very high risk environment

6 Context	• In Rio de Janeiro about 600 street and slum boys try to survive by male prostitution activities, but they don't consider themselves prostitutes. The knowledge about STI's /AIDS and other health issues is low among the boys. Moreover they are not open to information, because they are afraid to give the impression that they have something to do with prostitution or homosexuality (among peers homosexuality is not accepted) and because the usual information material doesn't fit their strategies to survive, their culture and their language of communication
	• There is an enormous lack of special information material, adapted to the street life of this population, but even elaboration of useful 'special material' will only have partial effect. From experiences with other marginalised groups, the only way to approach them is by face-to-face contacts. A study by IBISS on sexual exposure among 300 street boys gave the following results:
	  • 28% had anal intercourse before the age of 7 years
	  • 63% had anal intercourse between the age of 7 and 12
	  • 57% of these kids were anally (ab)used by older kids on the streets
	• Having anal intercourse among each other is a public secret, but the kids do not like to talk about it as a problem. They qualified anal (ab)use by older 'friends' as:
	  • It happens, what can I do: 68%
	  • Its a training for my friend, to become a macho-lover: 16%
	  • It is really a form of abuse: 4%
	  • I was total drugged at the time: 12%
	• For them admitting anal intercourse and talking about it in the own group meant:
	  • You are homosexual: 61%
	  • You have an illness (AIDS): 34%
	  • You are crazy: 5%
	• Ways to break this 'public secret' require innovative approaches, while poverty and lack of social perspective increases the phenomenon of prostitution and exploitation of youngsters

7 History and process	• IBISS is an NGO with its headquarters in Rio de Janeiro, Brazil. IBISS aims to develop new forms of preventive social health-care aimed at the poorest part of society, especially at marginalised groups such as physically, mentally and socially and/or economically disadvantaged youngsters (street and *favela* kids). In this way IBISS tries to contribute to the development of a 'Healthy Society' in which Human Rights are respected, access to public services (for example education and health care) is guaranteed for each citizen, where social injustice is eliminated and in which citizens are entitled to free cultural and mental development

Section	Content
	• While working with marginalised street boys who were collecting waste from the streets, IBISS staff observed that these street boys sometimes disappeared for short periods to certain parts in the city. Only later they discovered that the boys went there for reasons of prostituting themselves. In order to get better insight in what was happening, IBISS contracted two street educators to make an assessment of the target group and of the places where the services are offered, with the aim to later develop a project proposal (for donors) • The street workers first made contact with the boys and tried to establish a personal relationship with them, being present at defined hours present at the meeting places, so the boys could count on their presence. They stayed with the boys during night-time and tried to protect them from (police) violence. They offered the boys some security and safety, and a human and personal contact, they treated small wounds, referred boys with illnesses to medical services and paid sometimes some food for them. They also helped out in case of juridical and mental problems. During this field work the educators gathered the necessary data for their analysis and for further advocacy activities
8 Steps in implementation	1 Make a profound analysis of the sexual culture and habits inside the world of boy prostitution, especially how street kids deal with this strategy to survive, in order to elaborate new adequate preventive actions 2 Select and train on the basis of the information generated in the first step, a group of street educators to establish a trusted relationship with the street boys. This is required to fulfil the role of mentor of the boys and to teach them how to reduce their high-risk behaviour, to search for alternatives outside the prostitution world and to make them aware of their rights to assistance and treatment inside the public system 3 Once the group of boys is big enough, they are encouraged to organise themselves in a social group, in which they can discuss their own situation and fight together for their fundamental human rights 4 Finally IBISS established shelters for HIV/AIDS infected boys, where they receive the necessary medical, social and psychological assistance, and in which they will not be stigmatised and/or discriminated
9 Duration	Ongoing since 1992
10 Resources required	• Two street workers under formal contract with IBISS • Shelter
11 Indicators for monitoring	Qualitative • Changes in behaviour and attitude • Demand for condoms • Ability of the street boys to negotiate condom use • Openness in street boys about their sexual contacts *Note: Above indicators are measured by the street workers, using standard forms developed for that purpose by IBISS* Quantitative • Number of boys included in the project
12 Impact	• Increased involvement of the street boys in the activities of the project • Increased acceptance of safe sex practices and level of knowledge on how STI / AIDS is transmitted and how it can be prevented • Reduction of the use and abuse of drugs associated with riskful sexual practices • Increased self esteem and skills to handle sexual abuse and exploitation
13 Challenges and pitfalls	• The government permits street boys who are infected with the HIV virus, to receive assistance, but does not allow them to organise themselves in social groups • Financing of the HIV/AIDS activities is through central government, but every two years its policy is changed after elections and currently focuses its attention to the north-east of the country • It is difficult to avoid association with the criminal world. If for instance a prostitute is stealing from his client, there is immediately an article in the newspaper. However, at the same time, the police is blackmailing the street boys • The governor of Rio has declared zero tolerance on the street and therefore youth prostitution has moved to the saunas. This means less possibilities for street workers to reach the boys

Section	Content
14 Critical issues and lessons learnt	The most important lesson learned under this project is the unconditional need of choosing the side of the street boys in order to gain their trust
15 Source of practice and dialogue	Nanko van Buren (Executive director) Carlos Eduardo Gouveia Basilia (Consultant) IBISS Av. Marechal C5mara 350 / sala: 807 cepo: 20020-080 Tel: 9807.6622 / 2240.3215/2240.1352 Fax: 2240.2082 E-mail: carlosbasilia@ig.com.br ibiss@ibiss.conm.br Website: www.ibiss.com.br
16 Editor's note for learning	Particularly interesting of this unique programme is the enormous preparedness of the IBISS staff to involve themselves in this work. Many of the staff have started as street boys themselves. This is not only a major factor for a better understanding of the situation in which these youngsters operate, it also makes a big difference in ability to make contact with them

17 The 'Rap against Silence' project, Togo

Developed by: Focal Point HIV/AIDS, UNDP Office, Lomé, Togo
Key words: Youth, prevention, music contest, local radio, arts, Togo

Section	Content
1 Summary of the practice	Development of rap songs on HIV/AIDS as a way to reach youth. A competition on the best rap songs resulting in a Rap against Silence concert and recordings on cassette and CD's distributed to all local radio stations and NGOs working on HIV/AIDS with youth
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs, broadcasting companies, youth groups, schools
4 Problem addressed	• Lack of an appropriate communication channel for youth • Lack of information on HIV/AIDS in local languages • Isolation of rural radio stations and their audiences • Concentration of cultural activities in the capital • Lack of encouragement for local youth creativity
5 Purpose of intervention	• Raise awareness of youth about the advantages of HIV counselling and testing, the dangers of discrimination of PLWHA, prevention of mother to child transmission, and need to protect oneself against STI/HIV • Strengthen national network of radio journalists • Provide young people with an opportunity to perform for local and national audiences
6 Context	• HIV prevalence in Togo according to 1999 surveillance is 6% • Information and awareness campaigns on HIV/AIDS have been carried out throughout Togo, but have mostly been concentrated in the urban areas, in particular in Lomé and the Maritime region • The prevalence of HIV is high amongst young people; however, their perception of risk is still relatively low • Youth in rural communities are more difficult to reach due to a number of factors, including low school attendance rates, and comparative geographic isolation of villages • Togolese youth identifies with global youth culture, in particular with rap music, but they also feel excluded and unrecognized • Rap music speaks directly to the young, and that is the target audience of this project
7 History and process	In the summer of 2001, UNDP launched a project to reach out to young Togolese through rap songs: the musical genre they find most exciting. The Rap Against Silence project involved hundreds of amateur Togolese rappers around the country in a nationwide contest to produce songs on one of four AIDS-related themes. The regional winners performed their songs at the Rap Against Silence concert before an audience of thousands. The top four finalists got to record their songs at a professional studio, and have them put out as a mini-album by UNDP. Rap Against Silence was a joint project of UNDP, UNICEF, the UN Information Center, and the Togolese Network of Journalists Against HIV/AIDS. The project was chiefly organized through radio stations: three in Lomé and 11 across the rest of the country
8 Steps in implementation	1 First ideas for this project were shared between UNDP, UNICEF, the UN Information Center, the Togolese Network of Journalists Against HIV/AIDS, UNAIDS, youth NGOs and local radio stations who had received a training on HIV/AIDS programming 2 Participating radio stations received a booklet with standardised forms on subscriptions, jury selection, and criteria for selecting winners 3 Four themes were selected: discrimination of people living with HIV/AIDS, the advantages of testing, the three ways of HIV/AIDS transmission and prevention, and mother to child transmission. Information on each theme was provided to the participating radio stations that served as local focal points. Youth could find information at the stations about the themes and the contest

Section	Content
	4 Each radio station broadcasted educational and discussion programs on HIV/AIDS issues, along with invitations to local youth to submit rap songs for the contest 5 At each station, an interdisciplinary jury selected the best female and the best male rapper and sent a tape to a national jury who selected the ten best rappers of the country 6 These ten rappers were then brought to the town of Tsevie for the Rap Against Silence concert, on January 26, 2002, where they played to an audience of several thousand in the municipal stadium 7 At the concert, an interdisciplinary jury (including a professional rapper, representatives of HIV/AIDS-related NGOs and UN agencies) awarded prizes to the best three participants 8 The four best songs were recorded on cassette and CD 9 The mini album was launched at a life concert in the capital 10 1000 cassettes and CD's were distributed to communities through local radio stations, the jury members and NGO's working with youth on HIV/AIDS
9 Duration	Half a year from start to concert. The project is part of Art versus Aids programme, which was initiated by UNDP, Togo in 2000 and is still ongoing
10 Resources required	• Broadcasting stations with journalists trained in presenting HIV/AIDS issues • A national coordinator/coordinating body • A radio manual with guidelines and standardized forms for jury members and participants • Publicity material (posters, standard information for radio advertisements in local languages) • Recording studio • Financial resources (10.000 USD) • Concert hall/stadium for life concert • Network of NGO's that can provide local jury members and distribute cassettes
11 Indicators for monitoring	• Number of participants in the rap contest • Quality of the texts and music (such as appropriateness of information within local context and target population, artistic originality) • Number of visitors to the concert • Use and distribution of tapes/cassettes
12 Impact	• The project mobilized hundreds of young amateur artists from all over Togo. They learned not only about the impact of HIV/AIDS in their communities, but also about local media and music production • Radio stations improved their understanding of young peoples tastes and some have continued to work with local youth • Almost half of the finalists were girls • The rap songs are played on radio stations all over the country • The concert was completely packed with young people and provided NGO's working on HIV/AIDS with an opportunity to present themselves to new audiences
13 Challenges and pitfalls	• Rap can be perceived as a rather rough male music genre. Both girls and radio stations need to be encouraged to ensure girls participation • While cultural diversity should be encouraged, it is important that the key messages on HIV/AIDS are correct
14 Critical issues and lessons learnt	• Rural and urban youth can be mobilized through popular culture • Young people often dislike politics and want concrete projects and clear procedures. It is therefore important that contracts, project budgets, criteria for selection of judges, criteria for judging are publicly available to participants or other interested parties before and after the competition • Parents of selected participants may be concerned about safety of their children in a hotel. They should be provided with detailed contact information and be encouraged to visit
15 Source of practice and dialogue	Focal Point HIV/AIDS, UNDP Office, Lomé, Togo fo.tgo@undp.org For pictures see: http://www.pnud.tg/artvsaids/
16 Editor's note for learning	• The contest is a good way to pull in youth that would otherwise be difficult to reach for awareness raising • The involvement of the local radio stations that have a large audience in rural communities can be a good way to mobilise these stations to give more attention to HIV/AIDS

18 Resource centre for youth, Kumi, Uganda

Developed by: Create, Kumi, Uganda
Key words: Youth, peer education, awareness raising, prevention, Uganda

Section	Content
1 Summary of the practice	A community resource centre established to provide information, recreation, counselling and guidance for young people. Sexual education and training of peer educators at the centre, and outreach in villages and schools
2 Level of intervention	Community
3 Prospective users of the practice	Community organisations, NGOs
4 Problem addressed	• Limited access to accurate SRH information and poor communication between parents and their children on SRH matters • Limited access to academic books, non-conducive reading environment at home, and limited recreation • Low academic performance and low motivation and self-esteem leading to high school drop-out rate • Loitering, substance abuse, sexual abuse and a general lack of direction and hope in the future among youth • Stigmatisation of out-of-school youth • A high incidence of STIs and many early/unwanted pregnancies (32% of girls aged 14-18 have at least one child) due to limited knowledge on reproductive health issues and limited access and a negative attitude to contraceptive use • High vulnerability to HIV infection among youth
5 Purpose of intervention	The overall aim of Create is to empower young people living in the rural areas and the rural town to develop healthy lifestyles and to promote opportunities for them to grow into responsible citizens and attain a quality life. The direct purpose of the activities of the centre is to: • Increase academic performance, motivation for learning, self esteem and a sense of purpose in young people • Increase life skills, personal and community responsibility and ability to work as a team in young people • Decrease loitering and abuse of young people by provision of recreational facilities and a place to meet • Increase knowledge on sexual and reproductive health with young people and the community at large in order to decrease vulnerability to HIV/AIDS, STIs and unwanted pregnancies
6 Context	• Kumi district has 493 villages and a population of 393.000 in 2002. 44% of the population is under 15. Kumi is an agricultural region relying on subsistence farming. Trade and industrial activities in the district are generally low. There is high unemployment and pervasive poverty. Traditional kinship and extended family systems are breaking down, but many of their functions (such as instilling morals and values related to sexual and reproductive rights, human rights, and personal and community responsibilities) have not been taken over by the nuclear family, leaving young people without guidance and support • Health service coverage is low (one doctor per 25.500 people, one nurse per 3.000 people) and life expectancy at birth is 45.5 years. Under 5 mortality stands at 205/1000 life births • HIV/AIDS prevalence rates are declining in the district as in the whole of Uganda (Sentinel Surveillance, 2001). It is difficult to assess AIDS incidence because many people die unknown in the villages, their deaths often attributed to witchcraft or causes other than AIDS • There are many orphans in the district (21.557) with at least one parent dead (1991 population census) and these are predominantly cared for within the communities, but this support is stretched to the limit • AIDS awareness is high, but knowledge, access and feasibility of prevention is low, especially with the youth

Section	Content
7 History and process	• Create was established in 1998 with the creation of a library and study space for young people in the house of the director. After two years, a proposal to improve knowledge on sexual and reproductive health with youth was funded by ActionAid Uganda. This enabled Create to buy video equipment, a 100-seater tent /shade erected beside the house, desks and chairs. In addition, equipment was bought for basketball, volleyball, badminton and games for indoor use to provide a mix of recreation and education to the youth • Weekly sessions are conducted at the centre by a trained social worker and trained peer educators in which videos on sexual and reproductive health and other development issues are shown, followed by guided discussions. These sessions also cover topics related to human rights, personal and community responsibilities and life skills. Interest is high with an average attendance of 100 young people, aged between 10 and 24 • The social worker also gives individual counselling and guidance when she sees the need or when it is asked for. Interested young people, nominated by peers, are trained as peer educators in sexual and reproductive health, basic facts of HIV/AIDS and life skills, including condom demonstration. Condoms are obtained from government health units, other NGOs and drug shops/private clinics • Some peer educators are trained to help younger children (many of whom are orphans) in the centre with homework, with games, performances (drama, songs) and counselling • Peer educators conduct sessions in schools in and around Kumi town reaching about 5000 young people. After the group sessions, the female peer educators talk to the girls, the males to the boys to answer questions and to motivate them to come to the centre. Boys are effective in mobilising their sisters to come to centre • The social worker conducts sensitisation sessions on sexual and reproductive health and youth related issues during annual general school meetings, village meetings and radio talks • The centre receives and distributes the bulletins 'Young Talk' and 'Straight Talk' as well as civic education leaflets and posters received from various sources. These are discussed in the weekly education sessions
8 Steps in implementation	1 Generate support to establish the centre, formation of management team (6 members) and collection of donations (funds, books, chairs etc.) 2 Establish the library and invite young people to make use of the facility 3 Ongoing guidance and counselling by social worker and director (if present) 4 Resource mobilisation – writing of proposals for support (ongoing) and receiving support from Action Aid (2000-2002) 5 Procurement of video, recreation and other equipment 6 Planning, preparation and implementation of weekly education sessions by the social worker. Topics based on available resources (videos, straight talk bulletins and available sexual and reproductive health information documents) and on issues raised by the young people 7 Individual counselling of young people by the social worker on demand 8 Identification and training of peer educators, boys and girls. Sessions on sexual and reproductive health, HIV/AIDS basic facts, vulnerability to HIV/AIDS, prevention, life skills, support and care for PLWHA and communication skills 9 Planning and implementation of peer education activities in schools and working with younger children in the centre 10 Planning and implementation of adult information sessions in schools, community and radio 11 Ongoing search for documents and books for the library, videos for education and entertainment and support for the activities of the centre
9 Duration	Library and study centre since 1998, all other activities since 2000 and ongoing
10 Resources required	• Trained social worker (full time) and teacher (part-time) • Room to secure books and provide a quiet reading place, a tent/shade for the education sessions and meeting place, and an open ground for games • Equipment: chairs, tables, video, films (on AIDS, SRH, leisure, etc), books (suitable for primary and secondary education, and self-learning for out-of-school youth), indoor and outdoor games equipment • Some motivation incentives for the peer educators such as t-shirts (with SRH messages) and bicycles • The centre (static) services are ongoing and run with minimal financial requirements. However, school and village outreach activities are dependent on the availability of funds. At present there is no outside funding and hence these activities are reduced

Section	Content
11 Indicators for monitoring	• Follow-up meetings and reports from peer educators to discuss outcome of the sessions • Feed back from parents and teachers • Number of youth coming to the centre and attending sessions • Self-reported improvement in academic performance • Number of youth interested to become peer educators • Young people engage in self-help and common good activities (e.g., planting trees around a school) • Young people reporting change in risky behaviour, e.g., stopping alcohol/drug abuse, quitting bad groups • Willingness to take HIV test • Self-reported adoption of HIV/STD prevention behaviour (e.g., adoption of condom use, abstinence) • Self-reported sense of purpose and activities to meet towards desired goal (e.g. plans and activities to raise money and go back to school)
12 Impact	• An average of 30 young people per day come to the centre to study and/or to recreate • The weekly education sessions are attended by an average of 100 people • The school children using the study facilities are doing very well in school • The young people themselves manage the centre, keep it tidy and equipment in working order • A total number of 54 girls and 72 boys have been trained as peer educators. Of these 68 are active and present in the project area • Peer educators have changed their behaviour (sexual and general) and have become responsible adolescents with commitment to the community • Awareness of youth on sexual and reproductive health and HIV/AIDS has increased in school youth and demand for the peer educators from other schools is increasing • Parents appreciate the activities of the centre and their knowledge on sexual and reproductive health is increased by the school, community and radio sessions
13 Challenges and pitfalls	• High turnover of youth peer educators: young people grow and move on – change residence for education, search for employment and marriage, besides volunteering for a long period is difficult • There is not enough room especially when it rains and sessions have to be held in-doors • It is very difficult to find funding for activities. The social worker does not receive a salary when there is no outside funding • Funders do not like to finance administrative costs such as telephone, electricity and accommodation • Donors prefer short-term projects and expect quick results
14 Critical issues and lessons learnt	• Commitment and motivation of the social worker and the director is the driving force that is presently keeping the centre going • Adolescent males find it easy to pursue girls, but are protective to their sisters: brother peer educators are very effective in educating their sisters • The male peer educators are showing girls that not all men are sexual abusers and at the same time can explain male behaviour. The same applies to the female peer educators versus the boys. It has turned out to be an effective approach to increase mutual understanding • With little support and guidance, young people can work to address health concerns of their lives and communities
15 Source of practice and dialogue	Create Kumi, attention of Emmanuel Maraka. P.O.Box 32, Kumi or P.O.Box 26456 Kampala, Uganda. E-mail: maraka_etesot@hotmail.com Website: www.justcare.org/create
16 Editor's note for learning	• Initiatives such as Create are 'new products' and as such require support from those willing to take risk and make investment. The contribution of ActionAid (Uganda) Strategies for Action Programme deserves commendation • Initiatives in rural areas, including rural towns, require a mechanism of representation/ contact in the capital cities for better communication and accessing resources from the international community

Picture: Space where children can play and learn

INSERT Picture 21 CreateUganda.JPG

19 HIV/AIDS awareness raising by youth group

Developed by: Sang Fan Wan Mai Youth Group, Chiangrai, Thailand
Key words: Youth, awareness raising, peer education, puppet shows, radio, schools, Thailand

Section	Content
1 Summary of the practice	A youth group initiated puppet shows to raise awareness on HIV/AIDS in the community. Later they added radio talks and other awareness raising programmes for youth and the training of (school) youth in such programmes
2 Level of intervention	Community
3 Prospective users of the practice	Youth groups, NGOs, schools, communities
4 Problem addressed	• Youth has insufficient understanding of their own vulnerability to HIV/AIDS • Youth are seen as a problem by adults and their capacity for undertaking development efforts is not taken serious
5 Purpose of intervention	• Increase capacity in youth to think for themselves and to act responsibly based on correct information • To prevent youth becoming infected with HIV • Influence knowledge, awareness and attitudes of community members with regard to HIV/AIDS
6 Context	• Young people in Chiangrai started to see the effects of HIV/AIDS in their communities in 1993 when people started to fall ill and die. This brought fear and discrimination of PLWHA. The government awareness campaigns initially focused on high risk groups such as sex workers and their clients and consequently youth did not feel at risk • When also young people were seen to be infected, prevention activities were initiated focussing on youth. In 1994, Rak Thai Foundation (Care International Thailand) organised a training of youth volunteers called 'Motivation for Safer Sex' where 200 young people from two districts were trained in AIDS education and in communication. They learned how to make puppets for a puppet play
7 History and process	In 1996, 15 people who attended the training course decided to establish the Sang Fan Wan Mai Youth Group, half of them male, half female. The group distinguishes four phases of their development: **Phase 1**: the 15 trained members toured the district with the puppet show but needed to get more youth involved to increase coverage **Phase 2**: continue the puppet shows and focus on finding and training new volunteers (50 at the end of three years with 100 shows /year) through their shows and networking. Only 5 original members remained, they do planning and development of new activities. The volunteers choose one or two activities in which they are trained and once experienced can become members. Distribution of free condoms obtained through the public health services **Phase 3**: expansion through networking whereby volunteers are motivated to set up their own group with friends and start activities. Development and training in new activities such as drama, story telling, games, magic shows, sports competition as not all youth are interested in puppet shows. Sex education in schools **Phase 4**: realisation that the group does not reach enough people through their activities and interest in means of communication is changing. Development of radio broadcasts with music interspersed with interviews, stories, information and discussions, always with youth as main target group. Initially broadcast of half an hour per week through a local NGO, ACCESS, now three times a week for a total of 2.5 hours through the public radio system
8 Steps in implementation	**Phase 1 and 2**: 1 Training received on HIV/AIDS basic facts and communication through puppet shows 2 Set up an office in the house of the parents of one member 3 Development of stories for the puppet show based on interviews with different people held in the villages, on own observations and on suggestions by others to ensure that current issues in the community are addressed (now 20 storylines) 4 Training on making of the puppets and making puppets

Section	Content
	5 Planning and division of tasks and responsibilities between members and volunteers, implementation of performances. Puppet performances are either done according to the schedule/plan of the project itself or on invitation as part of community initiated activities 6 Discussion after performances based on questions from the audience 7 Identification of volunteers after the performances 8 Evaluation and feed back on performance 9 Meet once a week with the members and volunteers. Identification of key members involved and responsible person for each activity 10 Ongoing training of new volunteers **Phase 3 and 4**: 1 Development of new activities: drama, story telling, sports events, radio broadcasts, sex education in schools 2 For all activities the group meets and discusses issues to address in the performances (basic facts on HIV/AIDS, stigma, care, rights of PLWHA, orphans, life skills). They divide tasks if additional information needs to be gathered 3 Members do research on issues that need more information and identify and invite local experts that can give an input in the performance (and especially in the radio broadcasts). These may be doctors, psychologists, teachers, welfare workers – depending on the issue addressed 4 Planning of the performances, radio broadcasts and education sessions in schools (on invitation) 5 Implementation of activities: radio broadcasts (weekly 2.5 hours); puppet shows (twice a year); sex education in school, as a collaboration with a group of schoolteachers, parents and Sang Fan Wan Mai staff. The curriculum for sex education to be taught in school is planned by school administrators and Sang Fan Wan Mai staff. Once approved, the staff takes part in the Physical Education and Ethics classes in secondary school, grade 7-9; condom distribution 6 Participating in the youth council to advise on activities. This council is operational in each village (2 members) and at sub-district level for 45 villages (90 members), membership lasts a year. The youth council is set up to facilitate youth to be part of community problem solving for instance with regard to AIDS-related problems, drug problems and the crisis of cultural change 7 Training of volunteers in the type of activity that they choose. At present many youth receive training in being a deejay on the radio and intersperse music with messages on HIV/AIDS. This not only attracts more volunteers than the puppet shows, but also more audience 8 Assist and train volunteers to form their own group and develop their own activities 9 Twice a year a camp with all groups that have been started since inception in Chiangrai province (10). Here, an overall evaluation of the programme is done, experiences are shared and conclusions drawn from lessons learned
9 Duration	From 1996 onwards
10 Resources required	• An office • Transport (most members have their own motorbikes). • Funds for activities in the beginning with the puppet shows about Baht 200.000/year ($ 4650), now Baht 700.000 ($ 16.280). Funds come from the Department of Communicable Disease Control, UNICEF, national and international NGOs (1 Thai Baht (THB) = 0.03 USD) • 70% of the funds are spent on operational costs such as meetings, office cost, electricity, transportation, accommodation etc.
11 Indicators for monitoring	• Number of people attending performances, feed back on radio broadcasts (phone-in) • Questionnaire on awareness and behaviour (carried on to observe changes) among members and volunteers • Demand for condoms after performances • After each performance an evaluation is held with the audience and with the group
12 Impact	• Acknowledgement of adults of the impact of the group activities • More confidence with the group members and volunteers on their own capacities • Self reported behaviour change in group members and volunteers • ncreased reported condom use with youth • Unclear what behaviour change is happening in the community as this is difficult to measure

Section	Content
13 Challenges and pitfalls	• The attitude of many adults remains that youth cannot implement programmes on their own – they are still regarded as children. Their inputs in the discussion on prevention of HIV/AIDS are therefore not sufficiently taken into account • When youth marry they become 'adults' and leave the group • High mobility of youth leaving for schooling or work outside the district, resulting in high turnover of the volunteers • Ongoing effort in retraining new volunteers
14 Critical issues and lessons learnt	• It is necessary to fully understand the psychology of the audience and also of the volunteers when developing performances and programmes • It is necessary to summarize the lessons learnt before starting new activities
15 Source of practice and dialogue	Sang Fan Wan Mai Youth group (Jinda Kankaew, Chansuai Chanpeng, Katsarin Kankaew, Sangdaw Tangoen, Jeragan Jindatom) 271 No 2 Pasakluang, MaeChan, Chiangrai 57270. Tel: 053-664334 E-mail: dreamgroup@hunsa.com; A0182@hunsa.com
16 Editor's note for learning	• Awareness raising activities such as described here, need very good facilitation and discussion after the performances. It is not quite clear how the members and volunteers are trained to do this and what methodology they use • It is interesting that the group is continuously adapting its approaches for awareness raising to ensure that the target group is reached effectively • The impact of the activities on knowledge, attitude and behaviour is not monitored. Especially when making use of media such as radio broadcasts, it is important to develop a system for monitoring. The group is aware that this needs attention, but they do not really know how • The invitation to be involved in the development of a curriculum on sex education and subsequent peer education in classes is a very important achievement of the youth group

Picture: The puppets

20 Sex industry outreach program in Hong Kong

Developed by: AIDS Concern, Hong Kong
Key words: Awareness raising, prevention, stakeholders in the sex industry, clients of sex workers, Hong Kong

Section	Content
1 Summary of the practice	An outreach programme within the local sex industry in Hong Kong, targeting stakeholders (i.e. pimps, door keepers, cashiers) and sex worker clients
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs targeting Commercial Sex Workers (CSW), their pimps and their clients
4 Problem addressed	Transmission of HIV and other STDs within the sex industry in Hong Kong. Since Hong Kong currently has a relatively low prevalence of HIV, the critical issue is to target interventions to groups with a higher degree of vulnerability to prevent a more generalized epidemic from occurring. Because the CSWs are not permanent residents and highly mobile, focus is specifically on behaviour change (condom use) with the clients who are permanent residents
5 Purpose of intervention	• To increase HIV and STD knowledge among sex workers, their clients and industry stakeholders • To increase condom use among sex workers and acceptance of this among clients
6 Context	• Sex work itself is not illegal in Hong Kong, but many peripheral activities, such as living off the earnings of prostitution and soliciting, are. Sex workers are a highly stigmatised group, constantly being targeted by the police in clean-up campaigns. The majority of sex workers are from overseas with the largest single group coming from Mainland China. These women come over on short stay visas and work illegally before returning to China. The operation is syndicated and controlled by triad groups • The coverage of HIV interventions within Hong Kong's sex industry is currently inadequate largely due to political conservatism that has lead to a diluted and generalized 'public education' agenda for AIDS prevention work in the territory. In recent years there has been a greater recognition of the need to target interventions more effectively at the communities most impacted by the disease • A small survey conducted by the Community Planning Process workgroup in June 2001, showed that many of the sex worker clients interviewed, have engaged in high risk behaviour, with low condom use • An earlier survey of sex workers revealed that perceived AIDS risk and perceived ability to negotiate safer sex seem to be two important factors related to more frequent condom use at work. The most common reason for not using a condom at work was pressure from the client (79%)
7 History and process	• There was no HIV prevention outreach programme targeting sex workers' clients in Hong Kong. We started informally by just visiting establishments and giving gifts of free condoms to the gatekeepers. Once trust and recognition was established, we were able to spend more time with the keepers and visit more frequently. They would then refer us to other establishments nearby • We liaise with the district police offices to inform them of our activities (mainly for the safety of our outreach workers) • We currently employ one full time and one part time outreach worker, to conduct weekly outreach sessions in three different districts and settings within the local sex industry • Targeted establishments include massage parlours in Mongkok; a street side education booth is regularly set up in the middle of the Mongkok sex industry district; nightclubs, karaoke bars and internet cafés in Jordan and Mongkok. We also reach out to streetwalkers in Shumshuipo and Tsuen Wan districts • We collaborate with a local sex website which provides customers with information about the local sex industry; we have set up a Bulletin Board to answer questions relating to HIV/STDs, and safer sex practices

Section	Content
8 Steps in implementation	1 Employ and train staff for outreach 2 Develop and produce outreach materials 3 Random site visits to establish contacts for access 4 Follow up with more productive contacts to develop relationships 5 Focus approach on establishments/districts/contacts which have been most accommodating 6 Use established contacts for approaching new establishments 7 Set up a more visible presence at street level by hosting a street-side booth for sex worker clients on a weekly basis 8 Hold weekly outreach sessions. These involve one-to-one and group dialogue with our target populations. Sometimes this is active, as in the case of brothel-based outreach sessions where we make the first approach. Sometimes it is more passive such as with our street-side information booth that encourages sex worker clients to approach us for information. Conversations with clients typically take 20-30 minutes, and involve risk assessments, the exchange of safer sex and HIV/STD transmission information, and distribution of safer sex kits and booklets. Conversations with other stakeholders, such as keepers and pimps, are usually around 10-20 minutes long. A key goal here is to maintain a working relationship to secure access to clients and sex workers 9 For the sex web site, we take around 2-3 questions per day. The questions are answered by a staff member working on the sex industry outreach programme. We also have a couple of doctors who serve as medical advisors to help us answer questions of a more technical nature
9 Duration	The programme started in 1997. It was suspended between 1998 and 1999 due to resource problems. It has been resumed in 1999
10 Resources required	• **Human Resources:** A project coordinator manages the programme outreach team. We employ one full time outreach worker and one part-time outreach worker who accompanies the full-time outreach worker during outreach sessions • **Equipment:** Population specific safer sex kits, including condoms and condom instruction cards, are distributed during outreach sessions. Safer sex pamphlets, focusing on topics such as sexually transmitted diseases and community resources are also produced and distributed. Bulk packs of condoms, and selections of printed materials about condom use and safer sex are distributed to the sex industry establishments • **Transport** because the project requires workers to make frequent trips to outreach sites away from Hong Kong's city centre • **Funding:** HKD 320,000 (app USD 41,130)
11 Indicators for monitoring	• Number of sex industry establishments we have access to • Number/duration of contacts with stakeholders • Number/duration of contacts with clients • Number of condoms distributed • Number of safer sex kits distributed • Number of booklets/printing material distributed • Number of clients reporting condom use at last sexual encounter • Number of sex workers reporting condom use at last sexual encounter (indicating acceptance of condoms by clients)
12 Impact	• The programme has now established its presence within certain sectors of the local sex industry. This has resulted in relative ease of access to establishments and target populations • The programme has succeeded in generating opportunities for direct dialogue with sex worker clients within the contact of the local sex industry • The programme has ensured that a local website targeting sex worker clients also contains AIDS /safer sex information and gives clients an opportunity to discuss their concerns • The positive impact on behaviour still has to be measured because so far activities have focused on accessing to and building rapport with the clients and stakeholders
13 Challenges and pitfalls	• Once key stakeholders are arrested by the police or establishments forced to close, the programme can lose contact with key informants and supporters. Also programme materials (i.e. condoms, mini posters, booklets) have been seized by police as evidence for prosecution • Outreach work in the sex industry is not widely supported in Hong Kong. There is a fear that sexual health promotion will 'encourage people to have sex'. This conservatism makes it difficult to secure funds to ensure the continuity of the project • The sex worker population is highly mobile. Most workers are migrants on short stay visas. This makes it impossible to do much follow-up with contacts made

Section	Content
14 Critical issues and lessons learnt	• Since August 2001, the programme has had no outside funding, submission of proposals for funding has not yet been successful • With current resource levels the number of contacts we can reach represent only a small proportion of the total number of sex workers and clients in Hong Kong. The key issue for coverage is the number of outreach workers employed and the number of outreach sessions conducted. This will largely depend on the level of funding • We are planning to introduce HIV antibody testing services offered in premises in the middle of the sex industry district. It is hoped that the convenience of such services will help encourage vulnerable people to get tested (research shows that testing levels among vulnerable populations in Hong Kong is as low as 13%) • It is critical for programme success that efforts to penetrate the industry are sustained, that a variety of different approaches are tried and that a certain amount of creativity is employed when determining programme delivery methods • In a society with high rates of internet access such as Hong Kong the internet can provide a very efficient way to reach target populations. The anonymity it affords can make it easier for people to ask the questions they are most concerned about • The relationships with pimps, gatekeepers, and the police can help ensure access and protect the continuity of the programme • It was only by experimentation that we discovered that the most productive efforts to have direct dialogue with sex worker clients was to approach them on the streets where they hang out with each other before or after visiting sex workers. Opportunities for conversations with clients in brothels, while they do exist, are limited and it is much more productive to spend time with the keepers than the clients in this context
15 Source of practice and dialogue	AIDS Concern Dymosh Ng, Prevention Officer 17B, Block F, 3 Lok Man Road, Chai Wan, Hong Kong. Tel: +852 2898 4411 Fax: +852 2505 1682 E-mail: dymosh@aidsconcern.org.hk Website: www.aidsconcern.org.hk
16 Editor's note for learning	• It is a very interesting concept to address sex workers clients as they are a key factor in the decision of condom use. However, to address these clients is in many countries not as easy as described here. Often clients do not want to be seen walking away after visiting a sex worker. According to the NGO, all people in the street know why they are there and if the information booth is located in the right place, men feel at ease to hang around the booth as an informal 'group'. The outreach workers often talk to clusters of men together • In some places also the sex workers are targeted for information and awareness raising but this depends on the visibility of the sex workers. If they are working from the inside of the brothel this is more difficult than if they are walking the streets • One question that remains is the impact on behaviour change. Are the men, after receiving information, indeed adopting safer sex behaviour? It is a challenge to develop methods to assess this

21 The Toco Youth Sexuality Project, Trinidad and Tobago

Developed by: The Toco Youth Sexuality Project, Trinidad and Tobago
Key words: Youth, community, peer education, Trinidad, Caribbean

Section	Content
1 Summary of the practice	A community-based HIV/AIDS youth project based on the respect, protection and promotion of adolescent sexual and reproductive health and rights. It uses community resources, ties, norms and network to meet the health needs of young people aged 12-25 years to develop and maintain healthy lifestyles
2 Level of intervention	In/Out of School, Community, District, National and Regional levels
3 Prospective users of the practice	NGOs, Youth networks, Churches and Faith-based Organisations, Ministry of Education, National AIDS Control Programmes, International Development partner
4 Problem addressed	• Early sex and low condom use • Poor access to Sexual and reproductive health information and counselling for young people
5 Purpose of intervention	• To develop an informed, healthy sexual lifestyles with youth, including the capacity to protect themselves against undesired outcomes of sexual activity such as HIV infection, other sexually transmitted infections (STI), and unwanted pregnancies • To encourage an open dialogue on sexual issues in public and private fora, with parents, teachers, community and religious leaders • To ensure user-friendly and accessible counselling services (reproductive health, HIV/STI) through referral in collaboration with the Regional Authority and the Family Planning Association (FPA) • To ensure availability of and access to condoms, particularly for youth • To encourage and integrate sexual health education activities in local agencies • To develop a core proactive change agents who can develop further leadership skills and career enhancement skills to better enable them to contribute to community improvement
6 Context	• The project area (Toco) is the major town of the county of St. David with 15 villages (North-East Trinidad). Of the population (10,000), a third is in the age bracket 10-24 • The area has 13 primary schools and three secondary schools. Despite reasonable access to education, unemployment rates are high, particularly among youth (approx. 35% among out-of-school youth aged 15-24) • The area is served by six health centres, which are visited by a physician one to three times per week. The centres provide immunisation, antenatal services, and basic medical care though only on the days when the physician visits. Persons with more serious conditions have to travel to hospitals while the nearest STI service is available in the capital city Port of Spain (90 km away) • Prevalent culture of skin-to-skin sex • Enduring misconceptions about HIV/AIDS • Sex tourism is becoming a growing concern • Average age at first sexual intercourse is respectively 10, 14, 15, 16 among in-school males, in-school females, out-of school males and out-of school females (Toco Baseline survey, 1998) • Percentage of condom use: 42% of the sexually active young people never used condoms, 21.3% used condoms sometimes, and 10.6% always used condoms (Toco Baseline survey, 1998)
7 History and process	• In December 1996 a needs assessment was conducted by the Toco Foundation with the support of the United Nations Development Programme • Alongside with development issues (agro-tourism), concerns regarding youth, sexual violence, myths, misconception and increasing number of HIV/AIDS cases were raised • Issues were reported to the Toco Foundation Management and decisions made to address these • The foundation developed a plan of action, which was submitted to CAREC/GTZ. A GTZ consultant supported further fine-tuning of the proposal • Design and implementation were based on regular consultations and discussions held with the various religious leaders, principals and teachers, community leaders, and particularly with the youth • Involvement of PLWHA in designing, training, implementing and monitoring

Section	Content
	• Beneficiaries are primarily the youth (8-24) and sexually active adults in the county. The project originally targeted school-going adolescents (easy to reach), and then expanded to cover out-of-school adolescents, parents and the community in general • Originally, the concept of 'peer educators' was adopted. It proved impractical as young people felt it connotes a top-down approach (leadership). After long deliberation and consultation the concept 'peer worker' was developed indicating more professionalism
8 Steps in implementation	1 **Consultation with youth**: Invite young people who are interested in HIV/AIDS information and working with young people: Discuss the needs assessment findings and the peer education programme, and promote (sell) the idea of becoming a Peer educator 2 **Develop a curriculum and a training manual for peer education**: Hire national experts in HIV/AIDS and training to design a peer education programme and to be responsible for the peer educators training. They will also be responsible for the selection of appropriate professionals (e.g., trainer in drama, substance abuse experts, etc), to ensure that the training is holistic and comprehensive 3 **Implementation of the training**: 3 months in contrast with the 2-3 days of usual training; facilitation by skilled trainers including specialists in various issues 4 **Selection of Peer Workers and Volunteers**: Trainees are informed about the Selection criteria before the training. After the training, 6 trainees are selected and will become full-time staff. They would receive a minimum stipend as 'peer educators'. The others will be classified as volunteers who will be contributing based on needs and their availability 5 **Team building exercise**: to bond the workers as a unit. Confidentiality issues important to peer education are further developed 6 **Marketing of the programme**: Letters to community and church leaders, groups and schools, etc. 7 **Inception and session preparation**: Workers will conduct more research such as focus group discussion with target audience to identify topics and issues to be dealt with, and subsequent literature and accurate information search. These are translated into messages and dramas, role-plays. Common topics relate to sexuality, HIV/AIDS, parenting, relationship and violence, peer pressure, self esteem, self-efficacy and skills 8 **Work plan, service delivery and confidence building**: workers make appointments and plan for implementation and feedback sessions. Different methods are used ranging from presentations, scenario-based discussions, drama play and interactive discussions. Lessons learned from implementation are shared among workers
9 Duration	The Toco Youth and Sexuality Project has been in existence for the last 6 years. The Caribbean Epidemiology Centre/GTZ supports the initiative. A new proposal to scale-up the initiative, and expand activities towards has been submitted to international partners aiming to: • Establish the creation of abstinence clubs • Care and support to people living with or affected by HIV/AIDS • In collaboration with MoH and the Regional Health Authorities to make VCT services accessible to all persons on the Toco Coast • Document processes, effects and outcomes • Share lessons learnt and support initiatives at National, Caribbean countries and at international level
10 Resources required	• Training of peer educators • Supervision cost • Transportation • Salaries for full-time peer workers • Incentives for volunteers • Condoms, Behaviour change communication material • Equipment/material (office supplies, TV and video sets, etc) • Advertisement (billboards, pamphlets, rural radio component) • Back-up and support in Care and support to PLWHA, Abstinence Clubs
11 Indicators for monitoring	• Number of schools visited and number of sessions held in each school • Number of households visited • Number of churches visited • Monitoring workers performance during debriefing and feedback sessions • Donor's built indicators (number of condoms distributedo • Change in topics addressed over time
12 Impact	• Reached approx. 85% of the youth on the Toco coast both in and out of school, cutting across race, ethnicity, sexual orientation or gender

Section	Content
	• Through their house to house program, peer workers have visited over 1061 households in 15 villages • Through their school programs every primary and secondary schools was visited, reaching over 2,000 young people aged 6-19, on a regular basis • Community presentations were positively appreciated as testified by the many requests to conduct information sessions and parenting programmes at schools, community centres and churches • Workers were able to discuss and demonstrate condom use in schools and churches, which is unique around the world • Young people come to workers to discuss personal concern including rape, incest, pregnancy, HIV positive status • Linkages with the National AIDS Programme, the Tobago Needs Assessment Project, other youth programmes(Rapport Youth Information Centre) • The concept is being duplicated in other communities in Trinidad and Tobago and other Caribbean territories • Recipient of the Commonwealth award and endorsement by UNAIDS as Best Practice to be shared throughout the Caribbean and the World • Though attribution could be questioned, the county now presents the second lowest incidence of HIV/AIDS with 32 HIV and 19 AIDS new cases, and 8 deaths in 2000 (Ministry of health, 2000)
13 Challenges and pitfalls	• High expectations from the community and young people • Role modelling: peer workers need to display positive attitudes and behaviours • Get support for a comprehensive and intense training programme rather than the usual Training of Trainers / Cascade training models, which are not effective (decreasing duration and quality of training at each level)
14 Critical issues and lessons learnt	• When the community takes charge, it eventually gets support from the State, which does not wish to be left aside in the process (for instance, the Foundation started building its centre and received (forced) support from the State) • Ability to involve all the stakeholders in the community at all stages of programming • Credibility of the foundation based on the foundation record of accomplishment in the county and previous work (rural radio, women project, training in agro-tourism) • Belonging to the Toco community is critical to shaping lifestyles. Workers understand local norms, culture and challenges; peers accept them. Confidentiality, credibility and worker lifestyle do the rest • Training: proper allocation of time (3 months) for training, which includes theoretical aspect and actual implementation under supervision, and 1-week process of team building to bond workers as a unit. This proved more effective than the usual training models • Concept of `Peer Workers': visiting other peer education programme internationally, feeling that peer education resembles a top-down approach in which the peer educator is empowered to become a 'leader' who knows more than his peers and has to influence them. In contrast, the Toco workers are providing professional services and while they are perceived as 'models', they remain humble servants and workers • Initially there was a perception of the community that only doctors or nurses are equipped to handle such delicate issues. Therefore, the team must ensure that it is well prepared to deal with the issues at a professional level and to dispel community misperceptions and myths • Interactive approaches dispel the concept of teacher-driven approach, remove barriers built by young people towards teachers. A Toco project 'Peer Worker' worker will be dressed like its audience, turn his chair and sit the other way around, and will always keep a smile. They always send a 'How can I help you' message
15 Source of practice and dialogue	Toco Youth and Sexuality Project C/o Victoria Pritchard Resource Centre Galera Rd, Toco, Republic of Trinidad and Tobago Contact Person: Leroy Serapio Tel Office: +1 (868) 670 0068. Tel Home: +1 (868) 670 1505 E-mail: Dltoco@tstt.net.tt; tysp@tstt.net.tt Training material: Peer workers Training Manual *Choice or Chance: Choose Life* (See contact details above)
16 Editor's note for learning	Donors' expectations that 'volunteers' will work free are not realistic and result in dropout and high turnover of staff. Especially peer educators already under pressure (workload and difficult hours of operation) have personal expectations in life in terms of job satisfaction and should be supported consistently

22 Outreach voluntary counselling and testing (VCT) targeting MSM in Hong Kong saunas

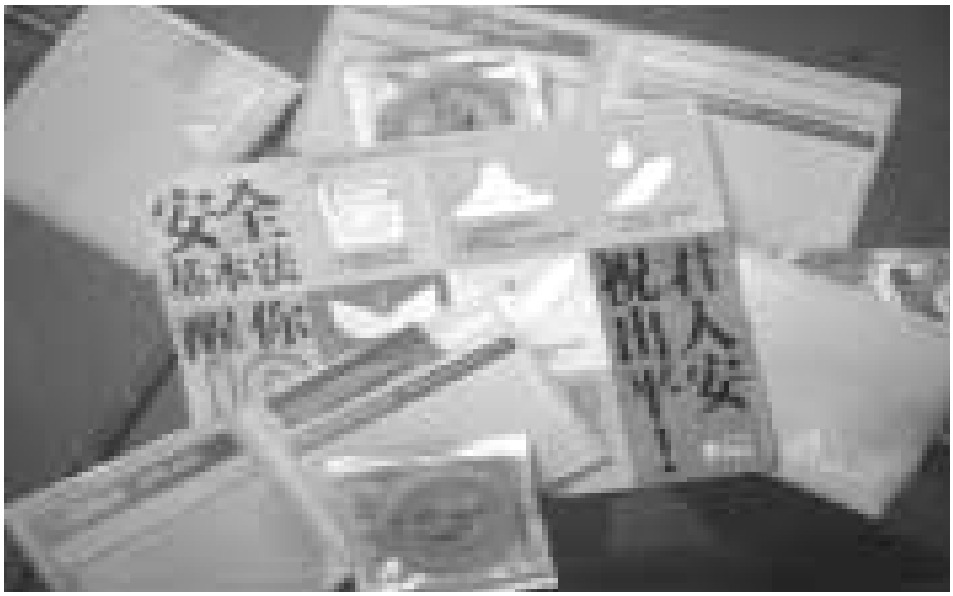
Developed by: AIDS Concern, Hong Kong
Key words: MSM, Voluntary counselling and testing, outreach, Hong Kong

Section	Content
1 Summary of the practice	A community-based VCT service targeting MSM at MSM specific saunas
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs targeting MSM, Public health services
4 Problem addressed	• The Hong Kong Department of Health (2001) stated that approximately one-fourth of new cases of HIV infection are attributed to homosexual contact • Because of perceived/real homophobia of mainstream service providers, MSM are unlikely to report their sexual identity and this makes it difficult to offer VCT services
5 Purpose of intervention	• To facilitate access to VCT for MSM • To increase the number of MSM getting tested • To increase knowledge of safer sex practice with MSM • To increase data base for the behavior and prevalence surveillance of MSM
6 Context	The MSM population in Hong Kong remains a highly stigmatised and invisible community. A complete absence of public policies that protect the personal (e.g. marriage, adoption rights, visitation rights) and working lives of these individuals forces them to remain closeted. In addition, cultural values that favour Confucian ideology and an emphasis on family over individual rights, force many gay persons to remain isolated. As a result, there is a proliferation of 'underground' venues where MSM find each other. Public cruising environments such as gay saunas, health clubs, beaches, and public toilets become popular meeting places where MSM find sex partners. The AIDS Concern's MSM VCT outreach project is developed in reaction to this phenomenon. It seeks to bring HIV and STI information to MSM and to provide testing services that are culturally appropriate and non-judgmental
7 History and process	• We first consulted with MSM sauna owners and their customers. After receiving much positive feedback from them, we decided to move forward with the service • We then consulted experts who had relevant experience in delivering VCT service and the skills in providing pre and post test counselling • We liased with relevant parties, such as medical providers, laboratories and police for back-up and support • We developed service protocols, including the procedure of using the service, and guidelines for pre- and post-test counselling • Staff (also MSM) was trained to render the testing service (formerly the oral fluid testing system, now the urine testing method) and provide pre- and post-test counselling • A three-month pilot project was conducted to evaluate the practicality of the service • Long term funding was found for on-going implementation after the successful experience of the pilot project
8 Steps in implementation	1 Conduct pre-test counselling at saunas with a focus on understanding the testing procedures. The service is only conducted at saunas that can provide private rooms for the service. The service hours are publicized at saunas and gay media, and on the day of the service delivered, posters will be put up around the sauna to let the men know 2 Send tested samples to the laboratory of the Department of Health for analysis 3 Give out reports to clients in person and deliver post-test counselling in which also safe sex practices are discussed 4 If found positive, the client is referred for medical follow-up
9 Duration	Conducted the pilot project from August to October 2000 and recommenced the service as from May 2001

Section	Content
10 Resources required	• Funding – about HK$ 600,000/year (about $ 70.000) (1 Hong Kong Dollar = 0.13 USD) • Trained Counsellors (the two current counsellors got social work training, and had in-job training specifically for HIV testing) • Volunteers to assist counsellors during testing sessions. For security reasons, the volunteers accompany the counsellors to ensure that accusations on sexual approach cannot be made. The counsellors focus on the counselling while the volunteers can deal with any other issues. In addition, the volunteers, who are MSM themselves, are at the same time trained in HIV/ AIDS issues • Saunas that can provide a private testing space • Laboratory support • Contacts for referral mechanisms, such as medical advice or medical follow-up for HIV positive cases
11 Indicators for monitoring	• Number of outreach VCT sessions • Number of participating saunas • Number of MSM tested • Number of MSM tested for the first time • Number of MSM counselled on safer sex practices • % of MSM reported improved safer sex practices knowledge • Number of MSM reported on their sexual behaviors • % of behavioral data on MSM to the Department of Health (DH) reported from our project
12 Impact	• 248 MSM got tested with our service from Aug 2000-Oct 2000 and from May 2001-Oct 2002 • 72% of those who got tested had never taken the test before. They said they would not have been taken the test if our service were not available • Easily accessible location, free of charge, and confidentiality were the three most popular characteristics of the service that motivated our contacts to take the test • Besides knowing their HIV status, the service also enhanced the contacts' knowledge on HIV testing, safer sex practices and HIV/AIDS • For those who compared our service with other testing services, they found our service more client-centered and less embarrassing. They also appreciated the pre-test counseling provided and the fact that a gay peer counselor was giving the service
13 Challenges and pitfalls	• Although the service has been made to be more accessible, many MSM still avoid getting tested out of fear that they may receive a positive result and have to endure the heavy stigma attached to persons infected with HIV • The service is dependent on the support of the sauna management. Factors beyond our control, such as the closure and renovation of saunas, insufficient space for testing (saunas in Hong Kong are relatively small) and lack of support on the part of sauna owners, may affect the continuation of our services
14 Critical issues and lessons learnt	• For minority populations such as MSM, who experience much discrimination, traditional approaches such as testing services in traditional medical settings, may not be the most suitable. A community-based method that respects the distinctive needs of vulnerable groups, allows for more flexibility in delivering the testing service, overcoming existing barriers to testing • By delivering the service in an MSM environment, it is easier for our MSM contacts to have an open and honest discussion about their same sex practices • Through face-to-face contact, misinformation about AIDS that prevents the target group from getting tested can be identified. For example, sauna users become more motivated to use our service when they understand that a good quality of life (available treatment and health maintenance) can still be possible after being infected • AIDS used to be quite a taboo subject in the sauna setting. It took some time to build up relationships with saunas and for these establishments to understand the underlying reasons to do HIV prevention work. Some owners now even play a more active role in the process. For example, one sauna offers discount coupons to encourage people to get tested • The response rate of the pilot project has shown that the fear that few would come forward to get tested proved wrong • Reluctance from some saunas can be overcome by having some successful examples. With two participating saunas blazing the trail, a few other saunas have become more open to the service and consider implementing it

Section	Content
15 Source of practice and dialogue	AIDS Concern Chung Lau, Prevention Officer/Outreach Worker 17B, Block F, 3 Lok Man Road, Chai Wan, Hong Kong. Tel: +852 2898 4411 Fax: +852 2505 1682 E-mail: chunglau@aidsconcern.org.hk Website: www.aidsconcern.org.hk Testing service website: www.saunatesting.com
16 Editor's note for learning	• This programme shows that bringing testing services to a target group that is reluctant to use testing services elsewhere for fear of discrimination, can be a successful approach • It is interesting to note that the partnership between the programme and the saunas has been possible and in future it may even attract more customers to these saunas

Picture: Safer sex kits distributed during outreach work in public cruising environments



23 Voucher scheme for S&RH health services, Nicaragua

Developed by: Instituto Centroamericano de la Salud (ICAS)
Key words: MSM, IDU, sex workers, sexual and reproductive health, STI/HIV, access to services, Nicaragua

Section	Content
1 Summary of the practice	A programme which introduces a voucher scheme to enable access of vulnerable populations to sexual and reproductive health services, free of charge
2 Level of intervention	District level (health care providers) and community level (vulnerable population groups)
3 Prospective users of the practice	NGOs, Government institutions (Health care departments, SRH clinics or PHC centres), health insurance companies, employers
4 Problem addressed	• Poor quality of sexual and reproductive health (SRH) care in Nicaragua • Poor access to S&RH services for vulnerable groups such as sex workers (SW), injecting drugs users (IDU), men having sex with men (MSM) and a high rate of partner change
5 Purpose of intervention	• To reduce the incidence of Sexually Transmitted Infections (STIs) in vulnerable groups • To diagnose and cure existing STIs • To increase use of safe sex practices • To prevent further development of the HIV/AIDS epidemic
6 Context	• Nicaragua is still at an early stage of the AIDS epidemic and was the last country of Central America to record AIDS cases • A cumulative number of 392 AIDS cases was reported in May 2002 • HIV prevalence is estimated at 0.2% among adults and at 2% among sex workers in Managua in 1999 • Absence of good quality SRH services • Existing services are stigmatising and have a low service quality
7 History and process	• When it was realised that limited access to SRH services for vulnerable groups is a barrier to reduce STIs and HIV transmission, a program was designed to improve access and quality of SRH services. A small pilot was carried out in which sex workers were given a voucher allowing them to visit a reproductive health clinic free of charge • This approach proved to be attractive for the sex workers and provided the basic concept for the voucher scheme. Funds were obtained to find out the potential of voucher schemes and to understand the needs and preferences of different vulnerable groups • ICAS (Central American Health Institute) acted as the voucher agency and fund-raiser. About 12 clinics/laboratories and 10 NGOs working with vulnerable groups were involved. Funding is presently provided by NOVIB (Dutch Oxfam) and USAID • Proposals for further funding to scale-up the programme have been submitted to different donors
8 Steps in implementation	1 Mapping of sex work sites in Managua on a city-wide scale by ICAS 2 Ethnographic study to identify vulnerable population groups, their needs and preferences 3 Development of a standardised SRH service package. Sex workers, MSM and clients were involved in the design of this package 4 Contracting clinics and laboratories through a competitive tender, assessing price, quality and location. Contracts are drawn up, which stipulate prices and require staff to receive training and to use the treatment protocols 5 Training of all clinic staff 6 Distribution of vouchers. At 6 months intervals, about 2000 vouchers are distributed to all sex workers at work sites (including glue sniffers and male prostitutes) directly or through one of the NGOs participating in the programme. The vouchers remain valid for 3 months and entitle the bearer to the standardised S&RH package free of charge at any of the 10 contracted private, charity or public clinics 7 The clinics are paid on the basis of the number of vouchers they return 8 Monitoring and evaluation of quality of services is done by ICAS. Service providers failing to provide an acceptable service quality or failing to attract users are replaced in subsequent rounds

Section	Content
9 Duration	The voucher programme started formally in 1995. Early 1996 the first distribution round was implemented. Since then 14 rounds have been realised. In 1999 the scheme was extended to incorporate regular clients and partners of sex workers. In 2001 MSM with a high rate of partner change were included
10 Resources required	• Human resources for the voucher agency: one medical staff, one sociologist/anthropologist, one data manager, one logistics officer and an assistant accountant • Availability of clinical and laboratory services in the public and/or private sector • Office with telephone and computer to print the vouchers • Financial resources. To run the full voucher scheme in Managua costs US$100,000 a year, about half are direct costs of providing health services (including condoms and health education materials), one third for salaries (including field workers) and the rest for office and transport costs • Training on how to run a voucher scheme and training for staff in clinics on STI consultation and treatment
11 Indicators for monitoring	• Numbers of vouchers distributed • Number of vouchers used • Prevalence of STIs in one time voucher users and repeat users • Knowledge about safe sex among vulnerable populations • Assessment of performance of clinics through street interviews with 10% of voucher users, medical record review and percentage of follow-up consultations
12 Impact	• Since 1996 more then 18,000 vouchers were distributed, more than 7,000 consultations provided and over 2,700 STIs detected and treated • Full coverage of the programme in Managua with a dynamic population of about 1,150 sex workers • Each round more than 40% of the vouchers are redeemed • For all sex workers using the vouchers, there is a reduction of prevalence of gonorrhoea of 5% per year. For syphilis this is 6% per year • Existing institutional structures are strengthened • The quality of SRH services is improved and a greater choice in services is provided for sex workers and clients through the voucher scheme • The programme is now being extended to Honduras, a country with one of the highest prevalence rates of HIV in all of the Americas
13 Challenges and pitfalls	• Shortage of funds during the first years when the program moved from research into an ongoing programme • High turnover and mobility of vulnerable populations • Training of staff alone will not ensure the quality of service at the clinics. It needs stringent monitoring and feedback. Also constant feedback from vulnerable populations is vital. If a service package is not updated according to needs and preferences, voucher redemption reduces
14 Critical issues and lessons learnt	• Key to success is the power of choice given to the consumer (demand-side) rather than to the supply-side (the health service providers) • The subsequent competition between health service providers creates incentives to raise quality and lower costs (the clinics compete for contracts based on price, quality and location, and are paid according to the number of vouchers they return) • Monitoring of the quality of the services provided and feedback to the clinics is indispensable • Good relations are needed with vulnerable populations' organisations or networks so they can express their needs and preferences and participate in the design of a service package • The programme expected reluctance of health care providers to receive vulnerable populations. Although the clinics did have initial fears that these populations would push out other clients, this is not the case. Thus the clinics have been collaborating enthusiastically • The programme is confident to maintain funding for the on-going programmes and for scaling up. Potential donors see the programme as an attractive mechanism to ensure 'good value for money'. The MoH recognizes the valuable role of the programme in detaining the AIDS epidemic, but efforts to get ongoing funding from the Ministry have failed so far

Section	Content
15 Source of practice and dialogue	Instituto Centroamericano de la Salud (ICAS) Apartado Postal 2234, Managua, Nicaragua Phone: 00-505-270-0252 or 00-505-270-0891 Fax: 00-505-277-0178 E-mail: bonos@icas.net or agorter@ibw.com.ni Website: www.icas.net (contains articles and presentations on the voucher scheme) Contact persons: Dr. Zoyla Segura and Dr. Anna Gorter
16 Editor's note for learning	So far, the scheme is dependent on donor funding and this raises questions about sustainability. It is not clear if government or social security funds will assume the responsibility of funding such a scheme in a situation where government-owned clinics tend to be short of many things (drugs, staff, equipment). Funding government clinics is likely to be a priority above funding a scheme for which also private clinics are eligible. It could be imagined that small user fees are introduced once the system has been well accepted among the users, but this is dependent on the economic situation of the users

Picture: A woman with a voucher

24 The 'Wear to Care' project, Togo

Developed by: Focal Point HIV/AIDS, UNDP Office, Lomé, Togo
Key words: Youth, schools, prevention, social mobilisation, T-shirt design, arts, Togo

Section	Content
1 Summary of the practice	Students use their creative imagination in the design of T-shirts to get an HIV/AIDS message across to their families and to their communities
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs, schools, youth organisations
4 Problem addressed	Lack of appropriate messages on HIV/AIDS for youth due to lack of opportunities for youth to participate in the creation of messages targeted to them
5 Purpose of intervention	• Enable youth to use their creativity to design appropriate messages for their friends and family • Organize cultural events in poor schools which lack of resources • Raise awareness about HIV/AIDS among students, teachers and school staff
6 Context	• Prevalence of HIV in Togo according to latest surveillance in 1999 is 6% • A national multi-sectoral institutional framework, Conseil National de Lutte contre le SIDA (CNLS) was created by presidential decree in October 2001 and there is an increasing awareness and interest HIV/AIDS issues among governmental and non-governmental organisations • Information and awareness campaigns on HIV/AIDS have been carried out throughout Togo, but have mostly been concentrated in the urban areas, in particular in Lomé and the Maritime region • The prevalence of HIV is high amongst young people; however, their perception of risk is still relatively low • Youth in rural communities are more difficult to reach due to a number of factors, including low school attendance rates, and relative geographic isolation of villages
7 History and process	• A local NGO, Groupe d'Action et de Solidarité pour le Développement (GASD) with support from UNDP, initiated the project 'Wear to Care', in which 750 Togolese youth, aged 8 to 18, competed to design a T-shirt to inform their communities about HIV/AIDS • An interdisciplinary, multicultural jury, including a medical doctor, an artist, a teacher, and an art critic, selected the most original creations • The award-winning design was printed on T-shirts, which were handed out on World AIDS Day. The T-shirts were worn by youth, members of the UNAIDS Theme Group, diplomats, and members of Togolese and Beninese organisations of people living with HIV/AIDS • The design competition took place after AIDS education and information sessions in the 10 participating public and private schools. Evaluation of pre-and post-test results showed that the strongest increase of knowledge had taken place in the poorest public schools. Two of the three winners were girls
8 Steps in implementation	1 The NGO obtained permission from government authorities to work in public schools based on the project description 2 10 schools were invited to participate and Directors were requested to provide maximum 75 students, a space in the school and support staff 3 Participants started with an anonymous pre-test to assess their knowledge about HIV/AIDS transmission and prevention and attitudes towards PLWHA 4 They were provided with information on HIV/AIDS by the NGO using the blackboard or sheets, video (if electricity was available), discussions and question and answer sessions 5 After the session they were given a post test to assess their knowledge and attitudes 6 If they still had energy they started to draw after a break. If not they came back at a later time for two hours 7 Drawing materials were provided 8 The executing NGO collected the designs and encoded them to hide the identity of the participants to the jury 9 Invitation of jury members

Section	Content
	10 Selection of winners 11 Printing of T-shirts 12 Distribution on World AIDS Day
9 Duration	The project is part of Art versus Aids programme that was initiated in 2000 which is still ongoing
10 Resources required	• Capacity to teach on HIV/AIDS to young people • HIV/AIDS education material • Drawing materials • T-shirt printing facilities • Funding: The total cost was $ 2800 (UNDP supported this project financially for World Aids day 2000). Each participant received a T-shirt of the winner in his/her age category
11 Indicators for monitoring	• Pre-post test results • Number of completed drawings • Number of printed t-shirts • Number of people who wear the t-shirts
12 Impact	• Dozens of schools have asked for a similar activity in their schools • The T-shirts are in high demand, and are still worn by students during sports events
13 Challenges and pitfalls	Students may think that their ideas about sexuality may conflict with teachers' values and norms. They may feel restricted to discuss sexuality openly for fear of repercussions in school performance assessments
14 Critical issues and lessons learnt	• Schools usually welcome opportunities for their students to express their creativity and participate in cultural events. HIV/AIDS however is a sensitive subject due to its association with (premarital) sexuality • To put students at ease it is important that the school staff explicitly supports free expression of ideas before the drawing session • School teachers should keep a distance from the students during the drawing sessions • Drawings should be encoded because some students may draw images which are considered offensive by others, including jury members
15 Source of practice and dialogue	Focal Point HIV/AIDS, UNDP Office, Lomé, Togo E-mail: fo.tgo@undp.org For pictures see http://www.pnud.tg/artvsaids/
16 Editor's note for learning	The approach used here can also be used with different target groups such as out of school peer educators and youth organisations

Picture: Example of a T-shirt
INSERT 30 Togotshirt.jpg

25 Young peoples' movement in Jhapa, Morang and Illam districts in response to HIV/AIDS, Nepal

Developed by: Save the Children UK, Nepal
Key words: Youth, prevention, peer education, Nepal

Section	Content
1 Summary of the practice	Mobilisation of young people, aged 12 -24 years, who volunteer to work as peer educators in their communities on HIV/AIDS/STI and reproductive health issues after initial training on HIV/AIDS (knowledge and life skills to protect them from HIV infection)
2 Level of intervention	School and Community level
3 Prospective users of the practice	District, national and international NGOs, Government institutions, Community based organisations
4 Problem addressed	Providing information is not enough to bring about behaviour change among young people unless a programme helps them understand the various issues related to actual practices and how to address these
5 Purpose of intervention	To reduce the potential impact of the emerging STI/HIV/AIDS threat on children and young people's lives by: • developing and reinforcing their skills to deal with the problem in their society (where talking about sex and sexual behaviour is taboo) • enabling them to discuss and understand the issues surrounding STI/HIV/AIDS prevention including how to support attitude and behaviour change among peers through their own initiatives
6 Context	• In Nepal, the AIDS epidemic is concentrated among sex workers, injecting drug users and labour migrants, with infection rates rapidly increasing in recent years. Adult prevalence (15-49-years-old) is estimated at 0.5% with a ration male-female 3:1 (UNAIDS, 2002; HGM/Nepal, MoES, 2003) • Jhapa, Morang and Ilam districts are the most densely populated districts in the eastern development region of Nepal. These districts have an open border with India, a very high degree of movement across the border and a refugee camp hosting more than 100.000 people • As a result, commercial sex work, drug abuse, trafficking of girls, domestic violence, migration and family separation are commonly observed phenomena • Save the Children /UK has been working in the area and has developed an awareness raising programme in the Bhutanese Refugee Camps to provide HIV/AIDS information but has not been able to influence young people's behaviours • The need to expand the programme beyond the camps was felt because of the sexual interaction among youth both inside and outside the camps. The expansion started in the five neighbouring villages and in Jhapa and Morang districts that have been identified at risk for HIV infection • All 75 districts in Nepal are subdivided in Village Development Committees (VDC) with a population of 4000 -10,000, depending on the size and topography of the district. The VDC office is the lowest unit of the political structure and it has elected members
7 History and process	• The previous Save the Children's activities in the Bhutanese Refugee Camps concerned provision of health services (both preventive and curative) and activities in pre-schools, disability and AIDS awareness • In 1998, a survey on knowledge, attitudes and practices (KAP) among children (both within and outside the camps) was conducted, which concluded that children lack of knowledge on sexuality, reproductive health and HIV/AIDS related matters. This survey was complemented by two other studies done on reproductive health needs of adolescents and the impact of early marriage on children. The studies revealed that in addition to providing information, there was a need to focus on developing life skills to support consistent behaviour change • The programme in the camps and the surrounding villages started by meeting health workers, teachers, parents and community leaders and explaining the outcome of the survey and the need to start awareness and prevention activities that are carried out by

Section	Content
	the youth themselves. After this, the project staff approached youth in the camps and the villages through schools and the VDCs and explained the outcome of the survey and the purpose of the project. Those interested to become volunteers (who are given the name as SoVAA) and aged 12-24 years were asked to fill up a volunteer application form for registration • Fifty volunteers from the villages and fifty volunteers from the camps came forward. With few of these volunteers, a curriculum was developed covering basic information on HIV/AIDS, reproductive health, STIs, sex and sexuality, condom use, what is peer education, what is peer pressure and how to handle it, problem solving, decision making, negotiation, how to cope with stress and emotions and postponement for having sex, etc. The training is conducted with participatory methods such as role-plays, skits, games, brainstorming, group interaction, demonstration, discussion, small group work etc. The curriculum was used in an initial training of 5 days for all volunteers, conducted by Save the Children • At the end of the training, the peer educators received materials (booklets, brochures, posters etc.), they formed groups and planned activities in their own communities and schools. Such activities include dramas and plays, making posters, putting notice boards with information about activities and about HIV/AIDS, condom promotion, referrals to health posts, discussions with peers, organising various extra curricular activities in the schools, participating in meetings of other community based organisations and in training programmes of other agencies. They also mobilise and train other young people to become volunteers • The different groups meet on a regular basis (some groups meet on monthly basis and some on two monthly depending on the geographical spread) to share on progress, successes, problems and challenges and their work plan. Staff from Save the Children attends these meetings but does not give financial assistance for them
8 Steps in implementation	1 Meeting with health workers, teachers, parents and community leaders to explain the outcome of the survey and to discuss the need for peer education activities to increase knowledge and skills in the field of HIV/AIDS/STI prevention 2 Meetings with youth in the community to identify volunteers 3 Registration of volunteers 4 Curriculum development jointly with the volunteers 5 Training of volunteers in workshops 6 Planning for activities by each group of peer educators 7 Implementation of peer education activities for children in their own communities/camps and schools 8 Networking between the different peer educator groups and regular meetings to share work plans, progress, successes, problems, challenges and solutions 9 Expansion of the programme in new wards, village development committees, schools by the SoVAAs 10 Identifying and training new and potential volunteers 11 Save the Children is collaborating and coordinating with organisations that are providing health services/STI services/youth friendly services to respond to the demand from the children and the young people
9 Duration	The Programme started in 1998 in the Bhutanese Refugee Camps and since June 2000 in the refugee affected village development committees, funding was secured from UNHCR for a period of 3 years (end of 2000). Since 2001, to allow for expansion and continuation of the work, Save the Children UK with Lutheran World Federation is co-funding the programme till March 2004
10 Resources required	• Initial and refresher HIV/AIDS and life skills training curriculum • Information, educational and communication materials - various posters, brochures, booklets on HIV/AIDS information, video films produced by other agencies and a manual on peer education (Nepali) produced by SC UK for use by the volunteers • Stationery support for workshops/training organised by SoVAAs • Support to SoVAAs initiatives and plans by Save the Children staff. Stationery support, travel and food (if they are to implement their activities outside their VDC), is provided by Save the Children, other support required (either financial or non-financial) comes from from the VDC budget, schools, other agencies and the community • Salaries for Save the Children/UK project staff members (2 project officers and one administration assistant), about £ 13,000 per year (1 British Pound (GBP) = 1.84 USD)

Section	Content
11 Indicators for monitoring	• Number of peer educators (SoVAAs) trained • Number of children and young people who received life-skills training from the peer educators • Case studies/reports/documentation on behaviour changes • Visits to clinics for treatment or counselling (in one of the VDC of Illam district, the number of visits for STI treatment or counselling has increased by 60%)
12 Impact	• The number of volunteers in the villages has increased from 50 in June 2000, to 2205 at present and is expanding into schools and communities as a youth movement • The number of villages having volunteers and activities has expanded from 5 to 28 and two municipalities where the programme is implemented. Since 2001, the programme in the seven refugee camps has been taken over by another agency • Young people have shown they can work together in the fight against AIDS and receive support from adults • Young people show that through volunteerism there can be a sustainable response to the epidemic • Increased levels of information about HIV/AIDS • Decreased level of hesitation and shyness to talk about HIV/AIDS and sexual issues • Improved communication and negotiation skills for safer behaviours • The volunteers are able to mobilise financial and non-financial support from adults and local government institutions such as the for instance the District Development Committee (DDC) of Illam district allocating Rs. 2500 to cover the cost of tea and snacks during the discussion of the programme; DDC and VDC offices providing rooms for meetings; VDC offices allocating money ranging from Rs. 500 to 10,000 for implementing HIV/AIDS programmes; inviting volunteers to attend various training and workshops organised by other agencies; schools providing rooms to organise meeting, debates, competitions, drama, space in the school notice board to publish information on HIV/AIDS
13 Challenges and pitfalls	• Increasing outreach to more vulnerable children and young people • Providing support to volunteers at times that are convenient to them – this may at times not be so convenient to the Save the Children staff
14 Critical issues and lessons learnt	• Ownership of initiatives by volunteers enhances motivation • Given the opportunity, young people are able to find innovative answers to their questions and problems, to analyse and reflect on their work and to make important decisions about the future of the programme and outreach to large numbers • Organisations should take a facilitative rather than a directive role for such programmes to succeed • It has to be taken into account that volunteers drop out and that the process of identifying and training new volunteers is continuous • Motivation is crucial to keep the volunteers. Thus volunteers are enabled to share their experiences and achievements in various platforms, they participate in further training and workshops and are themselves making decisions on their activities. They also receive badges and certificates
15 Source of practice and dialogue	Youth and Adolescent Life Skills Education Programme, Save the Children UK (Komal Sharma , Haribol Bajagain or Rajan Timilsina) Eastern Region Programme Office, Damak, Jhapa, Nepal. Tel: 977-1-023-580238 Fax: 977-1-023-580025 E-mail: k.sharma@sc-uk.org.np, r.timilsina@sc-uk.org.np; h.bajagain@sc-uk.org.np
16 Editor's note for learning	It is interesting to note that after the initial training of volunteers, the activities are being expanded and initiated by the volunteers themselves. The fact that they have been successful in linking up with schools, VDCs and other organisations will enhance motivation with the volunteers to continue their work and safeguard sustainability of the intervention

Picture: Meeting of the network of peer educators in Jhapa

26 Youth learning to take care in a poor neighbourhood in São Paulo, Brazil

Developed by: Grupo de Trabalho e Pesquisa em Orientação Sexual (GTPOS), São Paulo, Brazil
Key words: Youth, peer education, empowerment, Brazil

Section	Content
1 Summary of the practice	By training of teachers and adolescents, the project aims to reduce the vulnerability of poor adolescents in the suburb of Brazilândia in São Paulo
2 Level of intervention	Community level
3 Prospective users of the practice	NGOs, government institutions and private sector institutions working with adolescents
4 Problem addressed	• Vulnerability of adolescents to unwanted side effects of sex, because of lack of support and information about sexual and reproductive health services • Stereotyping of boys to show their macho sides and of girls being romantic, resulting in difficulties in negotiating the use of condoms and peer pressure to have unprotected sex • A general idea among adolescents that they are not vulnerable to HIV infection
5 Purpose of intervention	To reduce the vulnerability of adolescents to the risk of unsafe sex by empowering them through raising knowledge about HIV/AIDS, promoting positive values and attitudes and developing personal skills
6 Context	• The majority of Brazilian youth (31% of the total population of the country) is concentrated in urban centres and they start their sexual live consistently earlier than before. They do not use protection and this leads to an increased birth rate among adolescent females • More then 50% of PLWHA are found in the age group of 20 to 30 years. In the age group of 15 to 24 years, the proportion between men and women infected with HIV is 1:1 (according to data of 1998 of the National Network of Human Rights in HIV/AIDS) • The Project is situated in the northern part of São Paulo, Brazilândia, which has the highest percentage of AIDS cases in the city (18%). This area shows also the worst human development indicators in the City (conform a census in 2000) and is ruled by the drugs mafia • 70% of pregnant women that come to the health services, are adolescents. In Brazil, prenatal HIV testing is mandatory and the treatment is guaranteed by the health services. Procedures related to vertical transmission of HIV are being developed • Although public education in Brazil is free until the end of secondary education, frequently children and adolescents are entering the informal labour market and abandon school because of economic problems in the family. Poverty is extreme in this area

7 History and process	• The NGO GTPOS was asked by the municipality to develop a training programme for teachers of public schools and health workers focusing on three fundamental issues:
	  • Gender, the relation between women and men and their sexual well being
	  • STI/HIV/AIDS prevention
	  • The erotic and reproductive body
	• The project started in 1996 with the sensitisation of 360 adolescents in public and private schools in São Paulo. Of this group, 90 adolescents were trained to become peer educators in awareness raising and prevention of STI/HIV/AIDS. They conducted workshops, gave lectures and organised seminars with groups of youth and participate in regional and national meetings for adolescents, under the supervision and continuous training of GTPOS
	• In 1999 adolescents co-ordinated the first São Paulo Meeting for Adolescents and produced the music album Adolescents and Vulnerability
	• The Project in Brazilândia is one of the eight centres of the wider Project *Trance essa Rede*, in São Paulo. Each centre of the Project reports to headquarters and in direct connection with the other projects

8 Steps in implementation	**Phase 1: Preparatory activities** 1 Approach a community leader as an entrance in the community. Before moving into the at times unsafe suburbs, the project personnel will always announce its arrival and will be accompanied by a community leader, who will enter into contact those that potentially could participate in the project

Section	Content
	2 Presentation of the project to the interested institutions in the community. A proposal for an intervention is discussed with the local counterparts and if they show interest, they will define a project proposal with community representatives 3 The local stakeholders play a role as coordinator of the activities in the community, the selection of the participants, nominating the coordinator, assessing the time schedule and the forms of dissemination and selection of groups of adolescents and community trainers 4 Selection of the participants (adolescents and trainers) and a coordinator from one of the institutions in the community 5 Planning for training workshops **Phase 2: Development of training materials** 6 Development of training materials and documentation. The didactic material uses the proper language of adolescents. Methodological approach: the content of the course consists predominantly of discussions with trainers and peer educators, using to a limited extent printed text. The approach is very adolescent oriented and focus is on acquiring skills to reduce the vulnerability of the adolescents and to empower them. The participatory methodology used follows a cascade system, that in three steps reach the peer-educators in the community / streets. It uses simple systems of situations describing the daily life and concerns of the peers and adolescents; use of written education materials is minimal and restricted to some factual information on addresses etc. **Phase 3: Conducting the Training of Trainers course** 7 Developing a schedule for the trainers in Brazilândia 8 Sensitisation workshops for one group of trainers (about 30 in every group) **Phase 4: Identifying and training of peer educators** 9 The future peer educators are identified by the trainers from their own communities in an informal way by contacting personally potential candidates among the adolescent population. 10 Once identified, the future peer educators are invited to meet somewhere in their own community for a one day training session (15 participants per training) **Phase 5: Implementation phase (Peer education)** 11 Once the peer educators are trained they do their work in the community. This is done in a very informal way, at schools, in meeting places at nights and during the weekends; they may (but not necessarily) distribute some simple education materials **Note**: Due to a high turn-over of both ToT and peer educators there is a need for a continuous training of trainers and adolescents **Note**: The project also created a health and gynaecological service for adolescents of the suburb
9 Duration	The Brazilândia project started in October 2001 and is ongoing
10 Resources required	• Space in the community to hold the workshops and subsequent activities • Budget for trainers, training material, food for workshops, transport to bring adolescents to workshops • A co-ordinator and at least one community leader during the Project period • The Project costed USD 16.500, from October 2001 to December 2002
11 Indicators for monitoring	• Number of community groups participating in the project • Number of workshops organised • Number of ToTs trained (two groups in 2002) • Number of peer educators trained (6 groups of adolescents aged 12 to 17 in 2002) • Number of adolescents that participate in the activities (estimated a total of about 5.500 adolescents)
12 Impact	• In Vila Brazilândia a large number of institutions are now interested in the project. This resulted in the establishment of two centres for training of adolescents, located in a school and in a health post • Youth participating in the project became interested in other activities like writing poetry, establishing community radio, *capoeira* and meetings with other adolescents • The creation of health and gynaecological services for female adolescents from the area, creating proper space for sexual and reproductive health care • Male adolescents increasingly request gender specific reproductive and sexual health services as well

Section	Content
13 Challenges and pitfalls	• The high turn over of adolescents peer educators makes it difficult to safeguard continuity of the teams involved in the project • Resistance from religious organisations and other groups in the suburb • It is difficult to motivate youth for better health and sexual health and to raise their self esteem when overall living conditions are very poor and violent • The low self esteem of adolescents, emphasised by the violent and poor situation in the suburb • The problem to find funding for a proper evaluation of the results of the intervention
14 Critical issues and lessons learnt	Community based projects in poor urban areas with lack of basic infrastructure require NGO staff to have a flexible attitude and understanding of the limitations imposed by the poor environment. Staff need patience to win the confidence of the community
15 Source of practice and dialogue	Grupo de Trabalho e Pesquisa em Orientação Sexual –GTPOS (Maria Aparecida Barbirato, Francisca Vergueiro, Beth Gonçalves) São Paulo – Brasil. Website: www.gtpos.org.br E-mail: gtpos@gtpos.org.br francisca@gtpos.org.br
16 Editor's note for learning	• A major problem in Vila Brazilândia is the lack of perspective that youth has for the future and the extreme poverty in which they live. HIV/AIDS is regarded as just a part of the dangers that youth are confronted with, besides violence, drug trafficking and abuse, forced prostitution, unemployment, etc. This makes it difficult to mobilise youth for prevention activities • The sustainability of the project would increase, if from the start monitoring and evaluation are planned and budgetted for

27 'Choice or Chance': Video documentary of HIV/AIDS Projects, Trinidad

Developed by: Young Men's Christian Association (YMCA) with support of CAREC/GTZ
Key words: Youth organisations, documentation, Trinidad and Tobago, The Caribbean

Section	*Content*
1 Summary of the practice	Hosting and production of 'Choice or Chance' 2003: a documentary of best practices adopted by Youth organisations in Trinidad and Tobago
2 Level of intervention	NGO community, national level
3 Prospective users of the practice	Local, regional and international HIV/AIDS organizations, national AIDS programmes and multi and bilateral agencies
4 Problem addressed	• Lack of documentation and dissemination on practices used to address issues related to HIV/AIDS • Lack of understanding of the importance of any type of documentation of agency experiences in HIV/AIDS • Few or no skilled personnel in video documentation of HIV/AIDS related work • No appreciation of social marketing in promoting behaviour change and formation to combat the pandemic of HIV/AIDS in Trinidad and Tobago
5 Purpose of intervention	• To highlight and share the best practices of youth oriented programmes that address HIV/AIDS • To train youth agency personnel in the skills needed to produce video documentaries of their work
6 Context	The population of Trinidad and Tobago usually hear about HIV/AIDS work seasonally and aren't very informed about the dedication of those who struggle day in and out to create progressive sexual behaviour change and formation
7 History and process	• The YMCA's Community Outreach Department has a progressive track record of adopting and maintaining a contemporary youth culture approach to address the challenges to holistic and healthy Youth and Human development. It is with this in mind that the YMCA networks with all agencies that shares this vision • CAREC/GTZ funded this initiative to highlight the work of the Rapport project, the Toco Youth Sexuality Project, the Trinidad Youth Council, the YMCA, and the Tobago Integrated Youth Sexuality Project • YMCA formed a strategic working alliance with the Caribbean Epidemiology Centre (CAREC) and GTZ to document the best practices of Trinidad and Tobago youth work on HIV/AIDS • Subsequent meetings and interviews with each Youth organisation led to the production of a documentary that highlights the approaches and outcomes of each organisation
8 Steps in implementation	1 **Inception**: The Carribean Epidemiology Centre (CAREC) acquired the funds prior to the inception of the project and selected the YMCA based on the merit of the organisation's noticable video documentation of its work 2 **Organisation**: Meeting with all stakeholder agencies in the project, in this case five youth based organizations in HIV/AIDS work. The meeting addressed the following: The characteristics of Youth Work in HIV/AIDS, the selection of a youth to assist in production and presentation of the documentation; establishing a contact person per organization primarily responsible for coordinating the production crew's agenda; create a time schedule for shooting each group's work over a 2 week period 3 **Production**: On completion of shooting raw footage the team creates a preliminary paper edit of the material to shoot; states time the shoot started (include 5 seconds before the beginning), gives that segment a title, states time shoot ended (include 5 seconds post the end of the segment) eg. 10: 40 to 0:10:45, interview with Suzie Wong, coordinator of 'the women's support group', 0:31:25 to 0:31:30 4 **Editing**: Acquiring an editor for the documentary or the use of equipment to edit video documentaries. Editing of a 45 minute documentary can take 1-2 week/s with an experienced film/video editor

Section	Content
	5 **Further editing**: Host a screening of the video with all stakeholders; amendments may be suggested therefore editing may continue on the video 6 **Dissemination**: Through NGOs and instutional agencies
9 Duration	Approximately 3 weeks
10 Resources required	• 1 digital video camcorder (broadcasting quality), 1 tripod, one external microphone • 1 computer with external hard drive • 1 video editing programme eg *imovie* etc. • Human resource (if possible at least one trained volunteer in the area of film or video making)
11 Indicators for monitoring	• Number of youth based HIV/AIDS agencies that request the video for viewing • Number of young people volunteering for or requesting information from these agencies • Mass Media interest in HIV/AIDS issues • Greater awareness of HIV/AIDS and related issues • Reduction in the spread of HIV/AIDS amongst young people
12 Impact	• Increased youth interest in working/volunteering in the area of HIV/AIDS • Donor agency sensitization to funding of peer education programmes and Sexual and Reproductive Health Rights advocacy • Regional Youth Agencies in HIV/AIDS work adopted this approach at a Caribbean HIV/AIDS Youth Network (CHAYN) Meeting in the Dominican Republic
13 Challenges and pitfalls	• Finding the right time is not an easy issue for youth workers who work primarily on weekends or by invitation from communities • Acquiring editing facilities or editor at a nominal cost • Editing needs more time than was envisaged • Some prospective interviewees were not willing to be interviewed on camera
14 Critical issues and lessons learnt	• Youth organizations are very willing to have their work documented • Organisations need proper orientation on monitoring and evaluation of their interventions • Documentaries are great tools for sharing work inter-agencies and externally to donors and the general population • There is a need for an entity to specialize in providing the service of documenting the work being done in the realm of HIV/AIDS
15 Source of practice and dialogue	Young Men's Christian Assoiation (YMCA) Benbow Rd off Wrightson Rd; Port-of-Spain; Trinidad & Tobago Tel: +1(868) 627-7835; Fax: +1 (868) 627-8764 Contacts: Svenn Grant, Community Outreach Coordinator, svenngrant@hotmail.com Gregory Sloane-Seale, Outreach Director, sloaneseale@yahoo.com Caribbean Epidemiology Centre (CAREC) / GTZ 16-18 Jamaica Boulevard; Federation Park P.O Box 164; Port of Spain. Trinidad and Tobago. Contact: Bunnie Williams-Mitchell, Tel: +1 (868) 622-5593
16 Editor's note for learning	The documentation of organisations' work gives an insight in the enthusiasm, commitment of the people involved as well as the challenges they face in achieving their objectives. This helps peer organisations and donors to understand the processes involved in the development of these projects and not merely the outcome

28 Group therapy, 'Show you care, take care of yourself and others'

Developed by: Community Action Resource (CARe)
Key words: PLWHA, group therapy, care and support, Trinidad, The Caribbean

Section	Content
1 Summary of the practice	An initiative to provide emotional support to People Living with HIV or AIDS in Trinidad. The process fully involves people living with HIV/AIDS themselves as service providers: 'We are self supporting through our own due, and the generosity of individuals, groups and agencies'
2 Level of intervention	Individual and family levels
3 Prospective users of the practice	NGO, CBO, Networks of People living with HIV or AIDS, National AIDS Programmes
4 Problem addressed	• Lack of counselling and support programmes for PLWHA • Lack of correct information on HIV/AIDS • Lack of safe places for PLWHA to meet to address their concerns • Lack of knowledge of basic human rights
5 Purpose of intervention	• To provide emotional support to People Living with or affected by HIV/AIDS • To enhance the quality of life of People Living with HIV or AIDS
6 Context	• Trinidad and Tobago is a middle-income country. It is known for its carnival, urban violence, substance abuse, complex racial diversity and religious norms. The HIV/AIDS epidemic and its various impacts are mushrooming, facilitated by contradictions (sexual permissiveness and violence, religious values, wealth, racial and gender power differences) • Unlike in developing countries where non-governmental organizations (such as networks of PLWHA, faith or community-based organizations) play a large role in counseling, care and support to PLWHA, in Trinidad, it is left to the government to put services in place. While the country tends to adopt strategies promoted in developed countries (e.g., quality service delivery, free access to ARV), it has limited capacity to do so • PLWHA suffer from the overt stigma, ostracism, blame and discrimination expressed by society, health care providers, friends and colleagues, and family members than from the condition itself. The epidemic has reinforced the marginalisation of PLWHA, with family exclusion being common • In the absence of counseling, community sensitization and involvement (including PLWHA as participants), government health services will not meet the needs for care and support of people living with or affected by HIV/AIDS
7 History and process	• When the first case of AIDS was diagnosed, the national focus was on prevention, paying very little attention to those already living or affected by the HIV infection • In 1988, several young people infected with HIV began to meet weekly to discuss the many issues and challenges that they faced. They openly discussed their health status, feelings about living with HIV and individual strategies to positively live within a general environment characterized by high level of fear and stigma. In April 1989, a small support group was formalised. This forum was the first of its kind in Trinidad and the Caribbean and became a support system that empowered participants to make life-affirming decisions at their own pace • Initially started with eight people, CARe is now a registered NGO and charity serving over 300 clients. The organization has the support of professional resource personnel, which include doctors, psychologists and clergy. This network of committed or affected people plays a vital role in the organization • The first steps were supported by supported by a committed and well-informed psychologist and a person openly and positively living with HIV. The psychologist handed over the leadership successfully to other members. A management committee of 9 persons leads the organization, one third of which are People Living with HIV • CARe is well known for its counseling support, which includes: individual counseling, group therapy (Wednesday evening sessions), legal advice and social support, pastoral counseling and family therapy. CARe has also expanded its activities to include the following:

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	• Information and education: drop-in services and training • Community outreach: hospital visits, home care by peer-care givers, quilt project • Complementary health services: medical support, herbal therapy and physical and nutritional education
8 Steps in implementation	1 **Needs Assessment**: Through informal interactive sessions with clients at group therapy sessions and at the formal membership meetings at which members and board members are present 2 **Mobilization:** • Identification of PLWHA to contribute in sessions: PLWHA are asked to submit resumes of their educational background or are selected based on their training as peer educators or homecare volunteers • Physical space to accommodate counseling (secure and confidential) • Training in counseling: Support from a training agency for certification in Counseling (Caribbean Epidemiology Centre, CAREC). Selection of facilitator(s): suggested backgrounds include counseling, psychology, social work, community development etc. Training includes theoretical aspect and actual implementation in a real situation under supervision of trained counselors 3 **Information dissemination:** • Informing present and previous clients about the proposed sessions i.e. goals, frequency, feedback etc • HIV/STI Clinics, AIDS Hotline, National AIDS Programmes, NGO partners • Informing relevant agencies with history of work in HIV/AIDS – CAREC, UNAIDS etc. 4 **Implementation of sessions** • Establishment of ground rules including consensus on confidentiality, freedom of participation, no pressure or obligation to contribute, PLWHA participation only with exceptions being approved by all participants, open opportunity for feedback and suggestions concerning format of sessions etc. • Topics to be addressed: i. Every day life challenges faced by individuals ii. Confidentiality iii. Nutrition iv. Medical/ Treatment/ Adherence Issues v. Information sharing about capacity building initiatives and national events • An activity coordinator facilitates the session. All sessions are interactive. Specific topics are selected for discussion, but time is given for individuals to discuss their personal concerns. Resource persons are sometimes invited to deal with particular topics (e.g., medication, human rights). Persons from a religious body are also invited to conduct sessions on spirituality 5 **Review** • Monthly review on conduct and progress of sessions by the Board of Directors of the NGO • Annual review at the Annual General Meeting of the NGO • Biennial External Review
9 Duration	Formally started in 1989. On-going
10 Resources required	**Human resource and skills:** staff and trained resource persons, etc. **Facility and logistics:** The sessions are conducted at the office. The office is located in an area, which is easy to reach by the clients, but has a low profile because of stigma and discrimination. If clients do not feel safe they will not attend the sessions. CARe cannot afford to subsidize transportation cost, but refreshment is provided **Funding** (including management cost): salaries, incentives, drugs, social services, etc: The cost of running the office for the year is estimated at TT $ 338.100.00 **Training:** Home care training – TT $ 26,500.00 **Retreat for PLWHA:** TT $ 20,000.00 (1 TT$ = 0.162602 US$)
11 Indicators for monitoring	• Attendance (regular and new) at group therapy sessions • Feedback from participants • Evidence of sustained behavior change by clients adopting healthy lifestyles, adherence to and compliance with medication and participation in community programmes and becoming HIV/AIDS Advocates

Section	Content
12 Impact	• On participants: Behavior change, longer life span and breaking the transmission chain • On families: Greater acceptance of infected family member • On society: Reduction in the incidence of HIV/AIDS and stigma and discrimination • Replication or diffusion to other regions: CARe was the first PLWHA's organization in the English speaking Caribbean. Since the inception of CARe other Caribbean countries have modeled their PLWHA group after CARe. Members of CARe have started three other PLWHA groups in Trinidad and Tobago • CARe is recognized nationally, regionally and internationally and is frequently called on to support HIV/AIDS programmes at home and abroad
13 Challenges and pitfalls	**Resources:** CARe has problems in attaining financial assistance to pay operational cost and attracting and keeping volunteers who are professionals **Attitudes of health personnel**: Most of the stigma and discrimination that PLWHA have experienced have come from health care providers especially in government hospitals and clinics **Maintenance of Confidentiality:** There have been instances where clients have revealed the status of other clients. However this does not happen often and confidentiality is reinforced at each group therapy session **Layout of the facility:** there is not sufficient space and sometimes clients may have to stand. Inability to do one to one counseling on the evenings that there is group therapy **Sustainability:** Group therapy is a scheduled activity of the organization, much appreciated by the clients. If CARe has to leave it out of its programme due to lack of funds, it would loose clients
14 Critical issues and lessons learnt	• Some individuals find it difficult to access these sessions, because their low socio economic background • Confidentiality must be maintained so that the clients can feel safe to come to the sessions • The sessions must be structured and consistent (every week or once a month) otherwise we see a decrease in clients • HIV negative persons are seen as a threat to confidentiality by the clients and are only allowed to attend the sessions in the capacity of resource persons
15 Source of practice and dialogue	Community Action Resource (CARe) P.O. Box 1944, Port of Spain, Trinidad and Tobago Contact: Ms. Catherine Williams Tel/fax: +1 (868) 625 0632 E-mail: exdir@tstt.net.tt
16 Editor's note for learning	Group therapy is part of a large range of CARe' activities and does help people affected by HIV/AIDS to express/share their concerns and discuss options and solutions. In other parts of the world these group therapy sessions are coined 'Group counseling' or 'Peer support group discussions' since 'therapy' reads 'disease management' and reminds people of a 'doctor centered approach'. What usually happens during these sessions is that participants learn about how other people successfully face daily challenges (not coping out) including tips for adherence to and compliance to complex regimens, tips for dealing with stigma (family/working environment), etc.

29 Care and prevention teams in rural Zambia

Developed by: AIDS Project, Macha Hospital, Macha, Choma, Zambia
Key words: Home based care, prevention, Zambia

Section	Content
1 Summary of the practice	Home based care and prevention activities in a remote rural area, organised from a mission hospital
2 Level of intervention	Community
3 Prospective users of the practice	District health services, NGOs active in care and prevention
4 Problem addressed	• PLWHA in remote areas cannot be supported sufficiently by the health services of the mission because of the distances • Knowledge on HIV/AIDS is not accurate, leading to stigma and discrimination and a very low uptake of VCT
5 Purpose of intervention	• To support PLWHA, orphans and their families in remote areas with physical and psycho-social care • To strengthen community information and education on HIV/AIDS to lower infection rates and to decrease stigma and discrimination
6 Context	• Macha Mission Hospital has a catchment population of 150,000. It is a very large area and accessibility is difficult. The catchment area consists of several villages headed by a senior Headman, each with more than 200 people in his village • HIV/AIDS prevalence in the area is not known, but it is becoming a big problem due to its impact on peoples lives • Hospital staff alone cannot provide sufficient care to the AIDS patients • The majority of the population is very poor and has low levels of education and little access to information • There are churches in most communities, but these were not active in care and prevention before the programme started. At present they have become involved in an inter-denominational anti-AIDS Committee that has started AIDS activities in the various churches and has established in-church committees
7 History and process	• The hospital has been active in home-based care and counselling by the hospital staff since the 80s. With the increase in patients it was realized that care needed to become community based and this programme was started in 2000 • The hospital staff discussed the community-based approach with community leaders and headmen and explained what tasks and responsibilities a community volunteer would have to do. In turn, the headmen discussed this in the community and asked for interested volunteers • It took 1.5 years to mobilize the first community volunteers that included community health workers and TBAs. The first group was trained at the hospital in a one-day training in the local language, covering basic facts, nursing care, STDs, Opportunistic infections and TB • In the next communities, hospital staff talked to the headmen and volunteers visited the first community for orientation. This was more effective and community organisation was faster • Training was moved from the hospital to the communities and was prolonged to three days with additional specialised training if needed (for instance in TB treatment) • There are now 10 volunteer groups of 15-20 people. In addition, two volunteers were selected from each group to follow a one week training on counselling and home based care provided by Kara Counselling, a very experienced NGO
8 Steps in implementation	1 Hospital staff talks to the headman on home based care, orphan support and health education 2 The headman explains the system in the community 3 Those interested to become home base care volunteers visit a community with an established programme and learn about the experiences 4 Volunteers are trained by hospital staff 5 Volunteers visit houses of patients for care, teach families how to take care of the patients and counsel patients and families. These visits are done weekly, but more often

Section	Content
	if the patient is very sick. ORS, panadol, aspirin, soap, vaseline, razor blades are given when available. The Community Health Care Workers and TBAs usually handle medication 6 When patients need hospital care the family brings them 7 In the community the volunteers discuss HIV and AIDS, and explain preventive measures. They also talk about the advantages of testing and the dangers of traditional sexual cleansing practices 8 The volunteers also give talks in churches and schools, improving understanding and support 9 The hospital team visits once a month and supervises the volunteers at work with the patients and during a community education session. They help the volunteers to answer the questions asked in the session and give feed back on performance 10 The hospital team organises visits from volunteers to other communities for learning and sharing of experiences
9 Duration	From 2000 onwards
10 Resources required	• Trainers to train volunteers • Volunteers • Bicycles for the volunteers (two or three per group of 15-20 people) • Incentives for the volunteers such as pens, books and material for kitenge (wrap) • Drugs and materials for home based care (sweeps, brooms, hoes, axes, soap) • Funds for monthly workshops on volunteers' areas of need e.g. infection control and funds for exchange visits • Protective materials • Occasional donations of blankets and clothing
11 Indicators for monitoring	• A monitoring form is filled in by the volunteers • Bi-monthly visits for supervision
12 Impact	• AIDS patients receive better and more care • Stigma and discrimination are reducing, but slowly • More and more communities ask for training of volunteers • The uptake of VCT has increased (from 5 per month in 2000 to 30 per month in 2003) • The establishment of post test clubs and support groups is being planned • Traditional sexual cleansing practice has been reduced • As a result of the activities by the mission hospital, churches have become more involved and HIV and AIDS is discussed in church (this does not include promotion of condom use) • The Macha Interdominational AIDS Committee has been formed consisting of church leaders. Church leaders have talks on different topics (for instance stigma) with specific groups such as youth, women groups and community leaders
13 Challenges and pitfalls	• The hospital team has no training on community mobilisation and sensitisation or use of participatory techniques • Difficult to keep volunteers interested without incentives, more workshops and learning visits will keep up motivation • There is a lack of information material to give to the volunteers and lack of funds to translate existing material into the local language • Natural calamities such as drought, hunger, heavy rains may reduce activities of the volunteers
14 Critical issues and lessons learnt	• It takes time to establish home-based care groups in the communities. For mobilisation, a visit by an already functioning volunteer group is very effective • Changes in attitude are slow, but they do take place and patience is needed. This also applies to church leadership • Strong and rich NGOs that give money and food to other people/volunteers in the same area without regard to already existing structures, make it hard to mobilise volunteers on a more voluntary basis
15 Source of practice and dialogue	Macha AIDS Project, attention of Stanley G.T. Sitali, Aids field officer. Macha Mission Hospital, Box 630340, Choma, Zambia . E-mail: mhmri@musenga.org
16 Editor's note for learning	• The approach to mobilise new volunteers by taking them to a community where volunteers are already active, is working well. Not only can they get the first hand experiences and insight in what it means to become a volunteer, the visit in itself is already motivating • The same applies for the visits for learning and sharing, in the absence of any monetary incentives, such visits can be a great help to keep people motivated. However, this needs good preparation, organisation and funding

30 Care and prevention by community volunteers, Zambia

Developed by: Maramba Volunteer Group, Zambia
Key words: Home-based care, prevention, Zambia

Section	Content
1 Summary of the practice	Volunteers support households in patient care, and carry out prevention activities in their communities
2 Level of intervention	Community level
3 Prospective users of the practice	Community organisations, NGOs active in community based care and prevention
4 Problem addressed	• AIDS patients and their household members need support in care giving. Some patients are left on their own. Poverty is such that food supplements need to be given • Stigma and discrimination is high and knowledge on HIV/AIDS not very good • The volunteers themselves need to get some income as most have no formal jobs
5 Purpose of intervention	• To support PLWHA and their families with physical and psychological care • To strengthen community information, education and communication in HIV care and prevention though a variety of activities • To develop income generating activities to better support the community in care giving and to enhance the income of the volunteers
6 Context	Maramba is a low-income community in Livingstone town with a high HIV/AIDS prevalence. Unemployment and poverty levels are high. The area is quite densely populated. There is a local health centre, which provides some hospital care (it will be a mini hospital in the near future) as well as VCT, STI services (with youth friendly corner) and general health services
7 History and process	Home-based care used to be done by staff of the health centre, but demand was high and staff could not fulfil demand. In 1993, volunteers that had been involved in a health project, formed an anti-aids club and were in 1995 trained in home based care and prevention activities by SEPO, a centre under District Health Board. The volunteers are also linked to the mission hospital that is operational in the area and food supplements and drugs are provided through them. Because of the poverty of the volunteers, Income Generating Activities were started in 1996 with assistance of UNDP who gave funds to construct a chicken pen and chickens. They were also given land by the Council to grow vegetables
8 Steps in implementation	1 Identification of volunteers (now 24) 2 Training of volunteers by SEPO centre (6 weeks at the start and after this specialised short training on different subjects, including project management and DOTS, HIV/AIDS basic knowledge, aspects of home based care) 3 Selection of executive committee (7 people) and division of the areas in 5 zones, each zone has a leader and a secretary 4 The health centre initially identified patients for the volunteers to follow-up. At present people come to the volunteers by themselves for assistance. There are now 806 patients 5 Each household is visited once a week by two volunteers, if the patient is very ill or is not cared for by household members, this is more often 6 Once a week the volunteers run a group clinic in the community. Here they also hold focus group discussions on specific issues (HIV/AIDS/STI/TB, stigma, gender, sexuality, VCT) 7 In the households, the volunteers train the household members in care giving and palliative care and supervise them during practice. They also give health and HIV/AIDS education, discuss sexual education and discrimination, and try to address abuses to PLWHA in the households. They counsel patient and household members. They give drugs for palliative care and Opportunistic Infections (if they are available) teach how they should be taken 8 Referral to the health centre of very ill patients (sometimes carrying them there in a wheelbarrow) 9 Once a month they give out food supplements (provided through the mission or through SEPO centre) for affected households and during this event they talk about HIV/AIDS and

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	specific issues that are affecting the community (sexual behaviour change, sexual cleansing, stigma and discrimination) and give information on VCT 10 Each week the volunteers meet to discuss their work and to share experiences 11 Once a month they meet in the health centre with supervisors from the mission or SEPO centre 12 Many of the volunteers have taken in orphans, but lack funding to support all of them. They link up with the mission and SEPO centre that has special programmes for orphan care 13 At the start of the income generating activities a bank account was opened and income earned was for 50% put in the bank for sustainability, 25% to assist patients and 25% for the volunteers. Monitoring on record keeping was done by SEPO centre. These activities are not very sustainable because there are no more chickens and the vegetable growing is not very successful because of lack of water
9 Duration	Ongoing since 1995
10 Resources required	• Motivated and trained volunteers • Funding for payment of incentives to volunteers ($7 per month) • Supervision and support from health services for care and supervision and support for prevention activities (SEPO centre) • Funding for food support
11 Indicators for monitoring	• Number of patients • Number of household visits • Number of food supplements given out • Number of prevention talks held
12 Impact	• The care given by the volunteers is now recognised in the community and people directly come to them for assistance • More volunteers have joined. HIV/AIDS awareness and knowledge in the community is increasing • Stigma is decreasing and more PLWA are supported • The volunteers are now also asked for AIDS awareness sessions in the church and schools. They also link up with traditional healers • The regular meetings between groups at SEPO centre increase sharing of experiences and new ideas
13 Challenges and pitfalls	• It is difficult to sustain an adequate number of volunteers with the very limited incentive that they receive • The income generating activities do not function and although much effort is devoted to the vegetable garden, the lack of water affects the production and output is very limited • Lack of funds affects care giving and also leads to frustration when the volunteers are unable to help • A transit home is needed for PLWA that are pushed out by their families • Patients need assistance in buying drugs for Opportunistic Infections as these are not covered by the drugs supplied by the mission and SEPO centre
14 Critical issues and lessons learnt	• The integration of care and prevention works very well and enables the volunteers to reach beyond the directly affected households • The change from health supply focus with health staff visiting patients to patient focus with volunteers acting as supervisors for the households themselves has resulted in increased care and involvement in the households • The monthly meetings in the health centre, the ongoing training sessions and the quarterly meeting at the SEPO centre have resulted in increased commitment of the volunteers
15 Source of practice and dialogue	Maramba Home Based Care. SEPO centre P.O.Box 60545, Livingstone, Zambia Tel: 321846 E-mail: hope1994@zamnet.zm
16 Editor's note for learning	• One interesting aspect of this practice is the mix of public and NGO support. SEPO centre is coordinating this very well and has full backing and support from the District Health Management Team • With regard to the Income Generating Activities, it would be better if advice is sought from institutions that specialise in this and can give training to the group. As it is, this is not sustainable • Funding of volunteers is very important in a context of extreme poverty and lack of employment

Picture: Maramba volunteers working to grow vegetables

31 Pilot project on free ARV provision in resource poor setting, Uganda

Developed by: Uganda Cares, Masaka, Uganda
Key words: ARV treatment, Uganda

Section	Content
1 Summary of the practice	Free ARV treatment is given to 100 AIDS patients who come to the special clinic, weekly at first, later monthly. Counselling is given in referral centres. Adherence and compliance is high
2 Level of intervention	District
3 Prospective users of the practice	Health sector, NGOs and private sector interested in ARV provision for the economically disadvantaged in rural communities
4 Problem addressed	• Low motivation to go for testing of HIV status • People have inaccurate information on the effects of treatment • Doubts on adherence and compliance to ARV treatment in people with a low level of education
5 Purpose of intervention	• To provide standard ARV treatment to socio-economically disadvantaged people living with advanced AIDS • Demonstrate that ARVs can be delivered effectively in resource poor settings • Identify determinants of treatment success and to the quality and cost-effectiveness of using ARVs • Utilize and strengthen existing health care infrastructure for rapid scale up of ARV provision in Uganda • Develop a replicable model of HIV/AIDS clinical care appropriate to safe and effective provision of ARVs in resource poor settings
6 Context	• Despite progress in fighting the epidemic in Uganda, the country remains vulnerable to the negative impact of HIV/AIDS. The current HIV infection is estimated to be 1.1 million people, with 100.000 AIDS cases. AIDS is responsible for 12% of annual deaths in Uganda and a leading cause of death among people aged 15-49 years and responsible for the productivity of the country. Due to the adverse impacts on quality of life and on the national economy, measures such as treatment for opportunistic infections and anti-retroviral therapy are being taken • Although ARVs have been available in Uganda since 1998, it is not provided to the wider public through the public system, but has been confined to NGOs, commercial providers, research and pilot projects. An estimated 10.000 people are currently using ARVs. Most of these patients live in urban areas and pay entirely by themselves or cost share with their employers • The draft policy on ARV treatment has universal access as ultimate goal, but as yet access to ARVs is limited to people requiring post exposure prophylaxis, prevention of mother-to-child transmission (PMTCT), mothers participating in PMTCT and for persons in clinical or related research projects. The programme that is described in this practice is a research project
7 History and process	• The Uganda Cares Initiative is a partnership between the Ministry of Health and AIDS Health Care Foundation (AHF/Global Immunity). The Masaka Health Centre is operated as a collaboration between the above partners, the Masaka Regional Referral Hospital as well as TASO (The AIDS Service Organisation) Masaka, Kitovu Mobile Homecare services (a faith based NGO), AIDS Information Centre (VCT) and AIDCHILD (AIDS orphanage) • A steering committee was established with representatives of all above partners to monitor the programme • Main preparation for clinic opening started in 2002 with the establishment of the clinic, staff recruitment and training, procurement of basic equipment and supplies. Training of staff of the Masaka health care centre and doctors in the referral clinics was given by the Ministry of Health and AHF HIV specialists. Patient selection criteria were established. Patients should be: resident of Masaka district; ambulatory; come from a stable social network or family; not have been on ARVs before; adults having a CD4 count below 200; children having a CD4 count below 25% of normal range per age; not having an active

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	opportunistic infection; referred through TASO Masaka, Kitovu Mobile, the Masaka Hospital VCT unit managed by the Aids Information Centre or AIDCHILD; having a known address for purposes of follow-up; consenting to treatment and willing to comply with treatment schedules and follow-up procedures • The clinic is operational two days a week and has a staff of 3 consisting of a medical director, a paediatric consultant and a case manager (nurse). The treatment package involves counselling with an emphasis on ARV treatment information (possible side effects) and the importance of adherence • At present 100 patients (80 adults, 20 children of which 56 are female and 44 are male) are included in the programme. The patients are seen initially weekly for the first four weeks, then fortnightly for the next 4 weeks and then monthly if clinically stable and responding to the ARV regimen • For the treatment of illnesses, the patients go to the centres from where they have been referred (Kitovu Mobile and TASO) and where their treatment records are kept. These centres also give psycho-social counselling
8 Steps in implementation	1 Establishment of partnership, funding arrangements, clinic and purchase arrangement of medical supplies, ARVs and laboratory services 2 Recruitment and training of staff of the health care centre and of staff in the referral centres 3 Establishment of selection criteria for patients 4 Recruitment of patients through the referral centres 5 Counselling of patients on treatment information (what are ARVs, what are possible side effects, what is expected from the patient and the information that ARVs are not a cure but have to be taken for life), and need for adherence 6 Testing of blood and assessment of CD4 count. Those who have a CD4 count above 200 are put on the waiting list and are tested again after three months 7 New patients are seen once a week and receive pills for a week plus one extra day. The time of taking the medication (either once or twice a day) is established 8 They come back with the envelopes and contents. When too many pills are left, they discuss the reasons and counsel the patient again 9 After a month, the patients come twice a month, and thereafter monthly. The patients get a physical examination and a check on body weight, blood pressure, patient's level of activity, adherence to treatment, compliance with follow up, nutrition and social, family and reproductive health issues. CD4 count is done every quarter. The health centre itself has medication for some common opportunistic infections 10 Patients receive continuing support, education, monitoring and follow-up by their referral centres TASO Masaka, Kitovu Mobile or the AIC 11 In case hospital care is needed, they are referred to Kitovu hospital or Masaka Regional Referral Hospital 12 Patients are stimulated to form support groups 13 Patients who have been on treatment provide initial education to new patients. This is cross checked by the health centre staff before providing further education
9 Duration	Started in 2002, ongoing
10 Resources required	• Trained health workers • Drugs, medical supplies, laboratory testing facilities • Accommodation for the clinic • Partners that refer patients to be taken up in the programme • Partners that provide psycho-social counselling, out patient health care and hospital services for patients that need hospital care
11 Indicators for monitoring	• Number of patients • CD4 count quarterly • Records of physical examination, body weight, blood pressure, patient's level of activity, adherence to treatment, compliance with follow up, nutrition status • Number of patients dying (11 in the first year)
12 Impact	• Remarkable improvement in health in over 80% of the patients, average CD4 count at the start of treatment was 51, one year later this is 310 • Patient adherence to treatment is over 97% because they are highly motivated and respond very well to treatment and because regular follow-up is given by their referral centres TASO, Kitovu Mobile and AIC

Section	Content
	• Interest in VCT is increasing because people see the effects of treatment in patients enrolled in the programme • Interest to be part of the programme in people tested positive is increasing • Generally, children are not tested for HIV because of the trauma and effects on their upbringing (why send the child to school if it going to die), but with the possibility to receive ARVs this is changing • The model to work with partners that give follow-up has proven to work • The programme has demonstrated that ARVs can be provided successfully in resource poor settings
13 Challenges and pitfalls	• Eleven patients who were on treatment have died. This is attributed to the advanced stage of AIDS and related illness and not to ARV treatment complications • Demand for treatment is rising and cannot be met by the funding available • Accessing resources to scale up the programme and replicate the model in other districts
14 Critical issues and lessons learnt	• Adherence is very high but needs continuous support by both the health centre and the referral centres. Patients with low or no education are actually adhering better than patients that are educated • Patients when they start are weak and want to take the pills at 10 am, but when they start working again they will forget to take the pills at 10 am and therefore is suggested to from the start take medication at 7 or 8 am • It is critical to establish a good relationship with the patients and hence it is important that the same doctor and case manager are seeing the patient. It is important to give sufficient time for each patient to discuss not only treatment related issues but also social issues • At first any adult that was referred by the referral centres was taken up, when more and more people became interested because they saw the effects of the treatment, more attention was given to family members of initial patients (core family)
15 Source of practice and dialogue	Dr. Bernard Okongo, Medical Director, Uganda Cares Secretariat Office, Old Malago Hospital, P.O. Box 5347, Kampala, Uganda E-mail: bernardo@aidshealth.org. Anton Kerr, Director of Operations, AHF Global Immunity, 42 Ickburgh Road, London, E5 8AD, UK Email: antonk@aidshealth.org. See also http://www.ahfgi.org/uganda/index.htm
16 Editor's note for learning	This practice shows that treatment in resource poor settings is feasible, as also shown in the practice on ARV treatment in Northern Thailand. The relationship with the health care staff is crucial and the fact that it is always the same doctor and nurse help in establishing a personal relationship. Important is also the partnership with the referral centres where psycho-social support and education is given. In Thailand this support is given by the PLWHA group and it is conceivable that such a system could also work in Masaka once PLWHA support groups are established. This may only become relevant when more people are put on treatment and there are clusters of people receiving treatment living in the same area

Picture: The treatment room

32 Mpigi district home based care

Developed by: MPINASO (Mpigi District Network of Aids Service Organisations), Uganda
Key words: Home-based care, Uganda

Section	Content
1 Summary of the practice	Home-based care is given to people infected and affected by HIV/AIDS
2 Level of intervention	Community
3 Prospective users of the practice	Organisations operational at community level (volunteers, self-help groups, local leaders, religious leaders, health workers, schools, faith based organisations, local NGOs/CBOs)
4 Problem addressed	• PLWHA receive inadequate care in their homes • Public health services are too far and of low quality • Poverty prevents PLWHA to obtain basic materials to remain healthy (blankets, food, shelter) • Limited knowledge and capacity among the local population to care for PLWHA • Community commitment to assist PLWHA is insufficient
5 Purpose of intervention	• To provide increased care to PLWHA • To empower PLWHA to live a healthy life and to promote initiatives they themselves can undertake for positive living • To promote a more positive environment for PLWHA in the communities • To empower care givers with knowledge and skills for management of HIV/AIDS at community level
6 Context	• Mpigi district is a very large rural district (of approximately 2,995 sq kilometres of which 719 sq km is water), with a population of 414.543 people. Accessibility in many parts of the district is very difficult due to the limited and poor road network and lack of transport facilities • HIV prevalence is not really well established, but is estimated to be 15% and AIDS cases are estimated to be about 63.000 • The public health services in the district are inadequate and there are no testing services. HIV/AIDS support activities are mainly carried out by NGOs and community based organisations • The population is generally poor, engaged in subsistence farming and fishing with low levels of education. People live in large families and polygamy is very common
7 History and process	• The Uganda Network of AIDS Service Organisations (UNASO) was established in 1997 with the main aim to improve coordination among existing HIV/AIDS service organisations so that access to prevention, care and mitigation activities is improved for all. To become more effective, it was decided to establish district level branch organisations • Thus, Mpigi District Network of AIDS Service Organisations (MPINASO) was established in 2002 with the aim to promote cooperation and coordination through common resource mobilisation, sharing of information and expertise; to promote common standards in counselling and home care through development of guidelines; to strengthen organisational management of the member organisations and to influence policy making through a strong single voice from the district • MPINASO has a registered membership of 52 organisations and groups. Most are involved in home-based care and use a similar approach, based on the needs and problems that are being faced by PLWHA in the communities. This is the subject of this practice • The process generally starts with sensitisation of the community on the needs of PLWHA and on the need for a community to become a positive environment in which the community as a whole accepts the reality of HIV and AIDS and plans for prevention, care and mitigation of the impact. This is done through community meetings, house to house visits, and through already existing community structures • This leads into selection of volunteers for home-based care, based on interest, residence in the area and ability to read and write (necessary to report and for referral). On average two people per community are selected by the community

Section	Content
	• The volunteers are trained in the district by specialised NGOs. In principle each organisation funds and organises its own training of volunteers, but it may be combined if possible. The training covers basic facts on HIV/AIDS, patient care, counselling, monitoring and action planning. Modules used in the training come from a variety of sources (NGOs, MoH, WHO) • MPINASO establishes contacts with the relevant district authorities on care and mitigation of the impact and to obtain advice, technical support, material support, drugs, funding and assistance in the mobilisation of communities. These authorities include the Chief Administrative Officer (CAO), the Resident Development Committee (RDC), LC5 (district) council, the health services, planning department, community development department, the water department, the agricultural extension workers, the education department, the department of social services • Communities are mobilised to support PLWHA with basic needs wherever possible
8 Steps in implementation	1 Identification of needs of PLWHA, mapping of houses with PLWHA in the community by the NGO 2 Community mobilisation and awareness raising on the need for a supportive environment for PLWHA 3 Identification and selection of volunteers 4 Training of volunteers 5 Where possible volunteers receive a home base care kit with medical essentials/supplies antibiotics, cotton gauze, soap, scissors, gloves, condoms, soap. Otherwise they use whatever is available in the house 6 Planning of tasks for the volunteers and establishment of contacts with the PLWHA families 7 Ongoing home visits for care, counselling and health education by volunteers 8 Supervision of volunteers by the NGO (weekly meetings or monthly meetings) 9 Referral to health units of patients that need professional care (with referral note of the volunteer) 10 Monthly meetings with health workers and volunteers to discuss patients and problems being faced 11 MPINASO executive committee meets quarterly to discuss experiences and plan new activities. They also attend the UNASO general meeting where experiences across Uganda are shared 12 Regular community meetings to mobilize for continuing community support through established groups, including PLWHA groups, youth groups, guardian groups, orphans groups 13 Support to PLWHA to form their own support groups and to share their experiences with medication
9 Duration	Some of the NGOs/CBOs started their activities as long as twelve years ago, others were established more recent. The activities are ongoing
10 Resources required	• Trained volunteers (average 2 per community) • Experienced NGO facilitators for training and supervision • Transport facilitation for volunteers (bicycles or transport money) • Funds for home base care kits • Funds to attend and organise meetings to share experiences
11 Indicators for monitoring	• Volunteers fill in forms on their patients noting changes in the health condition • Number of patients (maximum 4 patients per volunteer per week) • Number of referrals to health services • Number of supervisory visits by the district/sub district nurse • Monthly meeting of volunteers and health workers
12 Impact	• More PLWHA are now disclosing their status • PLWHA live longer and die in an environment of respect and care • Families are taking more responsibility in caring for patients • Reduction of hospital admissions • Reduction of stigma and discrimination shown by an increase in public testimonies and active post test clubs • Behaviour change (reduction in unprotected sexual activity of PLWHA)
13 Challenges and pitfalls	• Lack of funds to better support PLWHA and their families • Lack of nursing equipment and drugs for home based care

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	• Lack of transport for the district network MPINASO to monitor the activities of the 52 organizations • Poor communication network in some areas (telephone and roads) • Difficulties in keeping volunteers motivated • Transport problems to get PLWHA to the health services • Lack of drugs in the health centres • Lack of trained health workers in the district at all levels • High expectations by the PLWHA from the community volunteers
14 Critical issues and lessons learnt	• It is difficult to find and keep volunteers because of pervasive poverty and lack of incentives and this endangers the sustainability of the home-based care system based on volunteers. To keep the volunteers motivated, they need to be given recognition in the form of publicity as service providers, certificates and invitations to meetings for sharing and learning • When the health of patients improves, they do not adapt or change their behaviour to remain healthy. Some clients after recovering get involved in unsafe sexual behaviour that is likely to expose them (and others) to further infection • The high expectations of the PLWHA on what the volunteers can do, frustrates the volunteers very much as they are so short of equipment and drugs
15 Source of practice and dialogue	UNASO Mpigi district network- Mpinaso. Executive Committee, P.O. Box 162 Mpigi (Richard Semujju, Concern Mpigi (semurich-@yahoo.com); Fredrick Bombo, Kalamba com dev.org.(fbomboug@yahoo.com); Grace Kizito, GASCO; Rehema Kasibante, NKOZI Aids project; Salongo Ssali, MASO; Nalongo Kyazze, Uganda Red Cross Mpigi; Sophia Lubega, MDDU)
16 Editor's note for learning	The development of this practice was done with the Mpinaso Executive Committee. The questions to be answered in the framework lead to discussions and this process in itself was a very good method of sharing knowledge and experience. It can be taken as a starting point for Mpinaso advocacy and priority setting for improvement of home based care services in the district as a whole

Picture: MPINASO members discussing the practice

33 Nursery for orphans and children affected by AIDS, Trinidad

Developed by: The Cyril Ross Nursery for HIV/AIDS orphans/children (Society of St Vincent de Paul)
Key words: Orphans, faith-based organisation, care, support and treatment, Trinidad and Tobago, The Caribbean

Section	Content
1 Summary of the practice	A Faith-based organisation's initiative to open The Cyril Ross Nursery for orphans living with HIV/AIDS in Port of Spain in response to the lack of practical options for them at family and Government institutions level
2 Level of intervention	Individual, Community
3 Prospective users of the practice	Faith-based organisations, NGOs, CBOs, National AIDS Programmes
4 Problem addressed	• The impact of AIDS on orphans and children in Trinidad: exclusion, abuse, discrimination, and stigma • The institutional response needs to be complemented by those of affected families and communities
5 Purpose of intervention	To provide a space where children orphaned due to AIDS are cared for and receive proper emotional and psychological support, meals, basic treatment and education
6 Context	The national context is characterised by fear of the infection, stigma surrounding individuals and families living or affected by HIV/AIDS, resulting in a feeling of hopelessness and helplessness in health care providers and extended families
7 History and process	• In 1993, newspapers reported the challenges faced by the main hospital in Trinidad in finding practical solutions to 25 children orphaned due AIDS that nobody claims and who still occupied beds • The hospital was trying to 'push them somewhere' because health care providers did not know what to do with them, and because these orphans will die anyway in the absence of anti retroviral treatment (ARV). Extended families failed to care for the orphans as well. No options seemed to be available for both the hospital and the orphans • A member of the Society of St Vincent de Paul then decided to transform a day nursery, which originally served factory workers who could not afford other health services into a nursery/orphanage to host these children • By the time, the nursery was ready (September 1994), 22 orphans had already died. The nursery thus opened with 3 orphans, of whom 2 were HIV infected. A senior Psychiatric Nurse was tasked to supervise the nursery. Community volunteers (the 'Mammies') took responsibility for the accommodation, care, and nursing work, all learning by doing but motivated by a strong personal commitment, even knowing that the infected orphans would die shortly or later anyway. By the end of 1994, three more children were hosted by the nursery and one died • Based on needs, children were referred to hospitals. However, workers felt that orphans did not receive proper treatment as nurses and doctors were not enough caring or sensitive to the orphans' situation. Overtime a medical doctor (U.S. citizen) committed to help by visiting periodically the nursery or by providing advice. A Nigerian doctor took over after the first doctor returned home. He kept the working relationship and set-up a monthly visit. A paediatrician also committed to support the nursery on a voluntary basis. Proper training of staff then started • After 5 years, the nursery received support from a Group of Ladies in the United Stated to provide ARV to 2 children (approx. 100 USD per month). A food company sponsored another child. The nursery also received support to provide ARV to 6 other children from other sponsors. Two years ago, access to ARV became a reality when the Government committed to offer free treatment to those in need • The nursery moved from 'coping' towards new strategies such as socialisation process, schooling. For example, a principal in a neighbouring Roman Catholic school accepted one child in his school, sensitising teachers to the needs of children living with HIV. An Anglican school also accepted 6 other children. This year, 14 children are in school. In all cases, confidentiality is ensured. However, the children themselves learned to speak out

Section	Content
8 Steps in implementation	1 **Inception**: Personal commitment of an individual driven by religious values and culture of helping. Personal commitment and experience of a social worker. The Society of St Vincent de Paul provided funding 2 **Start-up**: Refurbishing the facility and identifying volunteers in the community. Compliance to Government' rules regarding safety measures was assessed by the Ministry of Health, which carried out quality control supervisions ensuring that the facility complies with safety and ventilation requirements, etc. 3 **Networking and developing an informal referral system**: with good-willing hospital staff, organisations involved in AIDS care and treatment, and schools/teachers. This is based on interpersonal relationships 4 **Development of management protocols**: Organising the in-house day-to-day life and setting up procedures and guidelines for managing the nursery (accommodation, meals, recreation, etc.) including the management of grouping, disputes and fights between children. This is organised by the social worker already experienced in managing an elderly people house 5 **On-the-job training**: child counselling, ARV management, referral protocols by the social worker with support of practitioners 6 **Organisation of medical treatment protocols and education**: Treatment room with separate sections where each child is educated about the drugs (prescription, timing, side effects, etc.), and supported for adherence and compliance 7 **Monitoring progress and reorienting activities, layout and functioning of the nursery**: As children grow and move to adolescence, they request more privacy and the accommodation needs to be adjusted accordingly (single rooms for those aged 15 to 19, double rooms and a place where adolescents can put up posters of pop stars, etc.) 8 **Continuous fundraising and quality improvement**
9 Duration	Started in 1994. On going
10 Resources required	• Local premises: accommodation, toilets, kitchen, monthly clinic space, etc. • Salaries/incentives, human resources: volunteers (Mammies) and professional staff such as a pharmacist, trained nurse, etc. At present 3 supervisors (for 3 age classes), 1 cook and 1 assistant, 2 watchers and 2 cleaners, 1 teacher, and a director (social worker on part-time basis) are employed
11 Indicators for monitoring	• Number of children hosted over time • Death rate • Hospitalisation rate • Opportunistic infections (types and rate) • Adherence and compliance to treatment • Number of orphans attending school over time • Number of volunteers • Number of (extended) families reunited • Observational study conducted by medical doctors
12 Impact	• An observational study of 24 (54,5%) of 44 children, who are not on ARV therapy, assessing the incidence of opportunistic infections, showed that the nursery was able to reduce the number of hospitalisations by 80%, to decrease the viral load by 50%, and to reduce morbidity and mortality without ARV treatment (Omo-Igbinomwanhia, International Conference, Barcelona 2002) • Children improved quality of life, self-confidence and self-efficacy in dealing with stigma and are getting involved in classroom HIV prevention sessions • At the beginning, the death rate was about 3 children a month. At present 35 children are living in the nursery and under treatment, and 27 other outpatients (living with extended families) visit the nursery on a monthly basis for supply of ARV. The nursery hardly reports death cases. Most children are doing well psychologically and physically as the socialisation process and ARV treatment go on • More schools offering support • More volunteers among which students from the University (Social Science Department) offering services free of charge • More families volunteer to take charge of orphans. Some children have been fostered by families, among which two former 'Mammies'
13 Challenges and pitfalls	• The nursery is exceeding the capacity as agreed with the Ministry of Health supervisors: 35 children living in a building designed for 25 children

Section	Content
	• Stigma faced by staff and hostility of some neighbours • Attitudes of health care providers not welcoming HIV positive children • Attitudes of classmates ranging from support to ostracism. • Feelings and emotions of the children: acceptation, fear, and depression • Some children are disadvantaged, as they did not have the opportunity to go to school before • Managing children' disputes and fights! • Educating the children to fully adhere to and comply with the treatment despite the side effects (some children have to take 10 pills a day) • Lack of funding, for example, the nursery wishes to have a proper storage place for shoes • Security issues: staff are women and thus vulnerable, while there are drug addicts in the neighbourhood. A new facility in a different location will be built in the next coming 2 years (fundraising on going) • Managing staff burnout
14 Critical issues and lessons learnt	• One of the most telling and troubling consequences of the epidemic's spread is the number of children it has orphaned or seriously impacted • Sponsors are usually individuals outside the community or the country *Don't:* • Hide for a child what you are going to do • Let your children die in a hospital without assistance *Do's:* • Children always want to know about their parents, thus trace extended families. But, some children are homeless because their parents are mentally disabled or drug addicts or have died • Be sensitive to the fact that children 'distinguish' those who use gloves for any contact including greetings (hospital-like staff) and those who do not or selectively use gloves for medical interventions
15 Source of practice and dialogue	The Cyril Ross Nursery 7, El Dorado Road, Tunapung Port of Spain, Trinidad and Tobago Tel: +1 (868) 662 89 75 E-mail: judynimblett@hotmail.com Contact person: Judith Nimblett Cell: +1 (868) 685 43 77
16 Editor's note for learning	• Orphanages may not be the solution in the end, partly due to uncertainty about funding, lack of skilled and professional staff. However, this practice shows that in an environment characterised by stigma, orphanage/nursery is a practical option. Faith-based organisations are well placed to complement Government's efforts • The practice also shows that with proper medical care the incidence of Opportunistic Infections can be greatly reduced

Picture: A child and her 'Mammie' (Director of the Nursery) explaining in the 'pharmacy' how children handle their daily HAART regimens to a visitor

34 Psycho-social and home care for PLWHA, Ukraine

Developed by: Community Youth Organisation 'Club of self-help Life+' (Regional representative of the All Ukrainian Network of PLWHA), Odessa, Ukraine
Key words: PLWHA, home based care, psycho-social support, Ukraine

Section	Content
1 Summary of the practice	Psycho-social support and home care service are provided to terminal patients by members of an NGO (who are themselves PLWHA), assisted by a consultant physician and a consultant psychologist
2 Level of intervention	Community level
3 Prospective users of the practice	AIDS service organisations, health care providers, governments and NGOs/CBOs
4 Problem addressed	• PLWHA who are at the terminal stage of the disease cannot be cared for in hospitals, due to lack of beds • Psychosocial support for PLWHA is not provided by the government, even when they are in hospital • Families of PLWHA are not well informed on HIV/AIDS and are therefore not able to give proper care and support to their ill family member • PLWHA who live on their own cannot look after themselves when they are ill
5 Purpose of intervention	• To decrease mental and physical suffering of PLWHA in the last stage of their life • To link patients up to the public health care system and ensure that they are treated well • To take care of patients who live on their own or who have no support from their families • To train family members in taking care of patients
6 Context	• Ukraine is the most affected country of the formal Soviet Union with an estimated HIV prevalence of 1%. Of these, the majority of infections have been transmitted through intravenous drug use (72%). HIV infection is increasing, there are at present 59.397 people registered as HIV positive out of a total population of about 46 million people • Odessa is the region with one of the highest HIV prevalence in Ukraine and there are an estimated 16.500 HIV infections, of these 1200 have developed AIDS • There is only one facility (the regional AIDS centre) with 25 beds where AIDS patients can be hospitalised. There is no hospice in the region and hence many patients come to the hospital when they are terminally ill and die there. However, there are also many PLWHA who prefer to stay at home because they do not want to disclose their status • The outpatient department of the facility offers treatment for minor opportunistic infections. It provides ARV treatment to a limited number of patients. Counselling is only given as part of VCT and not as a general service • The level of knowledge of the health workers (doctors and nurses) on HIV related illnesses is relatively low even in the specific AIDS centre • Formally, there are specific 'trust' rooms in most policlinics as part of municipal HIV services, where doctors and nurses offer VCT, out patient medical services and home services to HIV patients. But these 'trust' rooms do not function well and effectively, and home based care is not provided
7 History and process	• A self-help group was established by two PLWHA in Odessa in 1999 for mutual help and support. One of these people was the first PLWHA to disclose in public in Ukraine. Ex intravenous drug users (IDU) themselves, they approached different Narcotic Anonymous groups and groups of IDUs to promote membership of the self help group. It was also announced through the media • In May 2001 the organization was legally registered as a community-based youth organization named 'Club of self-help *Life +* ', and became the representation of the 'All Ukrainian Network of PLWHA' in Odessa • As a registered NGO, they are able to link up with the formal health system and can be recognized as supporters for PLWHA who seek services of the formal system. The registration also allows the establishment of partnership with other NGOs and government institutions for social support and welfare

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	• The main aim of the organization is to improve the life of people living with HIV/AIDS and their families through counseling, psychosocial support and rehabilitation and outreach services for care and prevention. At present they have a membership of over 200 members in self help groups and give service to many more. There is now a paid staff of 35 (of these 10 are hired from outside) • To make an inventory of the needs of PLWHA in Odessa, the NGO conducted a participatory community assessment in December 2001 with support of the International HIV/AIDS Alliance • One of the needs identified was home care and psychosocial support to PLWHA and their families. A proposal for funding was developed, supported by the HIV/AIDS Alliance who then funded it with the funds they manage on behalf of USAID • Apart from actually providing the services, the project aimed to develop a model for home care and psycho-social care that could be applied all over Ukraine and guidelines are developed for providing these services • In June 2002 the members of the NGO (then 11) were trained for a day by a physician and a nurse of the AIDS centre and a doctor and a nurse from MSF, a psychotherapist of the *Life +* on topics such as care at home for terminal patients (including patients who are completely bedridden, TB patients etc.) and psycho-social counseling • Of the people trained, 10 members became permanent paid staff involved in the project. A physician and psychologist were identified to provide expert services to the patients when and where needed. They are paid on basis of a number of hours per day • On the basis of the experience in home care, guidelines were developed for use by other NGOs in different regions of Ukraine. At the moment 6 NGOs from 6 regions of Ukraine have adopted the model of home-based care. The continuation of this project after the first year is secured through financing from the Global Fund • The activities of the NGO soon became known among the target group and membership increased. The NGO is now implementing many more projects on different aspects of HIV/AIDS, such as documentation and information for PLWHA and their families, a community centre for PLWHA, care and support for infected children
8 Steps in implementation	1 Identify people interested to be trained in home care and counselling 2 Identify trainers and develop training programme 3 Conduct training 4 Work out selection criteria for clients 5 Identify PLWHA that are in need of the service (at terminal stage at home or in hospital, ill at home without assistance from family) in different neighbourhoods of the city. This was done on the basis of the earlier assessment, on the basis of information from the AIDS regional centre and MSF projects on vertical transmission, and on personal contacts 6 Select patients that are most in need (50 people can be supported) on the basis of interviews 7 Develop a time-table of visits by the social worker (approximately 2 visits in a week per client depending on their needs) and consultations with the physician and psychologist 8 Carry out visits at home (10 clients per social worker, there are 5 social workers) and provide PLWHA and their families with information and recreational books 9 Carry out visits for information and psychosocial support to patients of the in-patient department of AIDS centre 10 When needed, arrange that patients get health support from the health care system and assist them 11 Supply food to the clients 12 Conduct quarterly supervision and education sessions
9 Duration	Started in 2002 and is ongoing
10 Resources required	**Human resources**: 11 people: Director, Project coordinator, Information manager, Physician (consultant), Psychologist (consultant), Book-keeper, Social workers (5) **Materials**: first aid kit for social workers (gloves, aspirin, bandages etc.) **IEC:** information materials on HIV **Administration:** computer, printer, fax, telephone **Transportation:** funds for public transportation **Food support:** monthly food supplies **Training**: training on home based care **Financial resources**: about USD 30 000 for a year
11 Indicators for monitoring	• Number of clients reached (per month) • Number of home and hospital visits

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	• Number of consultations by physician and psychologist • Number of referrals to medical institutions • Number of referrals to non-medical institutions • Number of food sets distributed among clients
12 Impact	• PLWHA are better supported at the end of their life • Families are more able to support their ill relative • Increase in the quality of life of PLWHA • Increased adherence to therapy (where applicable) • Better medical treatment in municipal hospitals (decrease of the number of refusals)
13 Challenges and pitfalls	• The first aid kit that the social workers are carrying is too heavy to take on public transport and so taxis are being taken which increases cost • Change-over of staff, so new staff had to be identified and trained • Burn out and stress in social workers leading to problems in their own life. As a solution, the social workers themselves now meet each other regularly and get psychological support
14 Critical issues and lessons learnt	• The guidelines have to be written by people who have experience in home care and not by the information manager who had no experience in this • Demand for services is higher than can be supplied by 5 social workers. To be able to cover 8 regions of the city as was planned, the number of social workers need to increase to 8 people • The fact that the social workers themselves are PLWHA increases their acceptance and effectiveness in counseling their clients
15 Source of practice and dialogue	Club of self-help 'Life+', contact person: Sergej Fedorov (director), Novoselskogo Street 65, apartment 21, 65020 Odessa Tel. 048 714 37 88 E-mail: life_plus@ukr.net For information in English: International HIV/AIDS Alliance in Ukraine, office@aidsalliance.kiev.ua
16 Editor's note for learning	The initiative of this group is very important to support PLWHA in the absence of services for psychosocial support and home based care from the government. Because the social workers themselves are PLWHA, they are very effective in their counselling. However, the demand for their services is likely to increase even more in future and already they cannot meet demand. It would be good if the model developed by the NGO and shown to be effective, could induce government to start providing home care services as well

35 Management of ARV treatment by PLWHA group, Thailand

Developed by: Sai Samphan Association, Chiangrai, Thailand
Key words: PLWHA, counselling, ARV treatment, Thailand

Section	Content
1 Summary of the practice	The PLWHA group manages care for PLWHA including counselling services, traditional treatment (massage and herbal treatment), health information, treatment of common Opportunistic Infections (OIs). They purchase ARVs from the pharmaceutical industry at discounted prices through the Buyers Club established by the Thai Network of Positive People (TNP+). ARV treatment and follow-up is done in co-ordination with the public health services
2 Level of intervention	Community, hospitals
3 Prospective users of the practice	PLWHA groups, hospitals with outreach services, public health services
4 Problem addressed	• PLWHA do not have sufficient knowledge of traditional treatment methods • PLWHA without support from each other have more mental, social and health problems • PLWHA on their own cannot bargain for access to ARV at reduced prices or influence policy • The government quota of free ARV supply reaches a limited number of PLWHA • Adherence to ARV treatment is difficult without mutual support
5 Purpose of intervention	• Increase access to different types of treatment for PLWHA • Increase mutual support between PLWHA spiritually, mentally, socially • Increase PLWHA integration in the community • Advocate for rights of PLWHA and influence policies
6 Context	• In Northern Thailand, PLWHA started to form support groups since 1993, initially as a reaction to societal pressures against PLWHA and the PLWHAs individual difficult experiences after they had been diagnosed. Later, increased financial and technical support from public and private sectors (NGOs) and supportive policies stimulated group formation by facilitating PLWHA to meet each other. By the end of 1999, already 224 separate groups existed • In 1996, the Positive People Network (140 PLWHA groups) was founded in the North and became the first formal network in the country. Through the network, the groups have greater collective bargaining power to combat discriminatory practices in health-related and other services provided by the government and in their own employment. Moreover, internally the groups realised that sharing of accumulated experiences enhanced each groups potential and enabled them to address issues collectively • Since a number of years, the government provides free ARVs to a limited number of PLWHA from Provincial hospitals. The network is involved in the selection of recipients of these services and in the management of the holistic services given by these hospitals. Yet, many PLWHA that would qualify for the free ARVs fall outside the quota. The network in the North is part of the Thai Network of Positive People (TNP+) that have bargained directly with the Pharmaceutical Industry to obtain ARVs and drugs for Opportunistic Infections at cost price (1200 baht/month = 30US$) (1 Thai Baht (THB) = 0.03 USD)
7 History and process	• The Sai Sampan Group was established in 1994 to provide mutual support and exchange of information on health care. The establishment of the group and their training was done by a local NGO, ACCESS Foundation, where the group is also located • In 1995 they promoted health through the production and use of herbal medicine • In 1997 they started to integrate physical health activities with spiritual health activities such as yoga, meditation and herbal saunas • In 1999 with the help of ACCESS Foundation, they began work on counselling services and traditional massage • In 2000 they added the focus on holistic care in which community level organisations such as traditional healers, village health volunteers, workers from the health centre, schools and monks are mobilised to support PLWHA and to address HIV/AIDS as a collective community issue

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	• The price of ARVs was bargained down by the Thai Network of Positive People (TNP+) and the Buyers Club was established with the head office in Bangkok. Through this club, the Sai Sampan Group started in 2000 to provide management of treatment for their members who were able to afford the price of the drugs The steps in implementation below focus on this activity
8 Steps in implementation	1 Training in counselling of PLWHA and their families by ACCESS Foundation (7 days) for 6 members (5 female, one male) 2 Training from ACCESS Foundation in counselling for ARVs and drugs for Opportunistic Infections (3 days) 3 Counselling of PLWHA for ARV treatment with the following focus: 1) enough funds to be able to afford the drugs monthly 2) preparation to face the possible side effects 3) the need for discipline in taking the drugs (alarm clock) 4 The PLWHA that can afford the treatment are send to the hospital to consult with the doctors. These check if the patient qualifies for treatment: CD4 count below 200; already having had Opportunistic infections; never having taken ARVs before. If the patient qualifies, an ARV regimen is prescribed. Monthly check-ups are done in the hospital and new prescriptions given 5 The prescription is sent to the Buyers Club (monthly) by ACCESS Foundation with payment and the drugs are send to the Foundation 6 The PLWHA receiving ARVs meet monthly for monitoring, to get the drugs, to discuss experiences and to review the prescribed regimens 7 One group member is in charge of the herbal garden where herbs are grown that give relief and help cure certain opportunistic infections 8 There is a clinic operated by the trained group members where PLWHA can come daily for counselling, advice, treatment of (simple) OIs, herbal medicines and massage 9 Home visits are done when a PLWHA has difficulty in adherence, is suffering from an opportunistic infection or side effects of the treatment, or needs counselling. 10 Networking and exchange of experiences with the provincial network that manages the ARV treatment of PLWHA that fall in the quota system of the provincial hospital
9 Duration	Since 2000 the group manages ARV treatment
10 Resources required	• A place to meet and to conduct the clinic (in the office of ACCESS Foundation) • 6 trained PLWHA members (2 for counselling and drugs; 2 for herbal medicine; 1 for massage; 1 co-ordinator), paid a daily fee of Baht 200 out of funds from the office of Communicable Disease Control region 10 (CDC10) • Transport (provided by ACCESS) • Continuous support and technical advice from the NGO
11 Indicators for monitoring	• Adherence to drug regimen • Attendance at monthly meetings • Visits to the clinic for different services • Monitoring sheets of PLWHA • Number of home visits made
12 Impact	• At present 18 PLWHA receive ARVs through the group, other PLWHA also can get drugs and advice from the group (funded by the NGO) • Adherence is very good • The PLWHA service providers know the PLWHA in their group very well and are able to monitor closely • The group builds up experience on different kinds of treatment and is therefore also able to remain healthy longer with the help of traditional medicines and drugs for Opportunistic Infections • ARV treatment for children is at this moment managed by ACCESS Foundation as this requires specialised knowledge. At a later stage the PLWHA service providers will receive training for this • The holistic approach combining physical, spiritual and social care helps PLWHA to live fulfilling lives respected and supported by the communities in which they live
13 Challenges and pitfalls	• Many PLWHA cannot afford the cost of the drugs and have to wait until the government quota for free drugs increases • Sometimes the doctors' prescription of a new regimen is not correct and often the PLWHA service providers know this. It is very difficult for them to argue with the doctors who do not acknowledge their experience

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14 Critical issues and lessons learnt	• ARV treatment without involvement of the PLWHA group (as was initially the case in the provincial hospital) was not so successful because the hospital staff was not able to sufficiently explain ARV treatment, the need for adherence and the side effects in such a way that PLWHA would take the drugs consistently, neither was it able to monitor the PLWHA outside the clinic • PLWHA are very good in providing counselling and care services and support to each other if they are given the opportunity and have received sufficient training • The members have learned to appreciate the traditional wisdom in the form of herbal medicine as a cheaper and better alternative for many Opportunistic Infections. ARV treatment is only accessed if the immune system has become very weak • As a group and as a network, PLWHA are able to successfully advocate for their rights and for improved treatment and care • The PLWHA group and network need ongoing support from the government and non governmental organisations in terms of capacity building, networking, sharing of experiences and funding, but in the form of a respectful partnership
15 Source of practice and dialogue	Sai Samphan Association, c/o ACCESS Foundation, 293 Moo 2, Na Kai Road, Tambon Ron Viang, Muang District, Chiangrai 57000, Thailand E-mail: accesscr@aidsaccess.com
16 Editor's note for learning	• Other PLWHA groups in the North are involved in similar management for ARVs, either from the hospital setting (for PLWHA who receive free ARVs from the government quota) or as a member of the Buyers Club. Differences are mainly in degree of autonomy of the groups • Although at this moment only few people are treated with ARVs through the group, it is important that the approach has proven to work. When more funds become available for ARV treatment, the efforts can be scaled up and use can be made of the experience of PLWHA in treatment regimens • It is also interesting to note that both the health services and the PLWHA group use a mix of traditional and modern medicines, making use of the relative advantages of each medicine

36 Integrated support for children infected and affected by HIV/AIDS, Thailand

Developed by: ACCESS Foundation, Chiangrai, Thailand
Key words: Children, orphans, care takers, counselling, treatment, support, Thailand

Section	Content
1 Summary of the practice	Communities are mobilised to support children affected by HIV/AIDS and their caregivers through involvement of community leaders, district authorities and monks. Health workers are motivated and assisted to develop child-friendly services. Special days are organised for children and their caregivers to be together and provide mutual social and mental support
2 Level of intervention	Community
3 Prospective users of the practice	Communities, PLWHA groups, NGOs, public services dealing with children
4 Problem addressed	• Children affected by HIV/AIDS face discrimination in the communities • Children affected by HIV/AIDS and their care givers need mental support, care and compassion from the community • Public services are not child friendly and do not take the special needs of children affected by HIV/AIDS into account
5 Purpose of intervention	• To increase knowledge, awareness and capacity of communities to support children affected by HIV/AIDS and their care givers • To decrease discrimination of affected children in the community, in the schools and in the health sector • To enable affected children to lead a happy childhood in their own community and to enable them to sustain their own livelihood as adults

6 Context	• ACCESS Foundation is a Thai NGO established in 1991 to join in social efforts to control and to cope with the HIV/AIDS epidemic from a humanitarian and human/social development perspective. They have programmes related to care and support to PLWHA and their families, they train government and NGO workers in care service provision (counselling, home care) and behaviour change communication, they advocate to promote the rights of PLWHA and their families and support and strengthen PLWHA groups and networks
	• The number of children affected by HIV/AIDS is increasing and the NGO realised that few organisations have the awareness, capacity and knowledge to assist these children and their caretakers mentally, socially and financially and that communities have to be guided to support them
	• Problems that children and their caretakers face are for instance:
	  • Discrimination of the children of positive parents by other children and by adults;
	  • Discrimination of infected children in school based on fear for transmission by teachers and parents;
	  • Lack of funds for drugs, food, clothing and schooling;
	  • Lack of understanding of the psychological impact of being affected or infected;
	  • Lack of support to care givers of infected and affected children
	  • Lack of child friendly health services
	• Infected children receive treatment in the provincial hospital and have access to ARVs either through the government quota or through a donation from a senator

7 History and process	• ACCESS started to work with affected children in 1999, based on the concept that families have the potential to take care of the children if they are sufficiently supported • The process started by talking to PLWHA groups in different communities about the problems they are facing with regard to their children within the community, the schools and the health sector. Interested groups were assisted in bringing infected and affected children together to discuss what the children consider to be problems • With the outcome of these discussions, ACCESS and the PLWHA group consulted with the village leader, the local government administration and the monks to see if a community meeting could be organised. In the community meeting relevant organisations/people were brought together such as teachers, women groups, youth groups, aids committees,

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	relevant local government services and eventually leading to a plan of action for community level support and care • ACCESS staff has been trained on child development and counselling and in turn they train selected PLWHA group members on child counselling, on child development, on counselling caregivers and on home visits to follow-up on hospital based health care • With infected children, ACCESS staff members discuss their understanding of their status, explain the medicines and treatment and empower the children to take care of themselves and their life • They also work with health workers in the hospital where infected children are treated on the provision of child friendly services (e.g. reduced waiting times), child counselling, and the acceptance of PLWHA group members to carry out follow-up visits at home • In four communities, ACCESS organises special days for children and caregivers. The children (most up to 12 years old) play games and do activities and the care givers meet separately to discuss issues they are facing, to receive information and to support each other • Such meetings are also held quarterly in the ACCESS office for all affected and infected children and their caregivers that live in the area covered by ACCESS (in total about 300 children of which 100 are infected) • In addition, once a year, a 2 day camp is organised for children and caregivers (visit to the Zoo in Chiangmai or a journey by train to another city)
8 Steps in implementation	**Community mobilisation**: 1 Discuss child related problems within the PLWHA groups and decide if they want to start working on these problems within the community and directly with the children and care givers 2 Discuss with infected and affected children what problems they are facing 3 PLWHA group, affected children and ACCESS organise a meeting with local government administration, village leader and monks to discuss the issues and ask them to organise a community meeting 4 Identify organisations and people for the meeting, plan the meeting and invite the people 5 During the first meeting the issues are discussed with the aim to raise awareness. This meeting is followed by other meetings (as many as necessary) to come up with a community plan of action for care and support to infected and affected children 6 The PLWHA group members carry out home visits to mobilise support and increase awareness and knowledge 7 The community agrees on a plan of action and divides roles and responsibilities (such a plan may include children and parents meetings in school, aids awareness activities with different groups, home visits by community members to caretakers for social support, involvement of youth groups in activities for the children, handicraft production to raise funds, establishment of a support fund for the children) 8 The PLWHA group monitors the activities **Health sector**: 1 ACCESS discusses issues related to children with the health workers 2 Plans are made to improve child friendliness of services, this includes presence of adult PLWHA support in the hospital premises 3 Where necessary ACCESS gives training in child development and counselling to health workers 4 ACCESS staff carries out home visits to discuss understanding of status and treatment and side effects. They give counselling and empower the children to deal with their situation 5 Follow up visits of PLWHA to infected children and their caretakers are agreed and carried out 6 ACCESS staff monitors and supervises PLWHA support, but ARV treatment follow-up for the children is done by the staff as this requires specialised knowledge **ACCESS social and mental support**: 1 Training of PLWHA in child development and counselling. Ongoing supervision of monitoring of PLWHA members that work with the children and their caregivers 2 Organise special days in four communities for children and their caretakers 3 Organise quarterly meetings for all children and their caregivers in the office 4 Organise yearly outings
9 Duration	Since 1999
10 Resources required	• ACCESS receives funding for all its activities and these include the child related activities, it is difficult to separate these out

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	• The activities in the four communities and in the office with the children and their caretakers require about 200.000 Baht per year ($ 5000) (1 Thai Baht = 0.03 US$) • The community activities are either financed by the community itself or they organise government or donor funding (with or without assistance from ACCESS) • ARV treatment for children falls in the government quota or is funded by private individuals
11 Indicators for monitoring	• Community plans developed for AIDS infected and affected children, activities carried out • Home visits of PLWHA group members and community members in support of children and care takers • Child friendliness of services at the hospital • Understanding of their condition and treatment in infected children • Adherence to treatment • Number of children and caretakers attending special days and meetings • Weekly planning and monitoring meetings with ACCESS and PLWHA groups
12 Impact	• Awareness on issues related to affected children has increased in the local government, the village leaders and the community at large • Health services have become more child friendly and they pay the PLWHA for follow up home visits • Discrimination in the communities has decreased • Communities have organised support for affected children and their caregivers • Increased understanding and knowledge with teachers has resulted in increased acceptance of the infected and affected children in school • In some communities special funds have been established for support to children
13 Challenges and pitfalls	• It is difficult and takes long to mobilise community support for children as AIDS is not seen as a priority • Acceptance of PLWHA and their families remains a difficult issue • Rapid change-over of staff in governmental services (including health services) requires continuous mobilisation and awareness raising • PLWHA groups may become too dependent on support from NGOs
14 Critical issues and lessons learnt	• The community has to be prepared well before positive action can take place and this takes a long time • Capacity building of PLWHA leaders is necessary to enable them to work with the communities on an equal footing (not to be in a begging position) • NGO supervision and monitoring of trained PLWHA workers remains necessary
15 Source of practice and dialogue	ACCESS Foundation, 293 Moo 2, Na Kai Road, Tambon Ron Viang, Muang District, Chiangrai 57000, Thailand E-mail: accesscr@aidsaccess.com attention Ms. Nampueng Plang-ruen
16 Editor's note for learning	• The practice shows that even in a region where communities are relatively 'AIDS competent', special efforts have to be undertaken to mobilise people to focus on support to infected and affected children • The special days organised by ACCESS are important for the children for mutual support, to feel understood and to feel part of a group where most are facing similar problems • An interesting aspect of the practice is the discussions with the children themselves not only to help them understand their condition and to enable them to deal with this in a manner appropriate to their age, but also to involve them in planning for better support. This takes place in a environment where traditionally children are regarded as unable to make decisions or influence adult/community interventions

Picture: Children making drawings during their special day at ACCESS

37 Balcão de Direitos (Rights Corner), Brazil

Developed by: Grupo Dignidade (Group Dignity, Awareness and Emancipation for Homosexuals), Brazil
Key words: Legal advice, law, protection of human rights, partnerships, Brazil

Section	Content
1 Summary of the practice	Protection of the rights of persons who have sex with persons of the same sex, transsexuals, sex workers and persons living with HIV/AIDS and their families as a fundamental human right by giving orientation and legal advice
2 Level of intervention	Community level
3 Prospective users of the practice	Organisations aiming at providing legal support to PLWHA and other discriminated groups, and organisations promoting the human rights of these groups
4 Problem addressed	The violation of legal rights of homosexuals, transsexuals, sex workers, injectable drug users, PLWHA and people belonging to other discriminated groups
5 Purpose of intervention	• To provide legal assistance to homosexuals, transsexuals, sex workers, injectable drug users, PLWHA and people belonging to other discriminated groups through mediation in conflicts between the State, companies and individuals • To develop proposals for legislation and public policies for the protection of the above mentioned groups
6 Context	• The rights of gays and lesbians and transsexuals are formally safeguarded by the Federal Constitution and by the Universal Declaration of Human Rights as well as by other legal charters. However, in practice there is severe discrimination of persons that have sex with persons of the same sex, transsexuals, sex workers and PLWHA and their families • Society divides people infected with HIV/AIDS in three groups: 1 The innocents being children, betrayed women and haemophiliacs 2 Those who deserve the disease as a divine punishment (homosexuals, sex workers, injectable drug users and people living promiscuously) 3 Poor black people as potential carriers of the virus • The Project was launched in Curitiba, Paraná, in a very traditional and closed society where people are ashamed to talk about HIV/AIDS and homosexuality
7 History and process	• The Project Rights corner – Break the Silence was established in 2002. It is one of the sub-projects developed in Curitiba by the Grupo Dignidade (Dignity group) as a platform to promote the rights of homosexuals and the prevention of STI /AIDS. The immediate reason for creating this project were the many cases of violation of rights of homosexuals and other discriminated groups. It was supported by the special Secretariat for Human Rights – Presidency of the Republic of Brazil, after the Government of Brazil launched a National Program of Human Rights in 2002 • The project aims to provide legal support through the development of the following activities: • Legal information to citizens about their rights and obligations • Counselling and mediation in conflicts, looking for peaceful solutions and satisfactory agreements between parties • Taking to court the cases that cannot be resolved by mediation or counselling • Facilitating the receipt of basic civil documentation for the poor (birth certificate, wedding certificate, Central Register of Population and work permits) • Similar projects are financed by the Government in the States of Alagoas, Bahia, Rio de Janeiro, Rio Grande do Sul, Goiás, Pernambuco, Paraná, Rondônia, São Paulo, Amazonas, Espírito Santo, Bahia and for the Federal District of Brasilia • The legal staff working in the project do this on a voluntary basis
8 Steps in implementation	1 Identification of a group of (voluntary) lawyers by the Grupo Dignidade 2 Defining objectives and activities 3 Holding radio and TV interviews, to explain the population about the rights of homosexuals, transsexuals and sex workers and persons living with HIV/AIDS and their families. Promoting the existence of the organisation

Section	Content
	4 Taking in cases of discrimination on an ongoing basis resulting for instance in the inclusion of homosexual partnerships in the Social Welfare System of the state of Paraná, a case that caused a lot of turmoil 5 Facilitating to obtain basic civil documentation (identity card, work permit, etc.) for 517 citizens 6 Launching of the Civil Code for Partnership between persons of the same sex 7 Hold seminars on Human Rights emphasising HIV/AIDS and Homosexuality These activities are taking place in most cases at the same time, without sequential order
9 Duration	The Project started in 2002 and can continue even if financial contribution of the government would drop. In that case it might have to exclude a number of activities, for which financing is needed, but the motivated lawyers and trainees that work on voluntary basis would just continue their regular desk work of providing legal assistance
10 Resources required	• The Project has one lawyer, an IT technician and trainees in social service and law • At the moment all workers are volunteers • The State provides funds for the activities • One room in the office of the Grupo Dignidade in Curitiba – Paraná • Office equipment • Documentation for public information • Radio time
11 Indicators for monitoring	With regard to legal assistance and public information on human rights: • Number of participants visiting seminars • Number of cases in which legal assistance has been given • Number of assistance to court cases by the Project • Number of solved court cases (reconciliation, mediation or tribunal) • Number of unsolved court cases
	With regard to promotion of human rights: • Changing attitudes in acceptance and respect for the rights of seropositive people (no indicators are given)
12 Impact	The project has impacted on the legal protection of gay people, infected with HIV/AIDS. This conclusion is based on the following observations: • The clients of the project now go public in accusing individuals and organisations that violated their rights • The demand for services of the project has increased • The project team is beginning to carry out courses for adolescents about discrimination • In case of discrimination, people are beginning to call the police, and asking information about how to act • The public opinion is gradually changing, although slowly • The project is receiving a great number of letters from clients whose cases have been solved
13 Challenges and pitfalls	• Continued prejudice and discrimination of gays and transsexuals, sex workers and PLWHA • It takes a long time to change attitudes of the public • In the beginning of the implementation of the Project, the target group was scared of accusing its discriminators, afraid of reprisals, because violations of their rights are often committed by chefs, medical doctors, civil police and military
14 Critical issues and lessons learnt	• It is necessary to know how to listen to the clients and to show understanding • It is important to know the law of a country very well with regard to discrimination before being able to effectively take on cases • The professional volunteers need to have an open mind • This type of project must be executed by an NGO because the government will not be able to reach the target groups, while NGOs can. They can be trusted more in the view of the clients • For sex workers, legal advice is much more difficult because of lack of legislation that can adequately protect them

Section	Content
15 Source of practice and dialogue	Grupo Dignidade, Conscientização e Emancipação Homossexual (Group Dignity, Awareness and Emancipation for Homosexuals), attention of Silene Hirata, lawyer Travessa Tobias de Macedo n. 53, segundo andar cj. 03 – CEP 80011-970 – Curitiba – Paraná – Brazil Tel: 41 222-3999 E-mail: balcaodireitos@hotmail.com
16 Editor's note for learning	It is remarkable that the government is facilitating this project in 15 States, showing the importance that it gives to adherence to Human Rights. In countries where legal charters against discrimination do not exist, it may be much more difficult to implement activities as described in this practice. Yet, it is very important that the legal sector becomes involved in the support of groups that are being discriminated such as PLWHA and their families

38 The 'Child is Life' project

Developed by: Grupo Pela Vidda Niteroi, Rio de Janeiro (Group for Life)
Key words: PLWHA, adolescents, orphans and vulnerable children, psychosocial support, skills training, employment, social and legal protection, Brazil

Section	Content
1 Summary of the practice	An initiative by people living with or affected by HIV/AIDS to address emerging issues in relation to the social reintegration of adolescents living with HIV, most of whom infected at birth from mother living with HIV/AIDS
2 Level of intervention	Community
3 Prospective users of the practice	Networks of PLWHA, CBO, NGO, Schools, Youth organisations, Ministries of Education, Ministries of Social Welfare, National AIDS Programmes. Adolescents living with HIV and their caretakers
4 Problem addressed	• The majority adolescents living with HIV are orphans or live with poor families. They suffer from social exclusion and lack of education and job opportunities • Children as they become adolescents seek to know about the origin and history of their infection, and consequently the life story of the parents – which is usually not discussed with them • The adolescents are not only concerned about their HIV infection, but also with their sexual life and reproductive health and need information and support to live positively • Adolescents lack self-efficacy, skills and support to deal with the stigma attached to HIV/AIDS and the potential negative impact of disclosing their status to peers or sexual partners
5 Purpose of intervention	The goal of the project is the social reintegration of adolescents living with HIV. Main objectives are to: • Prepare them for life through the reinforcement of their behavioural skills for social contacts with other adolescents, and through skills building for self-employment • Improve the relationship and communication with their parents • Improve the quality of their lives and citizenship
6 Context	• Generally, the physical health condition of adolescents living with HIV in Brazil is good. They are all likely to be under HAART from birth within the broader context of an enabling health policy on access to HAART in Brazil. However, the social environment is still characterised by high level of poverty and stigma. A specific problem faced by adolescents living with HIV is that of exclusion from society • Grupo Pela Vidda Niterói is an NGO of people living with or affected by HIV/AIDS. Since 1991, the group addresses social exclusion and advocates for a better quality of life of people living with HIV/AIDS, solidarity, and the right to life, health and information as well as legal support, workshops on HAART, vocational courses, sensitisation and training of health professionals. The NGO works in the city of Niterói and surrounding municipalities
7 History and process	• Ten years ago, the NGO started to support children with HIV/AIDS. Not only with medication but also with clothes, school materials, nutrition aids, and social events. The community of Niterói was involved and helped to establish all these activities • In general, parents do not discuss with or disclose their HIV status to their children. The reality is that nobody could have foreseen that these children would survive the infection and reach adolescence. Due to the availability of HAART and continuous care and support, these children are adolescents today and start looking for rational explanations to their condition. Main questions are for example, *why do I have to take drugs all the time and so many times per day, why others do not*? • This has prompted the Grupo Pela Vidda Niterói to pay more attention to adolescents living with HIV and to start to start the Project Criança = Vidda (Child = Life) in 1994, focusing on integration in education, sports, culture, preparing and qualifying them for the future where they will face prejudice, exclusion and resistance. In addition, it gives psychosocial support to families with children living with HIV/AIDS trying to keep the children in their environment (extended family, neighbours, others). This strategy gives children the possibility to live a normal life and assures affective and social linkages

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	• In several workshops held by Pela Vidda, the adolescents themselves declared that they wanted autonomy and had the following priorities: health, no prejudice, to belong to a group (family), and have support to realise their material needs (house, room, courses, music, etc.). In short, they want to be autonomous. Other issues that that arose from the workshops include: *Can I marry? How not to infect my partner? General questions related to sexuality and safe sex: How to avoid pregnancy? Why would I tell my friends and be expelled from my peer group?* These issues were discussed and challenged during a national congress for youth in Brazil this year and resulted in many adolescents becoming resistant to disclose their HIV status • The Group is working through discussions with parents and children. Families and other relevant people are encouraged to discuss and generate actions to develop adolescents' self-sustainability. Adolescents are also empowered and trained on how to disclose their identity and affirm their citizenship • The project also has developed several courses for self-employment and skills building in which also dependency on social security is discussed
8 Steps in implementation	Once they identified the need to restore communication between HIV positive parents and their children, the Group started to organise in chronological sequence the following activities 1 **Need assessment among adolescents living with HIV:** In a workshop the volunteers of Pela Vidda discussed with groups of adolescents living with HIV the daily problems they face. This not only provided insights in parents' attitudes towards their children, but also in the social isolation experienced. Parents seem to think that their children do not know that they are infected and do not want their children to know about their condition, trying to protect them for the difficult life that is waiting for them. They also tend to forget that schools provide information about HIV/AIDS and children themselves might become suspicious 2 **Sensitisation and awareness-raising among parents on the needs of adolescents living with HIV**: Using the information gathered in the needs assessment among parents and adolescents in the previous step, the Group organised group sessions with parents to make them aware of the perceptions of their children and ways to deal with this, such as disclosure of their HIV status to their children 3 **Facilitation of HIV status disclosure to children**: Two different discussion groups of parents and children are organised. The first group for parents of children aged 6-9, the second for parents of children age 9 and above 4 **Skills building training** including jewellery, cooking, embroidery, painting, synthetic porcelain, English lessons and computer skills. The training is done as a first step to prepare adolescents for returning into social life, organised by trained volunteers from the community, using the premises of Pela Vidda 5 **Other activities to create self-reliance and to promote the reintegration of the adolescents in the community** include outings and visits to museums or zoos, and meeting with non-infected people
9 Duration	Grupo Pela Vidda Niteroi started in 1991, the project Criança = Vidda started in 1994 and is on-going
10 Resources required	• A space to meet initially in a centre for social welfare in the polyclinic for AIDS and paediatrics in Niterói. Then, the government supported the NGO financially and they now have an office and three full time social assistants • Volunteers: All (doctors, nurses, psychologists, etc.) specialists are volunteers • Local volunteers, who accompany the adolescents to reintegrate in society • The budget is approximately USD 10.000 per year, used for transport, bulletins etc.
11 Indicators for monitoring	• Adherence to HAART regimens • Number of adolescent living with HIV attending group meetings • Number of adolescents registering for and completing skills building training • Parents' attitudes toward disclosing their status to their children • Teachers and community' attitudes towards adolescents living with HIV • Number of teenage pregnancies
12 Impact	• Increased self-esteem and opportunities for integrating adolescents into the labour market • Communication between adolescents and parents restored • Communication with parents has imporved and they are more likely to disclose their HIV status to their children

Section	Content
	• Improved acceptance by schools: several children are attending schools in the village and teachers are informed and co-operative • Community members contribute to the project: more people are providing financial support or adopting children living with HIV
13 Challenges and pitfalls	• As children with HIV move into adolescence, there is a need to create more discussion groups of parents and adolescents, and a space for adolescents in the NGO • Finding new partners to increase the scope and activities of the project. The current number of adolescents living with HIV attending the centre for social welfare in Niteroi is 220, of which 125 participate in the project • Some of the adolescents are already pregnant. This is an indication that they do not use condoms and do not adapt their behaviour to their condition • In spite of all efforts to develop adolescents' skills, it is very difficult for adolescents living with HIV to enter into the labour market because of the stigma and discrimination
14 Critical issues and lessons learnt	• Equal attention to be paid to parents and adolescents • Attention needs to be paid to the social and economic environment (stigma, job opportunities)
15 Source of practice and dialogue	Pela Vidda Niterói Rua Presidente Dominicano, 150 Inga, Niterói/RJ/CEP: 24210-271 Contact: Narda Tebet Fax + 55 21 2719-5683/2719-3793 E-mail: gpvnit@pelavidda-niteroi.org.br Website: www.pelavidda-niteroi.org.br
16 Editor's note for learning	A unique project, particularly interesting because of its comprehensive approach in an area that so far has received little attention: meeting the needs of adolescents living with HIV

39 Gaining community acceptance of PLWHA through awareness raising and income generating activities, Thailand

Developed by: Community Health Project, Chiangmai, Thailand
Key words: Community, PLWHA, income generating activities, Thailand

Section	Content
1 Summary of the practice	A PLWHA group, established for mutual support, carries out awareness raising to increase acceptance in the community and initiates a handicraft production centre and saving and loan funds benefiting the community as a whole
2 Level of intervention	Community
3 Prospective users of the practice	Local government, community organisations, PLWHA groups
4 Problem addressed	• Exclusion of PLWHA and their families in the community • PLWHA lack information and knowledge on HIV/AIDS treatment and use of traditional and modern medicines • Poverty as a result of increased medical expenditures of PLWHA • Without help from the community, infected and affected children have limited chances to grow into adults that are able to sustain a living
5 Purpose of intervention	• To increase PLWHA support to each other spiritually, physically and socially • To increase acceptance and respect for PLWHA and their families (about 860 people) in the community • To network with the health system, other relevant public sectors and relevant NGOs to improve living conditions of PLWHA and other vulnerable groups in the community • To increase income for PLWHA and other vulnerable groups
6 Context	• In the early 1990s the HIV prevalence in Thailand showed a very steep increase. The Thai government launched an extensive prevention campaign focussing on awareness raising and behaviour change (100% condom use with sex workers). Although the campaign resulted in a containment of the epidemic (HIV prevalence is 2% in males and 1% in females in 2001, in total over 1 million people), the awareness campaign used very scary images and this lead to severe discrimination of HIV positive people and their families • This changed after 1993 when PLWHA started to form groups and received increasing technical and financial assistance from multi-sectoral public and non-governmental organisations • In 1996 a positive people network was established to advocate for human rights and access to treatment and to influence policy making • There are government schemes for skills training for income generating activities. There are also government and donor supported saving and loan schemes that are operational in rural Thai districts. This practice has made use of both these schemes
7 History and process	• The project for Community Health is established in 1993 by a HIV positive woman to enhance mutual support of PLWHA and to ensure good care and treatment by the health care system. By being open about her status, she motivates other PLWHA to join • A herbal garden is set up to provide and increase knowledge on herbal medicine for treatment of HIV related diseases • Awareness raising workshops are conducted in the communities involving the local government administration, the village chairman, schools, youth and women organisations etc. to enhance knowledge and awareness on HIV/AIDS and to increase support for PLWHA • Lack of income is identified as a major problem for PLWHA and other vulnerable groups in the community. In turn members of the group attend government skills training and together they set up a handicraft making business. With support from donors, a centre is later constructed that functions as a drop-in centre and as location of the handicraft workshop • In order to generate a fund to support PLWHA in the communities, the group becomes active in setting up two saving and loan schemes. This is open for all community members and part of the profit generated from the interest rates goes into the support fund • There are presently 1000 members in the Community Health project, most PLWHA and their families and other vulnerable groups in the community. Community leaders are represented in the management committee of the project

Section	Content
8 Steps in implementation	**Income generating activities**: 1 Members of the group attend a government training of the Ministry of Industry in handicraft making for three months over a period of three years from 1993. They save from the allowance they receive during this period. Some members put these savings together and buy machines and materials and start a handicraft workshop 2 Over a period of 7 years small handicraft items and souvenirs are made with very little profit 3 In 1999 with support of Japanese donors, a consultant comes to teach designs of different handicraft items to sell in Japan. The consultant also teaches production, marketing and commercial aspects of handicraft sales. This programme ends in 2001 4 Since then, the products are being marketed in Japan, USA and locally while market expansion to other parts of the world is ongoing through presence on trade fairs etc. They sell what they have produced or make products on order 5 There are presently 13 people working in the workshop of which 8 are PLWHA. They earn 100 Baht ($ 2) per day when they have been fully trained (new people receive on-the-job training) 6 50% of the profits of the workshop are put in a health care fund for PLWHA, the other 50% is to ensure sustainability of the production **Activities to increase acceptance and support to PLWHA:** 1 Organisation of meetings in communities at request or at own initiative, including schools and workplaces to increase knowledge on HIV/AIDS and to increase awareness on the need for support to PLWHA and especially their families 2 Coordination with the health care system to ensure proper attitudes and treatment of PLWHA by voicing concerns or reacting on complaints of members of the group 3 Mobilising interest in the village committee to start a savings an loan group, organising a visit to a successful savings group and establishing the saving and loan group in coordination with the district community development officer in 1999 with 260 members (not only to save but also to promote unity in the community). The savings have reached over 500.000 baht at present (1 Thai Baht (THB) = 0.03 USD) 4 A percentage of the profits of the saving and loan group (8%) goes to the PLWHA support fund as community contribution
9 Duration	Started in 1993, ongoing
10 Resources required	• Funds to buy materials and machines (mainly from members, but also from donors) • Construction of the workshop (donors) • Training in handicraft production; training in marketing and management; training in management of saving and loan schemes • Funds for learning visit and attending workshops • Transport of handicrafts is done from a loan from the community fund, and is paid back after sales
11 Indicators for monitoring	• Number of people in the PLWHA group • Handicrafts produced and sold • Number of people (PLWHA and non PLWHA) working in the workshop • Amount of funds in the saving and loan fund • Amount of funds in the PLWHA support fund • Number of PLWHA and non-PLWHA involved in common community activities
12 Impact	• PLWHA are accepted as an integral part of the community and not considered a burden, but a source of initiatives that benefit the community as a whole • PLWHA are members of the savings and loan groups (this is not the case in other communities) • Part of the profit from the IGA and the saving and loan groups is put in a Fund to support PLWHA • Not only PLWHA but also other vulnerable groups (old, handicapped) are able to make a living • Some of the profits from the saving and loan groups are used for development activities that benefit the whole community (such as improved water supply) • Access to information on development opportunities has improved • PLWHA and other people in the community are healthier and happier
13 Challenges and pitfalls	• Personal health concerns of PLWHA because they do fall ill • Donor funding for study visits and workshop attendance has stopped • Better prices for the products sold overseas may have to be negotiated as the price difference is now 1:10

Section	Content
14 Critical issues and lessons learnt	• Determination of the PLWHA leader is critical to develop the activities and to ensure sustainability and continuity • A well functioning saving and loan group requires commitment of the whole community • Networking with other public and non-public organisations is very important to give and receive support and to be kept informed of developments in HIV/AIDS and other aspects of community development
15 Source of practice and dialogue	Mrs. Pimjai Intamoon, Community Health Centre, 116 Moo 2, Tambon Don Kaew, Mae Rim District, Chiangmai 50180, Thailand Tel: 66-53-862939 E-mail: pimjai99@hotmail.com
16 Editor's note for learning	• As in the practice of the Prasarnjaj women group, the activities of the group are benefiting the community as a whole • The strength and determination of PLWHA have turned HIV/AIDS into an opportunity to improve the social and economic environment in which all people can work together for the good of all • The history of the handicraft shop shows that income generating activities can only become profitable if people are trained in production, marketing and commercial aspects and if they are able to continue developing new markets for their products

Picture: Women at work in the handicraft workshop
INSERT 35 IGA_Thailand.JPG

40 Co-operative of PLWHA for producing school uniforms, Brazil

Developed by: Grupo Hipupiara Integracao E Vida, São Vicente, Brazil
Key words: PLWHA, municipality, income-generating activities, Brazil

Section	Content
1 Summary of the practice	An initiative of the Hipupiara Group and the Municipality of São Vicente to support the production of school uniforms by a co-operative of PLWHA – as income generation activity – to enable social integration of PLWHA
2 Level of intervention	Municipality
3 Prospective users of the practice	Organisations of PLWHA, Municipalities, NGO, CBO, NACP
4 Problem addressed	High levels of unemployment, stigma and social and financial exclusion of PLWHA
5 Purpose of intervention	To reinforce self esteem and reduce financial dependency of PLWHA
6 Context	• The Municipality of São Vicente, a coastal city satellite of São Paulo has a population of 302.000 inhabitants (census 2000). Unemployment rate is about 23%. It is ranked number 30 for HIV/AIDS incidence rate in the country. Current male / female ratio is 1/1 • São Vicente has about 1.700 registered PLWHA, the majority of them belonging to a growing group of marginalized people (Injecting Drugs Users, Sex workers) • The Hipupiara Group is an NGO operational at municipal level. A number of volunteers established it after a number of meetings in the 'Café Vida', an initiative of the municipality of São Vicente to have PLWHA around the table to define their future in a structured dialogue
7 History and process	• The Hipupiara group sees its function in the first place as an organisation that promotes innovation and launches new ideas • When discussing with PLWHA about issues of self esteem, sexuality, compliance to treatment or whatever types of action, the question of income generation and social integration appeared crucial to the PLWHA. This prompted Hipupiara to request the support of the Social Fund of the municipality to set-up a sewing workshop, for which they established a cooperative of women • Since December 1999 the Group has been involved in various activities to support PLWHA such as: food support , legal assistance, lectures and HIV/AIDS prevention and support projects targeting children, IDU. It provides mental health workshops and music therapy and runs clinics for lipodistrophy, fitness, nutrition and psychology • The sewing co-operative, community bakery and civil construction are part of the efforts to create job opportunities, income generation and participation
8 Steps in implementation	**Advocacy and preparation:** 1 March 2002: Agreement on financial support from the Social Fund of São Vicente. The Social Fund of the State of São Paulo donated sewing machines and other equipment. The Group then received an order from the municipality to produce a total of 7.000 school uniforms and for clothing for children at the crèches 2 April 2002: Agreement on support in vocational training from the SEBREA. SEBREA, a national institution for support to micro and small enterprises was contacted for vocational training of the members of the cooperative 3 October 2002: Media attention and agreement on support by entrepreneurs in the region. Entrepreneurs in the region were also asked to support the project with fabrics, sewing thread, buttons, etc. and the Media improved the groups' visibility 4 To be a member of the cooperative, women pay a small monthly amount. In exchange for the work they provide, they only receive incentives in kind (food, training), medical assistance and refunding of transport costs to work. As profits will increase in the future, they may be able also to receive a small salary **Training of members of the cooperative:** 1 July 2002: Course 'How to improve your Business' by SEBREA of 46 hours per person 2 September to November: Training in pattern making and sewing for 120 hours per person

Section	Content
	Activities: 1 November 2002: initiation of the production 2 September 2003: Ongoing production of school uniforms 3 Continuously improving quality: meetings, consultation between the team of Hipupiara and the workers of the project
9 Duration	The Project is now underway for one and a half year and on going

10 Resources required	• Infrastructure, equipment and material:
	  • Facility of 50 m^2
	  • Sewing machines for a total of US$ 2500
	  • Working table for US$ 80
	  • Ventilation, cupboards, etc
	• Raw material
	  • Fabrics and threads for US$ 600
	• Timely and continuous training
	  • Entrepreneurial training
	  • Vocational training in sewing
	  • Training in pattern making and fashion
	  • Human resources (20 x 2 in the workshop)
	
	By Brazilian Law, the minimum number to start a co-operative is 20 persons. Workers work in two shifts of four hours per day, five days a week

11 Indicators for monitoring	• Number of volunteers participating in the cooperative • Number and frequency of activities: meeting, lectures, reports, and courses • Number of people involved directly (35) • Number of school uniforms per year (7.000) • Income generated / payment balance • Absenteeism at work rate (as indication of health condition / adherence to treatment)
12 Impact	• PLWHA back in social life • Self-esteem reinforced though work • Improvement of sexual and affective life • Increased adherence to and compliance with treatment because of increased self esteem, social integration and access to health services through the project • Integration with other segments of society through organised meeting points • Perspective of an income
13 Challenges and pitfalls	• Working with people without technical or managerial skills and experience • Finding a proper facility for the production is difficult because owners refuse to rent a place when they know the target group of the project • The health condition of the members of the cooperative is weak, leading to absenteeism and forcing the project to work with two shifts • The duration (sustainability) of the project will be determined by the ability to arrange assignments for production of sufficient scale. The success of Hipupiara is to a great extent depending on personal capacities and network of its management. The fact that the management is part of the PLWHA family makes them vulnerable in terms of health conditions, faced with higher risk of complications • Regular support from the municipality and from other sources are still required
14 Critical issues and lessons learnt	• The most important lesson is that it is possible to convert the isolation and the loss of perspective of life of PLWHA into a situation in which they reintegrate in society, the moment you believe in its feasibility • A second lesson is the need to make the project visible. This has created openings to obtain material from the private sector and gave access to professional trainers for small-scale enterprise development and the production orders they received from the municipality for school uniforms • To run an NGO like this will be more successful when the organisation or the person has intensive contacts with the government, entrepreneurs and civil society

Section		Content
15	Source of practice and dialogue	Grupo Hipupiara Integração e Vida – Hipupiara R. Freitas Guimarães 454 – Boa Vista – São Vicente/SP Tel/fax: 13 – 3466.4007 E-mail: hipupiara@hipupiara.org.br Contacts: Luiz Alberto Simões Volpe – luiz_volpe@uol.com.br Vera Lúcia Ferreira Cardoso – hipupiara@hipupiara.org.br
16	Editor's note for learning	The support provided by the Municipality and the personal efforts in networking, dedication and creativity of the management of Hipupiara have been critical for the success of the partnerships that were developed

41 Farm schools for orphans, Uganda

Developed by: Medical Missionaries of Mary, Mobile AIDS home care and orphans programme, Masaka, Uganda
Key words: Orphans, education, start-up assistance, income-generating activities, Uganda

Section	Content
1 Summary of the practice	As part of a broader programme of home-based care and orphans/family care and support, farm schools are established to cater for orphans aged 13-19 who have dropped-out from school. They are now being taught one week per month practical subjects such as reading, writing, arithmetic, bookkeeping, home economics and intensive integrated sustainable organic farming. The rest of the three weeks of the month they put into practice the skills acquired under the supervision of an agricultural extension worker and a field coordinator. They also receive counselling as individuals, families and groups
2 Level of intervention	Community level
3 Prospective users of the practice	District authorities, NGOs, CBOs
4 Problem addressed	• Orphans and their families are not able to sustain themselves • Orphans drop out of school and receive no formal or informal education • Orphans have a lot of psychological problems
5 Purpose of intervention	• To create an enabling environment where orphans acquire knowledge and skills in intensive integrated sustainable organic farming necessary to sustain themselves now and in future • To ensure that orphans are supported in their own communities • To prevent short and long term psychological impacts among orphans through the provision of individual and group counselling, family and bereavement counselling • To reduce HIV infection by promoting awareness and behaviour change
6 Context	• About 1.4 million Ugandans are currently living with HIV or AIDS, and although the HIV prevalence in Uganda has declined from 23% in the early ninety's to 6% in 2001, many people have died. As a consequence there is an enormous and growing orphan population (880,000 orphans aged 0-14 in 2001 – UNAIDS) • Most orphans are taken in by the extended family, but the capacity in these households and even in the communities to care for the orphans is limited. A report from the Ministry of Gender estimated that 25% of all households in Uganda have taken in at least one orphan • There is a high political commitment in the fight against HIV/AIDS in Uganda and the National Strategic Framework includes a specific focus on the mitigation of the impact at individual, household and community level. The guiding principles include a multi-sectoral approach (emphasising participation of all sectors of society in the control of the epidemic), decentralisation of interventions and community participation in dealing with the epidemic
7 History and process	• Kitovu Mobile AIDS Home care, Counselling and Orphans programme was initiated in1986 by Sr. Ursula Sharpe a Medical Missionaries of Mary sister. Initially, the programme focused on the provision of care for PLWHA, counselling and preventive AIDS education. Positive living was promoted during counselling sessions. However, it was soon realised that in order to live positively, various needs have to be met. Thus, the programme included the provision of school fees for orphans, house construction and repair, food supplements and other materials • In 1989, it was felt that socio-economic needs required support in income generating activities. • From 1988 to 1997, the programme supported over 8000 orphans to attend school. However, this support ended with the introduction of Universal Primary Education (UPE) with the assumption that UPE would provide the basic needs for orphans to go to school. But it became clear very soon, that the percentage of school dropouts among orphans was very high • This high dropout rate led to the establishment of the farm schools for orphans in five sub-counties, each with about 100 orphans attending. The selection criteria for the orphans (and other vulnerable children) to join are: basic ability to read and write, aged between 13-19, school dropout, access to land. The school is operational one week per month, the

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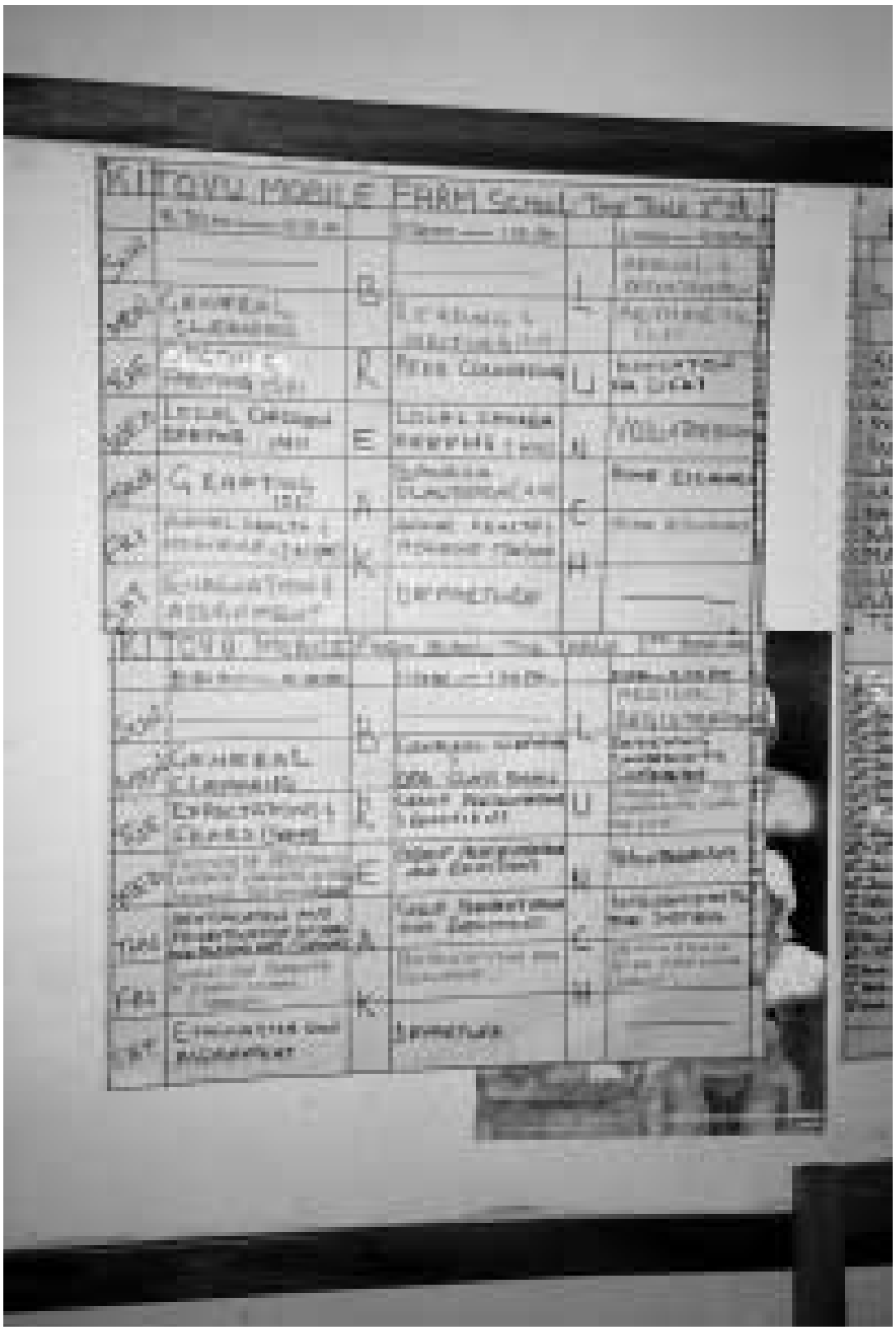
	other three weeks the orphans are practicing the learnt skills in their own fields. The space for the school including the accommodation throughout the training is provided by the community, as is the food during this period. The course lasts for a period of two years • In addition, there are demonstration plots in each local parish (in the home of one of the orphans) where various modern farming skills are demonstrated. In each sub-county, an agriculturist supervises the work of the orphans and a field coordinator follows up the orphans (assessing the living conditions, giving psychological support and keeping in contact with the guardians). The orphans also receive materials support and farm supplies in form of seeds, seedlings poultry, goats, pigsty and piglets on an individual basis while materials like wheelbarrows are given in-group. Each trainee is attached to a group and a start up assistance is given to the group. Orphans are encouraged to establish clubs among themselves to promote teamwork and accumulation of a capital base. These clubs also receive a variety of support such as either a boar centre, granaries, beehives, wheel-barrows, water drums or spray pumps • Apart from the farming activities, there are extra curricular activities such as drama, cloth making and design, exchange visits and competitions • Regular guardians meetings are held aiming at building strong relationships with the guardians and reviewing their responsibilities as per the activities planned • The programme lasts two years after which the orphans graduate and are able to sustain themselves and their families • The whole farm school programme is embedded in the other programmes that are supported by the NGO in the communities in which over 800 community volunteers are involved. These programmes include home based care, counselling, a variety of training programmes. Support for a limited number of orphans in formal education is given to the exceptionally intelligent at primary secondary and tertiary level
8 Steps in implementation	1 Situation analysis on number of orphans that have dropped out of school and qualify for the farm school 2 Mobilisation in the community for space for the school, accommodation and food support during the class-week 3 Selection of orphans for enrolment 4 Recruitment of facilitators/ animators for the topics covered in Mobile Farm School: • Crop husbandry (organic farming) • Animal husbandry • Agricultural economics (planning, bookkeeping) • Reading, writing (writing applications, proposals, compositions) • Arithmetic • Life skills education • Counselling (group and individual) and behaviour change • Home economics (cooking, sewing, handicraft) 5 Recruitment of agriculturists and field coordinators for support to the orphans 6 Distribution of mattresses, blankets, school uniforms and farm tools to orphans 7 School one week per month, spent at the training centre 8 Field practice in their own field (three weeks per month) 9 Supervision through home visits by agriculturist totals up to14 visits per year per trainee on average and field coordinator makes 8 visits per year per trainee on average per sub-county (about 100 orphans) 10 Ongoing distribution of farm supplies to individuals and groups throughout the training period 11 Family and individual counselling on request, ongoing support by community volunteers 12 Orphans and guardians meetings whenever necessary throughout the two year training period 13 Exchange visits twice a year 14 Follow up on graduated students 15 Support to established working clubs
9 Duration	Farm schools started in 1998 and are ongoing. The course itself takes two years to complete after which a listening survey is done in the nearby sub county for generative themes. If lack of proper farming skills is an issue, a farm school is set up in this particular area to arrest the situation
10 Resources required	• Farming tools (hoes, pangas, wheel barrows) • Seeds (groundnuts, maize, beans, vegetable seeds) • Seedlings (passion fruit, grafted orange, moringa, mucuna, neem tree, vanilla etc.)

Section	Content
	• Piglets, pigsties, life stock dewormers • Beddings, uniforms • Agriculturist (salaried, one per sub-county, for 100 orphans) • Field coordinator (full time receiving allowance, motorbike) and community volunteers (yearly motivation depending on funds) • Support to the established clubs • Trained teachers/facilitators/ animators and counsellors • The program staff in all the five departments total up to 65 (fulltime) • The whole programme in 5 sub-counties approximately costs Uganda shilling 236,844,054 (about US$ 118,500) per year • The programme is supported over a longer period by international NGOs like Kindernothilfe, Ireland Aid, Concern/ Trocea, DANIDA, Daina Fund, Mcknight, UACP, George Link, Steven Lewis and from specific grants
11 Indicators for monitoring	• Number of trainees in the six farm schools total up to 600, 298 females, 302 males) • End of year exams on theory • Practical exams periodically • Number of trainees graduated 380 • Number of clubs formed (now 5 in each sub-county, a total of 15 clubs) • Reports from field/home visits by agriculturist and field coordinator
12 Impact	• Increased food security, improved diets • Increased income from the sale of produce resulting in improved living conditions • Other training institutions are asking the trained orphans to teach their modern farming skills • Communities are benefiting by consulting the trainees and adopting modern farming skills taught by the trainees • Increased nutritional values in food not only for orphans but also their families and PLWHA in the community • Improvement in local pigs raising as the boar projects help improve the local breed • 15 clubs formed by orphans • Environmental protection by using organic farming methods
13 Challenges and pitfalls	• Unpredictable weather affecting crop production • Inability of orphans to perform well due to family conflicts and land disputes • Child abuse and abandonment by the guardians • High incidence of malaria leading to absence in school • Drop-outs (total of 53 girls and 44 boys) due to need to earn cash, heavy workload at home, pregnancies/forced marriages, indiscipline • The outbreak of swine fever has affected pig production projects
14 Critical issues and lessons learnt	• The farm schools used to have more boys than girls, and the aim is now to achieve more gender balance. This requires follow-up on girls' enrolment and staying power • The integration of all programmes enhances the impact of the individual programmes
15 Source of practice and dialogue	Medical Missionaries of Mary, Kitovu Mobile AIDS Home Care, Counselling and Orphans Programme. Robina Ssentongo, Programme Director. P.O. Box 413, Masaka, Uganda Tel: 256-(0) 481-20113 E-mail: rsentongo@utlonline.co.ug, mmmuganda@utlonline.co.ug
16 Editor's note for learning	This is an excellent programme that reaches many orphans. The NGO receives sufficient funding, which may not be possible for other NGOs. However, it may be possible to start a similar school system on a much smaller scale and with less activities (such as the extra support to the clubs, or the variety of agricultural produce). Once started and effective, it may be possible to attract more funding and expand the programme

Picture: School time table



42 Combining counselling and skills training for PLWHA, Zambia

Developed by: Kara Hope House Skills Training, Lusaka, Zambia
Key words: PLWHA, counselling, skills training, Zambia

Section	Content
1 Summary of the practice	A four month training programme for PLWHA aged 18-50, that helps them to come to terms with their status, helps them to live positively and gives them skills that can help them earn some income
2 Level of intervention	Community
3 Prospective users of the practice	Post test clubs, counselling centres, home based care groups and other HIV/AIDS community based organisations
4 Problem addressed	• People that have tested positive have difficulties in accepting their status and live positively • PLWHA need to earn an income that enables them to remain healthy as long as possible
5 Purpose of intervention	• To give people psychosocial support through counselling • To rekindle hope and to assist PLWHA in forming peer support groups • To assist PLWHA to concentrate on something else than HIV/AIDS and at the same time provide skills to generate some income • To help PLWHA to access micro-credit to start an income generating activity
6 Context	• Zambia has an AIDS prevalence of 21.5% in adults (2001). Stigma and discrimination of people living with AIDS is predominant and people that have tested positive feel isolated, fear disclosing to their relatives and are often depressed • People who have tested positive may have lost their job as a consequence of being ill or may already have been unemployed. Finding employment is very difficult in Lusaka with an unemployment rate of about 60%
7 History and process	• Kara Counselling is an NGO that has been a pioneer in the development of counselling practice in Zambia for over a decade. The majority of HIV/AIDS councillors in Zambia have been trained through Kara Counselling, resulting in well-established links within the communities in Lusaka • Kara Hope House started as a counselling drop in centre, later VCT services were initiated and a post-test club was formed. A group of PLWHA formed the positive living squad for outreach activities • The organisation realised that PLWHA not only need psychosocial support but also assistance in earning a living. In consultation with PLWHA, a project was established at Hope House with the main purpose to promote positive living among PLWHA through skills training and counselling • The group counselling sessions and individual counselling aim to help people come to terms with their status, to empower them to disclose to their social environment and to link with organisations of PLWHA. The skills training is to restore self confidence, to teach some skills and to help people concentrate on something else than their problems
8 Steps in implementation	1 Clients are identified through the six Kara VCT centres operating in different residential areas in Lusaka and through other HIV/AIDS support organisations. A maximum of 35 trainees are taken per intake 2 Daily activities start with a 30 minute reflection 3 Group counselling is done in two groups of 15 people per four months (at present 60% female and 40% male). The sessions take place twice a week. At the start of the programme, the group members identify key problems and the sessions are adapted to deal with these issues over a 10-week period. Some of the commonly identified issues include: death, stigma, loss, grief, fear, and depression. The programme also teaches people on how to take care of themselves, covering health education, hygiene, common diseases, referral systems in health care and guides them to existing community level organisations offering support to PLWHA 4 Individual counselling sessions are given on demand and may include family members

Section		Content
		5 60% of the time is devoted to skills training. People select usually two subjects out of tailoring, wood carving, papier-maché, tie and die, batik, crocheting, candle making, doormat making 6 The trainees are encouraged to form support groups through which they can access micro credit 7 25% of the clients become part of the outreach team that gives testimonies in schools, work places and institutions for prevention purposes, to fight stigma and discrimination and to promote VCT 8 Follow-up meetings for ex trainees are held every quarter but individuals can drop in at the centre any time 9 Kara counselling links support groups to Micro-financing institutions
9	Duration	Four months with quarterly follow-up meetings as long as the ex trainees are interested
10	Resources required	• A place to conduct the sessions • Materials to be used in the skills training • Experienced counsellors (2, that also do VCT counselling) and skilled teachers (at present 3 for 35 trainees) • Budget of $ 24.000 per year at present, covering VCT and skills training. They would need $ 60.000 to fulfil demand and to include a micro-credit scheme
11	Indicators for monitoring	• Acceptance of status indicated by disclosure to family and friends • Integration with group members and group formation after the training • Handicrafts made during the skills training • Income generating activities established and sustained by individuals or as a group
12	Impact	• When people join the groups, they feel hopeless. Already after a month in the training, this feeling is changing and trust and support is growing within the group. People are enabled to live positively and disclose their status within and outside their family • The skills training restores the feeling that they can still be active and earn an income and access to micro-credit assists in this process • Increased assertiveness enables people to start looking for employment and helps in being successful in finding jobs. The availability of the skills training programme stimulates people to go for VCT and therefore may reduce the spread of HIV • The trainees also encourage others to go for VCT especially after successfully going through counselling
13	Challenges and pitfalls	• Demand for the training is high, leading to long waiting lists and sometimes causing people to loose interest. People who have tested negative in another VCT centre try to come in stating they are positive (hence an insistence on re-testing) in order to get access to the training and later on to micro-credit • The training centre is sometimes shunned in the neighbourhood and its visitors discriminated. This discrimination may lead to reduced interest in VCT • Since Kara does not offer start up capital and relies on linking the trainees to micro financing institutions, morale may become low among the trainees when they are not able to keep themselves occupied after the course • Dependence on the organisation may be developed and may lead to some individuals finding it difficult to fit back into the community after training
14	Critical issues and lessons learnt	The possibility to invite spouses and other family members for counselling facilitates disclosure in the family and helps the clients to cope with identified key problems as these are often family related
15	Source of practice and dialogue	Hope House Skills Training, 174 Luanshya Road, Villa Elisabetha or P.O.Box 37559, Lusaka, Zambia Tel: 227087 E-mail: hopekara@zamnet.zm or kara@zamnet.zm, attention Stanley Chama
16	Editor's note for learning	The main aim for the skills training is to take people's minds away from their problems and this has proven to be a successful approach. The development of skills for income generating activities is a secondary benefit. However, with the high rate of unemployment, this spin-off seems to become more and more important for the PLWHA. However, for income generating activities to be successful, the demand for products needs to be explored and a market established. This is not the case at the moment and with the pervasive poverty in Lusaka, it is doubtful if such a market can be found

Picture: Skills training in woodcarving

43 Support and vocational training for orphaned girls, Zambia

Developed by: Kara Counselling – Umoyo, Lusaka, Zambia,
Key words: Orphans, counselling, skills training, employment, Zambia

Section	Content
1 Summary of the practice	A one year training that provides psychological and life skills support to orphaned girls aged 15-18. They receive vocational training and work placement after the course
2 Level of intervention	City wide, communities
3 Prospective users of the practice	NGOs, social welfare institutions
4 Problem addressed	• Orphaned girls in the age of 15-18 without family have difficulty in sustaining themselves and are particularly vulnerable to become infected with HIV • Orphaned girls traumatised by the loss of their parents and the period preceding that loss, have difficulty in overcoming their psycho-social problems
5 Purpose of intervention	• To enable orphaned girls to regain their self esteem and purpose in life • To teach these girls skills to become economically self-sustaining
6 Context	• Zambia has an AIDS prevalence of 21.5% in adults (2001) and an estimated 570.000 orphans (2001). Traditional family support systems are breaking down, especially in urban areas, resulting in orphans being left on their own • Unemployment levels are in the range of 60% in Lusaka. Stigma and discrimination surrounding HIV/AIDS is still high. Home based care is organised through NGOs and through the public health system
7 History and process	• Kara Counselling is an NGO that has been a pioneer in the development of counselling practice in Zambia for over a decade. The majority of HIV/AIDS councillors in Zambia have been trained through Kara Counselling, resulting in well-established links with home based care groups operating in Lusaka • In 1994 the increasing problem of orphans was recognised by organisations active in HIV/AIDS at different levels and orphaned girls between the ages of 15 and 18 were identified as being particularly vulnerable and traumatized by the loss of their parents. This led to the plan to establish a centre to provide these girls with practical life skills to enable them to cope with life and to restore hope in a future through counselling and training during a period of one year. Girls under 15 are not considered because they are not allowed to work in the formal sector • Support from donors was sought and received and Umoyo centre was constructed in 1996. The first year, 17 girls were admitted and this increased yearly. At present 47 girls are enrolled per year. Although demand for enrolment is higher, more cannot be accommodated because it is not possible to ensure work for more girls after completion of the one-year training. The increase in the number of girls would also entail a corresponding increase in the number of staff, to keep the required quality • Links are established with organisations and work places for job placements after the training is finished • A home base for the girls is identified in their community where they can go once a month for a weekend to keep the social ties. This can be the house where their siblings live or the house of a distant relative or a trusted person • 8 staff members are working in Umoyo centre, all trained in psycho-social counselling in addition to their specific expertise (tailoring, block making, carpentry etc.) in which they teach the girls. A part-time qualified literacy teacher teaches the girls in numeracy and literacy. A number of workshops are organised with outside experts to help the girls understand issues of human rights with an emphasis on women and children. At the end of the training all the girls are trained in peer education, to equip them with skills to enable them to help their friends, when they get back to the community. The girls are encouraged to form support groups in their communities

Section	Content
8 Steps in implementation	1 Orphaned girls are identified through home based care organisations and other institutions working with children in difficult circumstances 2 The girls are interviewed and an assessment is carried out to ensure that they do not have family to support them 3 47 girls are admitted as a group once a year 4 The group is divided according to educational level in 4 small groups that each have one staff member that permanently guides the group 5 Initial focus is on psychological counselling and social skills. The girls get training in agriculture, home management, knitting, tailoring, brick making, carpentry as well as literacy and numeracy integrated into the other subjects according to level 6 After a period of half a year the girls go for industrial attachment to places of work where they gain insight into the kind of profession they may want to choose 7 At the end of the year, the girls get either funds to set up their own business, a job through mediation of the training centre or a 3 to 6 months further training elsewhere paid by the centre and followed by job placement 8 Every month the girls go home for a weekend to avoid alienation from their social environment and to practice coping skills learned in the training. The weekends are evaluated in-group sessions, with special focus on social (and sexual) behaviour 9 At the end of the year, the girls develop a plan for their future and are held accountable for this by the centre. Monthly follow-up visits are made and supervision is also carried out by the home based care teams
9 Duration	One year of training, followed by monitoring over a period of a year
10 Resources required	• A place to provide the training and to house the girls • Staff skilled in counselling and life skills education, skilled professionals for vocational training • Established links with home based care groups and organisations, links with work places for job placements • At present operational costs are $ 65.000 a year
11 Indicators for monitoring	• Behaviour of the girls both in the centre and during their weekends in the community • Tests in vocational subjects • Income through employment • Reports from home based care groups • Monthly visits assessing living conditions and coping mechanisms
12 Impact	• The girls have come to terms with the loss of their parents. They have increased self confidence, are more mature and in control of their lives • Most are working very hard and are able to earn a living through their vocational skills • Many girls are providing a stable environment for their younger siblings and supporting them through school • At present 145 girls have completed the training. Many are still in touch with the centre and each other and become role models for the new girls
13 Challenges and pitfalls	• In the initial weeks, there is a lot of mistrust and fighting among the girls • The girls are enrolled voluntarily and are free to leave the training. This happens to about one girl a year • Finding job placements is very difficult as unemployment levels are very high • Where girls become self-employed competition is very high and profit margins are low • Many girls have no formal education and it is difficult to enrol them in formal training institutions for follow-up training
14 Critical issues and lessons learnt	• The girls need constant encouragement to gain their self confidence • The spread of HIV/AIDS cannot be reduced without addressing socio-economic problems in the communities • In the process of development, no-one should be overlooked because if given the opportunity, everyone can grow • Girls can learn negotiation skills and are able to challenge people that create barriers for a safe and healthy life • None of the graduated girls have married and all work extremely hard, not taking rest. It is almost as if they are possessed and the centre is assessing if this may be caused by too much emphasis on success and ability to make a living • The centre should not be seen as a school but more as a means to enable potential that all people have

Section		Content
15	Source of practice and dialogue	Kara Counselling – Umoyo. P.O.Box 37559, Lusaka, Zambia, attention Mr. Mwamba Mutale Tel: 233562/229849 E-mail: kara@zamnet.zm
16	Editor's note for learning	This is a very impressive programme to break the continuing cycle of poverty and despair in which so many orphans find themselves. The girls that have graduated serve as a role model for other girls and are generally able to support their siblings. Thus, the programme has a wider impact in the community It is obvious that a programme like this cannot be implemented without external funding, especially because highly qualified staff is needed

44 Sipho Eshile (beautiful gift) feeding scheme, South Africa

Developed by: Sipho Eshile womens group, South Africa
Key words: Orphans and vulnerable children, nutrition, psycho-social support, South Africa

Section	Content
1 Summary of the practice	Feeding scheme for orphans and other vulnerable children, organised by women in the community – recently expanded to include provision of school uniforms and school fees in order to reduce school dropout
2 Level of intervention	Community level
3 Prospective users of the practice	Community groups that want to support orphans and other vulnerable children and their care givers
4 Problem addressed	• Orphan headed households and households without income have great difficulty in providing food for the children. This is one of the reasons why children drop out of school and/or have difficulties in learning • The children experience discrimination and stigma and have psycho-social problems
5 Purpose of intervention	To enable vulnerable children to complete their education, to give them a sense of security and hope for the future
6 Context	• South Africa with a total population of 44 million, has an increasing HIV/AIDS problem (5 million infected) and will have over 1.5 million AIDS orphans by 2005, expected to rise to between 3.6 and 4.8 million by 2010 • Women over the age of 60 and men over the age of 65 have a right to government support of 620 Rand/month. For this reason many of the orphans go to grandparents. In addition, the government has different types of grants to support children and caregivers, but these are difficult to access (birth certificate, death certificate etc required), especially for poor people (1 South African Rand (ZAR) = 0.14 USD) • There is still a large silence surrounding AIDS and it is relatively difficult to organize community support for those infected and affected • In the community of the practice (near Bronkhorstspruit) with a population of 200.000, 40-60% of the adults is unemployed
7 History and process	• Six women in the community decided to support needy children with the provision of food. They started to cook from a garage and offered food to children in need. The number of children increased fast (now 200) • After three months, they approached a mission nearby (Sizanani Village Trust) for support. A cooking stove and food support was given, first for one month, and then extended • Sizanani also assisted in linking with the Department of Social Development and the Catholic Bishops Conference for additional funding. This funding enabled the women to rent a house • A second group started to operate in another part of the community. Here a community centre was built with donor support, to function as a multi-purpose centre for all activities related to orphan support, including training and care-giver support groups • Both locations were supplied with tables, chairs, fridge, sufficient plates, cutlery etc. • The six women volunteers receive an incentive from Sizanani of Rand 300 ($30) per person per month • An additional volunteer was attracted to do activities with the children twice a week (sport, drama, music) • The women give emotional support and help with homework • All volunteers received a short training on child care, family preservation, counselling, stress and conflict management • Children are referred through the Department of Social Development, the school or come on their own. The volunteers visit the homes of the children to assess their need for food and further support to the care givers • Sizanani also funds school uniforms and fees if the schools do not wave these

Section	Content
8 Steps in implementation	1 Weekly planning for meals is made 2 Food is bought and cooked 3 The children come from school at 14.00 pm 4 They get food and drinks 5 In turn they have to do cleaning and washing up together under supervision of the volunteers 6 The other children play outside or do activities with the activity volunteer on the days he is there 7 At 16.00 they go home 8 The volunteers have to do bookkeeping in which they are trained and assisted by Sizanani 9 Home visits are made to support care givers
9 Duration	Ongoing, started in 2001
10 Resources required	• Cooking equipment, plates, cutlery, fridge, tables, chairs • Space located in an area accessible for the children and large enough to conduct the different activities • Funds to pay rent, water, electricity, transport, administration and food (in 2002, 65.000 Rand from Department of Social Development and 80.000 Rand from the Catholic Bishops Conference) • Assistance to transport the food from Sizanani (pick-up truck) • Bookkeeping skills, planning and management skills and teambuilding skills • Skills to give psychological support to the children and their caregivers • Skills to network with community stakeholders such as chiefs, teachers, church ministers, political parties • Skills to establish a legal CBO • Funds/assistance to buy uniforms and pay school fees (optional)
11 Indicators for monitoring	• The number of children receiving food (now 200) • Visits to orphan headed households and caregivers • Monitoring is done by all donors
12 Impact	• Children have a sense of belonging, a place where they feel safe and where they are not discriminated • No hungry children roaming around the streets • Care givers, mainly grandmothers supported in their tasks • Children can grow up in their own extended family and/or community • The children are educated not only at school but also at the centres where the women volunteers teach them 'values and norms', give them responsibilities in the centre and help them with home work • The community gets organised around at least one aspect of the AIDS pandemic
13 Challenges and pitfalls	• Lack of management skills leading to problems in organisation, mistrust and division among the women • Children may feel stigmatised attending the programme
14 Critical issues and lessons learnt	• Commitment of the women to start the scheme and subsequent support from the NGO, the Bishops Conference and the Department of Social Development • The sustainability of the scheme is at present very dependent on the support of Sizanani • The women need a more thorough training on various aspects of the work they are doing (this is planned by Sizanani)
15 Source of practice and dialogue	Sipho Eshile Womens Group c/o Sizanani Village Trust P.O.Box 1372 1020 Bronkhorstspruit, South Africa
16 Editor's note for learning	• In view of the increasing need for support of orphans, it is not realistic to assume that the women groups in the communities are able to provide the services that they are giving without support from outside • The stipend that is being given by Sizanani is very motivating for the volunteers as most of them are not employed • In some other orphan feeding schemes supported by Sizanani, the orphan headed households also receive food packages for the weekend

Picture: Orphans having their meal

45 Support from monks to a Positive Women Group, Thailand

Developed by: Prasarnjai group and Phra Athikarn Thanawat Techapanyo, Hua Rin Temple, Chiangmai, Thailand
Key words: Faith based organisations, income generating activities, PLWHA, Thailand

Section	Content
1 Summary of the practice	Support of monks from the local temple leading to community acceptance and income generating activities of a positive women group in a rural area in Northern Thailand
2 Level of intervention	Community
3 Prospective users of the practice	Community based organisations, faith based organisations
4 Problem addressed	• High discrimination of PLWHA and their children/family in the communities • PLWHA do not live as long as they could because of their mental status as a consequence of the discrimination • Decreased income of families of PLWHA
5 Purpose of intervention	• To decrease discrimination of PLWHA and their families • To increase community support and acceptance of PLWHA • To provide spiritual guidance and support by the monks to PLWHA • To improve access to treatment • To increase income of PLWHA
6 Context	• In the early 1990s the HIV prevalence in Thailand showed a very steep increase. The Thai government launched an extensive prevention campaign focussing on awareness raising and behaviour change (100% condom use with sex workers). Although the campaign resulted in a containment of the epidemic (2% male and 1% female infection in 2001, over 1 million people), the awareness campaign used very scary images and this lead to severe discrimination and few people disclosing • This changed after 1993 when PLWHA started to form groups and received increasing technical and financial assistance from multi-sectoral public and non-governmental organisations. From 1996 onwards efforts were aimed at the establishment of a positive people network to advocate for human rights and access to treatment and to influence policy making • The positive groups in the North are engaged in a multitude of functions from support and care of infected and affected people to management of ARV schemes and income generating activities. Discrimination has decreased but is still existent • In public health care, a general scheme provides health care and basic drugs for all for $ 0.6 per visit. This scheme does not yet cover drugs for all Opportunistic Infections or ARVs
7 History and process	• The founder of the group tested positive in 1993 and joined a positive group in another district. With this experience she started a group (Prasarnjaj) in her own community in 1995 with advice from the health centre. The group of 5 women was not accepted in the community and faced severe discrimination • The abbot of the community temple had been trained by the Sangha Metta project (see practice 1). When he paid a visit to the health centre and realized the plight of the women, he decided to help them. He gave them a meeting place in the temple grounds, he spoke to the head of the village to enlist his support and he discussed HIV/AIDS and the situation of PLWHA in his sermons and in all his functions in the community. Monks joined the members of the group in their visits in the community to gain acceptance, especially to neighbours of PLWHA that had disclosed, and to give care and support to households with people who were ill (who might be infected) • The initial focus of the group was on acceptance and reduction of discrimination in the community and on social and spiritual counselling of PLWHA and their families. This was done by the members of the group and by the monks. At a later stage, health care and sharing of experiences in treatment was added to the activities, with weekly check-ups by volunteer doctors and monthly check-ups and information from the health centre given at the groups' centre. The group managed to bargain for free care for PLWHA in the health centre, covering some but not all drugs for opportunistic infections

Section	Content
	• The abbot assisted the members of the group (now 35) by facilitating their attendance in vocational trainings on tailoring and handicraft held by both the government and NGOs. Sewing machines and spinning wheels were bought through donations of the community, the temple, the district administration and group income out of product sales. Sales were limited, but a visit of a Japanese monk to the abbot resulted in a ten-year order for material and ready-made kimonos from Japan. A Japanese consultant gave training for production of material and kimonos
8 Steps in implementation	1 Establishment of the women group in 1995 2 Home visits for acceptance in the community (failed) 3 Involvement of the abbot and group location in temple grounds 4 Abbot active in awareness raising with community leaders, local government administration, local NGOs to stimulate support for PLWHA 5 Monks include HIV/AIDS education and awareness raising in all their activities in the temple and the community 6 Home visits in the community by group members and (sometimes) monks for awareness raising and spiritual support 7 Home visits by group members to sick PLWHA for mental support, food support and health information 8 Ongoing spiritual guidance and support to PLWHA by monks 9 Monthly meeting with health staff (doctor, nurse) at group location for check-up and information 10 Ongoing networking with other PLWHA groups in the district and with NGOs involved in HIV/AIDS 11 Government training for group members in handicraft funded by the temple, start of handicraft as income generating activity 12 Visit of Buddhist monk from Japan resulted in training from Japanese consultant for interested group members and order for 10 years work (since three years) 13 Purchase of spinning equipment and sewing machines funded from own sources, temple sources and donations organised by the abbot 14 Ongoing income generating activities (Japanese and other work), members paid per output; the work is so much that presently also other community members are involved
9 Duration	Group started in 1995, income generation since 2-3 years
10 Resources required	• Skills training for members • Sewing machines • Raw material for spinning • Spinning wheels • Health education and information from the health system • It is difficult to mention all resources needed as most support to the group is given by the temple
11 Indicators for monitoring	• Community involvement in HIV/AIDS activities • Health condition of PLWHA • Number of PLWHA and members of other vulnerable groups involved in the groups' income generating activities • Products sold • Group and individual visits by staff of the health services • AIDS-related activities done with automatic collaboration and coordination among community members • PLWHA and non-PLWHA review and reflect progress and outcome at the village meeting (held 3-4 times a year)
12 Impact	• Community acceptance increased, knowledge and awareness of HIV/AIDS increased, involvement of community to support PLWHA increased • Increased role of monks in helping the community in times of crisis and suffering • Improved living conditions for PLWHA, increased self esteem, empowerment and involvement • Improved collaboration with institutions and organisations operating at community level • Increased economic security for PLWHA and other poor community members
13 Challenges and pitfalls	• People who have recently discovered their positive status have difficulties in accepting this and refrain from joining the existing group due to self discrimination

Section	Content
	• More PLWHAs members need to be trained to participate in the income generating activities (at present the division between PLWHAs and non-PLWHA is 1:1) • It is difficult for PLWHA to find and keep regular jobs or incidental paid work such as agricultural labour • Sustainability of income generating activities (after 10 year order ceases) needs to be addressed • Taking care of infected and affected children • Involvement of elderly
14 Critical issues and lessons learnt	• Without the involvement of the abbot, all activities would have been much more difficult to succeed • The multi-sectoral collaboration in which local government, the health sector, schools, monks, community leaders and community organisations (women, youth etc) are involved in supporting PLWHA is crucial. Without support of even one sector, collaboration and its coordination would not work • For income generating activities to be sustainable, it is necessary to ensure a continuous market for the products. The group will need to diversify its clients. They are starting with this at present • Regular review of activities by PLWHA and community members is important to strengthen collaboration and to adjust strategies
15 Source of practice and dialogue	Mrs. Somya Uthajan (Prasarnjai group) and Phra Athikarn Thanawat Techapanyo, Hua Rin Temple, Tambon Tung Stoke, Sanpatong District, Chiangmai 50120, Thailand Tel: 66-53-830430, 66-9-559053
16 Editor's note for learning	• The work that has been generated by the ten-year order from Japan is so much that many non PLWHA are involved. They all work in the same room and this in itself greatly increases acceptance and support to PLWHA in the community • The practice also shows the influence monks have on the community by integrating HIV/AIDS in their religious teaching and adhering to the principle that all human beings are equal and therefore discrimination is unacceptable

Picture: The women at work in their building on the temple grounds

46 NGO and Local Government co-operation in a rural district in Uganda

Developed by: HealthNeed Uganda, Soroti District, Uganda
Key words: District, multi-sectoral collaboration, Uganda

Section	Content
1 Summary of the practice	HIV/AIDS programme activities on care and prevention supported by a local NGO, are integrated into the local government planning system. The sub-county (sub-district) HIV/AIDS team in Local Government pays the incentives of volunteers, finances (co-funding) and monitors programme activities. For this a Memorandum of Understanding is developed with the Local Government Administration
2 Level of intervention	District, sub-district and community
3 Prospective users of the practice	Local governments, NGOs, CBOs
4 Problem addressed	HIV/AIDS care and prevention activities carried out by NGOs and CBOs are not part of planning, implementation and monitoring of HIV/AIDS interventions of the Local Government. This causes inefficiency, lack of transparency and insufficient responsiveness to needs identified at community level
5 Purpose of intervention	• To mobilise district and sub-district government to integrate HIV/AIDS activities in their programmes • To involve Community Based Health Educators (volunteers) in decentralised planning at sub-district level • To integrate Community Based Health Educators into the heath care system
6 Context	• Although the HIV prevalence in Uganda has declined from 23% in the early ninety's to 6% in 2001, many people have died and about 1.4 million Ugandans are currently HIV-positive • There is a high political commitment in the fight against HIV/AIDS in Uganda and the National Strategic Framework includes a specific focus on the mitigation of impact at individual, household and community level. The guiding principles include openness, participation and a multi-sectoral approach. Emphasis is put on participation of all sectors of society in the control of the epidemic, decentralisation of interventions and community participation • HIV/AIDS activities in Soroti district have been hindered by an unstable environment due to guerrilla activities and tribal cattle raids resulting in a large population of displaced persons. This situation has improved now and many NGOs and CBOs are active in HIV/AIDS prevention, care and mitigation programmes. A process is underway to improve co-ordination and collaboration between these NGOs and CBOs and the local governments, greatly helped by the decentralisation of government planning and services to the districts and sub-counties
7 History and process	• HealthNeed Uganda (HNU) was established in 1998 as a local NGO to implement an integrated health programme with HIV/AIDS prevention and care activities in three districts covering 20 sub-counties. The programme was started as a health project by Medicins sans Frontieres (MSF-Holland), to provide health services for a population of internally displaced persons (result of a guerilla warfare in North East Uganda). A Dutch NGO-HealthNet International and eventually a local NGO-HealthNeed Uganda (HNU) later continued this with a more developmental focus • The aim of the programme is to provide the general population with HIV/AIDS/STD knowledge and skills to reduce HIV transmission; to improve the quality of care/support and counselling to PLWHA at home and in health facilities; to support families affected by HIV/AIDS; and to strengthen district, sub-county and community capacity to implement, monitor and evaluate HIV/AIDS/STD activities. The programme activities in the community are carried out by a well-established network of 180 part time community based health educators (CHE) with a CHE coordinator in each sub-county • In 2000 a review of the programme was carried out, concluding that demand for support services was changing and increasing in the communities and that a 6 person technical staff in the NGO was insufficient to implement this. It was also realised that the activities

Section	Content
	of the CHE were not linked to the public health system and that the various actors involved in HIV/AIDS activities at sub-county level were not co-ordinating very effectively • So, HNU together with the local government at county level (LC 4), organised meetings to discuss how to improve partnership between the government and the non-government organisations with the view of improving access to services by PLWHAs. Many different stakeholders were present including chairmen of the sub-county administration, religious leaders, councillors, parish chiefs and CHE coordinators. This process was repeated in four other counties in the district. On the basis of the results of the discussions, a framework for co-operation was developed, resulting in a standard Memorandum of Understanding between HNU and a sub-county administration
8 Steps in implementation	1 Organise a meeting at county level to discuss how to improve partnership between the government and the non-government organisations 2 Development of a standard MoU format between HNU and the sub-county (LC3) administration 3 Discussion with the political leaders at sub-county level to mobilise their support for a public-private partnership in the sub-county HIV/AIDS programmes 4 Establishment of a 5 person HIV/AIDS team at sub-county level with staff from different departments, including health, social development, planning, and councillors. This team monitors and supervises the implementation of activities at community level 5 HNU develops a strategic approach for different activities in which integration at sub-county level is needed. These include: • Communication and awareness creation with a focus on strengthening exchange of information and experience and on forging a spirit of tolerance through advocacy • Community homecare and support that gives direct support through CHE (home based care and counselling) and strengthens the service delivery system by linking the CHE teams to the local health facility • Sexual and reproductive health education and referral to give extra attention to in and out of school youth through the training of community peer educators and support to life skills education in schools • Orphan support through mobilisation and support to community planning and implementation of activities in which the orphans themselves participate • Resource mobilisation and institutional capacity building through strengthening the links between policy makers at sub-county level and the communities, by supporting NGO networks, by supporting planning and budgeting at lower government levels and resource mobilisation for home care services near the local health units 6 Organise a meeting at sub-county level to discuss the strategic approach and to assess activities carried out in the sub-county by different stakeholders. In this meeting also the CHE coordinator is present to ensure that the needs identified at community level will be included in the planning. Develop a plan for activities in which the tasks and responsibilities of the LC 3 and 2 (different departments) are outlined as well as tasks of CHE, CHE coordinator, CBOs and NGOs. An agreement is made on funding for the activities, including funds provided by HNU and funds provided by the government 7 Signing of the Memorandum of Understanding (MoU) between HNU and the sub-county (see example). This MoU is part of the government planning for HIV/AIDS 8 Implementation of activities by CHE and CHE coordinator, facilitated and supervised by the sub-county team 9 Reporting on activities by the sub-county team to HNU, including financial reporting on a quarterly basis 10 HNU visits activities in the sub-county to give technical support in training, problem solving, supervision and design of programme activities
9 Duration	Since 2000 and ongoing
10 Resources required	• Lunch token (U.Shilling 1500/day), bicycles and continuous training of CHE[1] • Funding of activities through international donor (ICCO) and local government funds (U.Shilling 200,000,000 per year) • Funding for monitoring costs (stationary, transport, report writing) U.Shilling 150,000 per visit – 24 visit per year
11 Indicators for monitoring	• MoU on specified activities • CHE reports on activities to CHE coordinator (monthly), such as visits to patients and other activities carried out

Section	Content
	• CHE coordinator reports on activities of CHE to sub-county (monthly), such as number of patients, number of volunteers involved and types of activities carried out • Sub-county reports on activities to HNU (quarterly), such as co-ordination and integration of public and NGO activities • Records of payments made to CHE and programme activities in accordance with local government financial regulations
12 Impact	• There are budget lines for HIV/AIDS prevention and care activities in the sub-district budget • Co-funding is realised in public-private partnership • Local government administration is involving volunteers in the planning process • Volunteers are being paid lunch token (incentives) by the local government in an open and transparent manner • Local government is monitoring funds (provided by donor funds through the NGO), activities and impact of CHE • Ownership of the CHE programme is established in local government • Communities recognise the services provided through the local government
13 Challenges and pitfalls	• The CHE were used to prompt payments of their incentives by HealthNeed, with the local government administration it takes much longer • It is difficult to keep the HIV/AIDS team in Local Government motivated • Continuous transfer of Local Government staff and changes in political leadership require ongoing efforts to build commitment and understanding of the approach
14 Critical issues and lessons learnt	• The needs of the community are changing (for instance, before, communities needed information and knowledge on HIV/AIDS, at present they need support in care and counselling) and programme activities need to respond to these changes • The development of commitment in Local Government and the administrative changes required for integration is a process that takes time to grow • The existing policies on decentralisation are very supportive to the integration process • The transfer of responsibilities in paying and monitoring has to be complete (and not piecemeal) to effectively build ownership in local government • The MoUs are an absolute necessity to keep the programme functioning with the constant transfer of local government staff and changes in political leadership
15 Source of practice and dialogue	HealthNeed Uganda, P.O.Box 180, Soroti, Uganda Tel: 256 (045)61222 E-mail: hnu@infocom.co.ug
16 Editor's note for learning	• The standardised MoU is helping to overcome the burden of the frequent changes in government staff, which is common in many countries • The sustainability of the incentive for the CHE is questionable if HNU funding stops. However, it is conceivable that by that time, a funded continuum of care can be established in the health system with the CHE at the lowest level

HealthNeed Uganda

Memorandum of Understanding

between

HealthNeed Uganda (HNU)

and

_____ **Sub-Country**

Regarding HealthNeed Uganda-CHEs Activities.

Whereas HEALTHNEED UGANDA is approving a grant to the Sub-county, it remains responsible for ensuring that these funds are spent in an effective way and in accordance to HEALTHNEED UGANDA programme and or objectives

HEALTHNEED UGANDA would like to collaborate with _____ Sub-county in relation to its HIV/AIDS/STD activities. HEALTHNEED UGANDA has approved a grant of UG SHS. _____ in the current financial year _____ (Date: from _____ to _____). Thereafter considered as sub-county revenue. The Sub-county has also accepted to budget and spend UG SHs _____ as agreed with HNU (10%). This 10% contribution will be fulfilled between April and May.
The sub-county will oversee and administer the proper utilization of HEALTHNEED UGANDA funds as follows: CHEs lunch token _____ , _____ , HIV/AIDS/STD Activities _____ , monitoring costs (stationery, transport, report making etc) _____ .

This grant is made in relation to the resolutions made by the Sub-county and agreed between HEALTHNEED UGANDA and. _____ Sub-county. Copy of the resolutions and Sub-county budgets (Health sector budget) are attached and forms an integral part of this agreement. Also attached are the roles and responsibilities of Sub-county coordinators and CHEs.

This specific agreement of understanding shall come into force on _____ and will last for _____ until _____ .

It may be extended for another period with mutual consent of the parties concerned.

It is hereby agreed as follows:

1 HNU will be responsible for ensuring that these funds are spent in an effective way, and in line with all laws and regulation within Uganda.

2 HNU will visit the sub-county from time to time, at least once in quarter to discuss progress and any other issues that either HNU staff may wish to raise or the sub-county. HNU may wish to inspect records/reports or any other records available for the programme during the visit. Mutual convenient times will be arranged for these visits.

3 HNU will provide funds for HIV/AIDS activities including monthly lunch token for CHEs. The funds will be disbursed to the Sub-county accounts on a quarterly basis. However, the funds will be requisitioned on monthly basis. These funds will be part of the sub-county revenue but conditional to HIV/AIDS activities. The funds will be accounted for based on the financial regulations (local government) existing.

4 For subsequent HNU funds to be released the following reports will be prepared by the sub-county: minutes of the last meeting (meeting of the sub-county authority), progress report by sub-county chief, plan for the next month, and accountability of previous funds.

5 HNU field staff will visit the Sub-county as often as possible to train, discuss field problems, supervise and design programme activities.

6 All funds contributed to the sub-county have to be spent in accordance with the budget agreed upon. Any changes in expenditure/use of any funds can only be reallocated after written consultation to and permission from HNU.

7 The Sub-county will assume full responsibility over the CHEs and their activities. It will also ensure that the CHEs are mobilized, monitored, supervised and facilitated in their community work: Provision of introductory letters or identification as health educators.

8 The sub-county will supervise all activities of CHEs in that sub county.

9 The sub-county will budget and provide local contribution (funds, human resource...) for the HIV/AIDS activities.

10 The sub-county chief will report to HNU according to the formats and reporting procedures as stipulated by HNU.

11 The sub-county accepts CHEs as sub-county volunteer persons and that they will be responsible for the effective implementation of HIV/AIDS activities by CHEs.

12 The disbursement of funds will be subject to the general performance of sub-county as assessed by HNU.

13 At least once a quarter, the two parties shall meet to review the implementation of this agreement and the agreement itself.

14 This agreement maybe modified or supplemented by mutual consent between the duly authorized representative of both parties provided such changes are in accordance with the general objectives and purpose of this agreement

15 Either party can terminate this contract at any moment if the above requirements are not fulfilled.

Signed and agreed upon

Date: _____

HealthNeed Uganda **Programme Manager**	**The sub-county chief**
_____	_____
HealthNeed Uganda Board	**Sub-county L/Council III** **Chairperson**
_____	_____

Resolution

In respect to the contract signed the sub-county has resolved that:

- The Sub-county local council III (LCIII) will be the decision making body in the sub-county responsible for CHEs activities. Any conflict arising from the activities of CHEs will be forwarded and resolved by the local council III (LCIII). The sub-county chief remains the immediate supervisor of CHEs activities.

- All the HIV/AIDS activities will be integrated into the overall sub-county plan and that the sub-county health committee (Sub-county Secretary for health) will oversee, plan and budget, and coordinate the implementation of all health activities including HIV/AIDS activities. And that one person among the CHEs will be seconded to the Sub-county health committee and thereafter becomes a member in that committee.

- All the funds and any other support that HNU extends to the sub-county will form part of the sub-county resources and that such funds will be utilised according to the sub-county plan or as agreed by HNU and the sub-county. And that for management of this funds the following persons will be signatories to the account to be opened by the sub-county: Sub-county chief, Sub- accountant, CHEs Sub-county coordinator and one person to be appointed in HNU office. This therefore presumes that the respective sub-counties will present their plan already agreed or that one that incorporates the health sector (HIV/AIDS activities inclusive) as condition for negotiating the funding and or support.

- The sub-county will ensure that the activities of CHEs at the parish level will be integrated into the parish development committee (where such a committee is not in existence, the sub-county local council will resolve to form and or reactivate the committee) and that the CHE(s) will be seconded to the committee as resource person on health matters but specifically HIV/AIDS issues.

- The sub-county will meet from time to time to deliberate on sub-county health matter to include HIV/AIDS issues as expected of their committee. And that part of this discussion will include matters related to the welfare, support and motivation of CHEs.

- The sub-county will receive reports from the Sub-county CHEs coordinator at least once in month. Copies of this report will be submitted to HNU on quarterly basis. This therefore presumes that the sub-county will meet at least once in a month to review and plan health activities but specifically HIV/AIDS/STD activities for CHEs.

- The sub-county will carry out the following activities among others; monitor/supervise and report CHEs activities, performance appraisal for CHEs, ensure proper financial management of CHEs funds and undertake full responsibility for CHEs activities and or actions

HealthNeed Uganda Community Health Educator
The community health educator (CHE) is a voluntary employee of HEALTHNEED UGANDA (HNU) programme that has been seconded to the Sub-counties to carry out Health related activities but specifically HIV/AIDS/STD awareness campaign and support.
The main responsibility of the CHE is to implement HIV/AIDS/STD activities as agreed by the sub-county and HNU. The CHE is the main link between the programme and the beneficiary communities at the parish and village level. The activities of the CHE will include but not restrictive to massive education on HIV/AIDS/STD, mobilising community support groups, counselling, Home visit/care to PHAs and monitor and report community based related activities. CHE is answerable to the Sub-county Coordinator in his/her sub-county who is the focal point person for the programme in the sub-county

Roles and responsabilities of CHEs

1 To mobilise and educate/create awareness on HIV/AIDS/STDs in the community/village. He/she is to implement all programme activities.
2 Work in close collaboration with the health units in the areas of work.
3 Develop daily work plans in collaboration with other CHEs and parish partners.
4 Participate and or attend all parish meetings that are related to their work and those called by subcounty coordinator and any other meetings called by HNU office.
5 Support health unit staff in carrying out-reach services in the communities.
6 Distribute all IEC materials and condoms received and or supplied by the sub-county coordinator or by other organisations
7 Liase with local groups or persons in the parish and or village on all relevant project matters
8 Monitors the activities in their specific areas and reports to the sub-county CHE coordinator for immediate action/attention.
9 Any other additional responsibility as agreed by the Sub-county and HNU

Specific activities

- CHE(s) has to prepare activity workplans (programme/information on field work) and send them to the Coordinator. He fills in correctly monthly monitoring forms and forwards to the coordinator for approval and submission to HNU office.
- It's the duty of a CHE to mobilise and educate/create awareness on HIV/AIDS/STDs in the community. He/she is to implement all programme activities for instance counselling of clients/orphans/affected families/home visits etc in his/her parish or villages of work. Support and or conduct village discussion groups (straight talk sessions) and organise educational talk for such groups
- CHE has to attend all meetings scheduled by subcounty CHE coordinator and any other meetings called by HNU office.
- CHE can identify and refer clients (STD/PHAs pateints) to health untis by correctly filling in a referral form and make follow-ups for these clients to their homes/health units. He/she is responsible for extending counselling services to HIV/AIDS/STD pateints.
- It is the responsibility of the CHE to assist health unit staff in carrying out-reach services in the communities. This will be done as agreed/planned by the health unit staff.
- Has to distribute all IEC materials and condoms received and supplied by the Coordinator or by other organisations working in the subcounty to the community / target groups.
- It's the CHEs duty to seek for permission from the relevant authorities within his parish/village(s) of operation when implementing programme activities and or on behalf of HNU in case of field monitoring.
- Has to participate in LC, PTA, prayer meetings on behalf of the Coordinator and HNU.
- CHE must participate in drama practice and shows organised by the drama facilitator at various venues within the subcounty. Drama participation is compulsory to all CHEs.
- Identifies risky areas/areas of high transmission /health related problems and reports to the Coordinator for immediate attention.
- CHE is answerable to the CHE Coordinator in his/her sub-county who in turn is answerable to HNU office and subcounty reference point.

47 People living with HIV/AIDS coming together in the Caribbean

Developed by: The Caribbean Regional Network of People Living with HIV/AIDS (CRN+)
Key words: PLWHA, networking, leadership development, Trinidad, Caribbean

Section	Content
1 Summary of the practice	A process to develop a regional network and national networks of people living with HIV/AIDS in spite of an environment characterized by high level of stigma and discrimination towards people living with HIV/AIDS
2 Level of intervention	Community, national, regional and international
3 Prospective users of the practice	PLWHA support groups, networks of NGOs, National AIDS Control Programmes
4 Problem addressed	Lack of organizations of PLWHA and lack of involvement of PLWHA in policy and strategy development in Trinidad and Tobago and in the Caribbean
5 Purpose of intervention	To empower and support people living with or affected by HIV/AIDS through advocacy, capacity building, partnership and network development and resource mobilisation
6 Context	• High level of stigma and discrimination towards PLWHA • 'Sensationalisation' of HIV/AIDS by the media • Challenges in 'going public' • Low literacy, poverty and lack of skills of many PLWHA

7 History and process	• In 1993, at a time when disclosing was impossible because of stigma, a committed and well informed psychologist worked with a person living with HIV to develop a vision to form a regional network of PLWHA that would support individuals in countries to create national networks and face the challenge of speaking out and contributing to national policy and strategy development
	• During a conference in Brazil she met another person with HIV and discussed the vision. Subsequent identification of other committed PLWHA in the Caribbean led to the inception of the network CRN+ in 1996 with a core group of 13 selected to look at issues of governance and to make recommendations for the composition of the regional board
	• Then, started a process of information sharing, mutual support, leadership and capacity building, and resource mobilisation as well as partnerships building
	• The network worked to promote a fair balance between prevention and care/support activities, with the following objectives:
	  • To establish effective communication strategies to ensure the flow of information
	  • To establish equal access to treatment information for all PLWHA groups in the wider Caribbean
	  • To involve all countries in the wider Caribbean
	  • To create a database of expertise within the network to maximize available capacity and utilization of skills
	  • To develop strategies for lobbying and advocacy in the wider Caribbean
	  • To strengthen partnerships with agencies which share similar aims and objectives

8 Steps in implementation	1 **Identification and empowerment of individuals**: Started in Trinidad with several persons living with HIV/AIDS with the vision of creating a National network of PLWHA. They were supported by several professionals to build personal skills and a solid structure for the organization. Getting more PLWHA on board proved difficult and it was decided to start with a regional network 2 **Bringing together a Regional Core Group of PLWHA**: Attendance at international conferences gave the opportunity to lobby, to network with donors and with individuals living with HIV/AIDS in different countries and to build consensus. Support was received from the PAHO regional office in the form of a small grant to cover ten Caribbean Islands and form a regional network. Subsequently PAHO Washington and WHO Geneva agreed to provide financial support together with CAREC who provided technical support and thus the Caribbean Regional Network of PLWHA (CRN+) was created

Section	Content
	3 **Development of a strategic approach**: A core group of thirteen was selected to work on the structure and governance of the organization, adopted at a meeting in Antigua, April 1997, and followed by the first Annual General Meeting and selection of the first Board later that year 4 **Supporting the creation of other national networks**: Building capacity of national networks and institutionalization of an annual capacity building workshop with support of the Caribbean Epidemiology Centre (CAREC). Transformation of hopelessness into hopefulness 5 **Creation of the first national network of PLWHA:** Advocacy to get the Trinidad Network registered at the Attorney General (AG) level, to become a legal entity, with support of well connected members, the National AIDS programme manager, doctors, nurses and CAREC 6 **At CRN+ level**: Development of a business model and a public relation strategy. Advocacy to promote CRN+, culminating in the organization of the 10th International Conference for PLWHA in Trinidad 7 **Using the opportunities** provided by the Greater Involvement of PLWHA/UNV/UNDP/UNAIDS, the Global Network of People Living with HIV/AIDS (GNP+) and other international organisations/institutions to strengthen national networks and improve quality of projects
9 Duration	7 years of existence. On going-strengthening
10 Resources required	• Core institutional support for: • Salary (coordinator and support staff) • Office, stationary, equipment and maintenance • Communication: Telephone, Fax, email/internet • Workshops and supervision, funds for networking related trips • Annual budget approximately 50,000 USD
11 Indicators for monitoring	• Number of national networks • Membership at national level • Self development of members • Participation in different regional and national councils and board where decision affecting the lives of PLWHA are taken • Inclusion of concerns of PLWHA in Regional and National policy and strategy documents • Change in families and communities' perceptions of PLWHA
12 Impact	• Today CRN+ has representation in some 29 territories and has supported the creation of 10 National networks and continues to increase membership base. The Regional board includes representatives from the Dutch, English, French and Spanish territories • Development of a joint project by NAPWA and CRN+ • Organization of the 10th International Conference for PLWHA (Trinidad, 2001) attended by more than 400 people living with HIV/AIDS • The CRN+ secretariat in Trinidad, development of a vision, a regional 5-year strategic plan, and a 2-year operational plan, which will be funded by several bilateral and multilateral agencies • CRN+ is a founding member of the Trinidad and Tobago HIV/AIDS Alliance (1996), which includes several organizations working on HIV/AIDS and has been hosted by CRN+ until recently • CRN+ is been part of the CAREC advocacy team to advocate especially to break the silence at prime minister and cabinet levels. In one country, a person living with HIV is now appointed as senior NAP staff member • Collaboration and partnerships with regional and international bodies in the Caribbean and being recognized as the authentic voice of PLWHA in the region and a major stakeholder in the regional response
13 Challenges and pitfalls	• High level of stigma and discrimination and difficulties in speaking out • Low level of education and lack of skills of many PLWHA • There continues to be little or no access to treatment • There is no discussion around issues of compliance, side effects and drug resistance and PLWHA are not asked for their opinion
14 Critical issues and lessons learnt	• Courage and commitment of individual PLWHA is essential as is support from key professionals and large organizations such as CAREC, HIV/AIDS International Alliance, Center for Disease Control (CDC Atlanta) • It is important that people give 'a face to the numbers' • Communication strategy and public relation skills are critical for partnership building

Section	Content
	• In the Caribbean, regional strategies are more easily adopted and then spread throughout Islands. The concept of the Global Network of PLWHA works
15 Source of practice and dialogue	Caribbean Regional Network +, *The Heart of the Caribbean* Tragarete Road, POBox 5061, Port of Spain, Trinidad and Tobago Contact person:Yolanda Simon Tel: +1 (868) 622-8045, Tel/Fax: +1 (868) 622-0176 E-mail: crn@carib-link.net http://www.xs4all.nl/~gnp/carib.html
16 Editor's note for learning	• Generally speaking, a top-down approach to Network creation faces criticisms, as it may not reach down to local organizations or does not necessarily meet needs expressed by these local organizations. However, the bottom-up approach proved difficult because of lack of organizations • In contrast, role models at international level have been instrumental in reinforcing confidence and self-efficacy in many people living with HIV or affected by AIDS who were then able to face various challenges in their home countries

48 Transforming local experiences into national learning: Project Somos, Brazil

Developed by: Grupo Dignidade, Brazil
Key words: MSM, community, training, scaling-up, Brazil

Section	Content
1 Summary of the practice	An NGO promoting the rights of the Gay, Lesbian, Bisexual and Transvestites (GLBT) community. Prevention of STI /HIV/AIDS by giving institutional support to fifty Centres for Training and Consultation in five Brazilian regions
2 Level of intervention	Community level across five regions in Brazil
3 Prospective users of the practice	Local NGOs that support GLBT groups as ultimate beneficiaries of the activities of the Project
4 Problem addressed	Lack of capacity of local NGOs in reducing the marginalisation and vulnerability to HIV of MSM and GLBT communities, especially when they have low education or are older
5 Purpose of intervention	To strengthen the capacity of local NGOs in promoting action for the prevention of STI/HIV/AIDS and citizenship of marginalized GLBT groups
6 Context	• HIV/AIDS seriously affects the MSM community. About 40% of the reported HIV/AIDS cases are in MSM in the age bracket 16-25 • Public health services have difficulties in reaching out to the GLBT community, and there is a lack of organisations that have access to resources. There is lack of partnership between GLBT related organisations and the public health services. This is particularly true in the less developed regions such as in the North and Central East of Brazil • With the creation of the Brazilian GLBT Organisation it became possible to establish linkages with the National STI and AIDS Programme of the Ministry of Health
7 History and process	• The initiative (Project SOMOS) came from MSM through the 'Grupo Dignitade' in Curitiba. Having recognised the need to take action and organise the GLBT communities, the group took one year to develop a working relationship with the National Programme on STI/AIDS and to develop ideas on how to train and strengthen GLBT communities and their organisations • This led to a agreement to create Regional Centres for Training and Consultation and to visit (recently) established groups, with the objective to establish local partnerships • A General National Co-ordination Centre that provided the initial training to the Regional Centres was established in Curitiba • Each Regional Centre is responsible for the identification and training of groups in their regions and provides technical support. They also communicate with the National Coordination Centre (by telephone, electronic and periodic visits to the Centres)
8 Steps in implementation	**First year:** 1 Identification of Co-ordinators and Assistant Co-ordinators for the Regional Centres 2 Training for Co-ordinators and Assistant Co-ordinators of the Regional Centres using interactive training techniques, covering the following four main areas: • **Intervention:** Awareness creation activities with target groups to reduce unsafe sex practices • **Creation of an enabling environment:** Training of partner organisations, contacts with media (positive visibility), conducting events and positive public awareness raising in relation to MSM/GLBT • **Advocacy**: promoting the establishment of anti- discrimination legislation in three domains (discrimination, violence and human rights of GLBT) • **Institutional development:** Training in project management for NGOs including the planning, implementation and evaluation of projects, human relations and self-esteem building, and the development of leadership and sustainability 3 Elaboration of action plans in which each Regional Centre makes a selection of groups and starts regional trainings, aimed to elaborate an action plan for intervention for HIV/AIDS prevention among GLBT groups in their own cities

Section	Content
	4 Implementation of plans in which the local groups return to their cities and start their projects 5 In the course of the year, each group receives two visits of two days by the General Co-ordinator of the Project 6 At the end of the first year, each Regional Centre organises an evaluation and planning meeting with the stakeholders. The Regional Co-ordinators thereafter meet with the General Co-ordinator to assess the actions for the second year of the project **Second year:** 1 During the second year, the Project repeats the activities of the first year, with a national training workshop for Co-ordinators of the Regional Centres 2 The first year, the project limited itself to the theme of Institutional Development. The second year the contents are extended to four areas of intervention (Intervention, Enabling Environments, Advocacy and Institutional Development) 3 Each Centre conducts its Regional training and supports the activities of the stakeholders, which includes an evaluation and planning meeting at the end of the period **Third year:** 1 Restarting the cycle of activities. However, Regional Co-ordinators can now restrict themselves to facilitating the action planning process
9 Duration	Within a 2 year-period (1999-2002) the project gradually extended its activities to all 27 states of the country and has entered now the phase of consolidation
10 Resources required	Leadership with the capacity to conduct interactive training and with understanding of management of NGOs, planning, implementation and evaluation of projects and the ability to establish partnerships (to act as Co-ordinators of the Regional Centres for Training en Consultancy) **Physical resources:** Infrastructure, equipment and material: office, computers and printers, telephone, fax, overhead projector, TV, monitors, video and flipcharts **Financial resources:** For the payment of various costs, fees for the co-ordinators and assistants, office, telephone and postal services, travel, lodging for trainees, perdiem, printing of promotional material (folders, posters, banners), production of support material (reports, booklets, manuals), seed money for projects of stakeholder groups, condoms and gels **Training:** • Timely and continuous on-the-job training • Instructors training in adult education • Annual training for co-ordinators and groups of stakeholders **Human resources:** • 1 General Co-ordinator and 1 Assistant • At each regional centre: 1 Regional Co-ordinator and 1 Assistant
11 Indicators for monitoring	• Process indicators (number of trained persons, meetings, elaborated plans) • Efficiency indicators (number of regions covered, number of target population covered) • Effectiveness indicators (increase of knowledge and skills in relation to the four main areas of the project) • Impact indicators (sustainability of activities of partners trained by the Regional Centres)
12 Impact	• Local groups are now much more confident in finding solutions to their problems and have become more effective in protecting themselves against the virus. New approaches are developed to reach GLBT groups • Improved communication with the media has resulted in a better visibility of the MSM/GLBT movement and a more favourable image in society • In terms of promotion of human rights, municipal laws against discrimination have been approved • The strengthening of political linkages and partnerships contributed to improved visibility of the gay movement, reinforced self-esteem and sexual identity. It is assumed that these factors, jointly with the dissemination of information on healthy sexual behaviour, will have an impact on the reduction of STI and HIV incidence
13 Challenges and pitfalls	• The low level of education of some of the GLBT groups made it necessary to simplify the planning process and to slow-down the speed of implementation • Lack of experience of local groups in establishing partnerships and advocacy is a major impediment to making progress

Section	Content
	• Problems to motivate people for interventions. Because of (initial) distrust of the target population persistence is required to start local projects • Expectations of immediate results with some group leaders, who do not recognise that the process of empowerment of an organisation requires time
14 Critical issues and lessons learnt	• Need to have a training methodology that is flexible and adaptable to specific local conditions • Taking into consideration that the government is one of the main resource providers, there is a need to reassess the extent to which it is possible and acceptable to establish a partnership with the government. Among the target groups there is a common belief that considers the government generally as the 'the enemy' that regards GLBT as 'marginal' communities. Experience shows the importance to establish the dialogue and to reach a mutual consensus on the need to work together • There is also a need to form partnerships with other organisations such as universities for training, trainees in law and social assistance to assist the target population, lawyers to fight abuses of human rights and abuse of homosexuals etc. • Indicators for behaviour change and safer sex practices need to be developed to enable better monitoring of the impact of the project • A project of this nature produces effective results only in the medium and long term due to the length of time it takes to establish and organise groups
15 Source of practice and dialogue	General Co-ordination of the Somos Project ABGL – Secretaria Internacional Toni Reis / David Harrad Travessa Tobias de Macedo, 53 - sala 3 80020-210 Curitiba - PR, Brasil Tel: 55 41 222 3999 Tel/Fax: 55 41 232 9829 E-mail: tonidavid@avalon.sul.com.br
16 Editor's note for learning	This practice shows the importance of government support to organisations of groups that are difficult to reach by the government. Where in large cities, creation and visibility of organisations of the GLBT community may be accepted, this is not the case in less developed regions. Here they very much need the support and capacity building that are being supplied through the network. The fact that the support is peer to peer increases its effectiveness and helps the local NGOs to become self-reliant. Once the network is established, it can focus on content and implementation of interventions, learning from each other through the network

49 Sepo Centre coordination of multi-sectoral aids prevention and care at district level, Zambia

Developed by: SEPO centre, Livingstone, Zambia
Key words: Coordination, district, prevention, care, Zambia

Section	Content
1 Summary of the practice	A centre serves as a node for co-ordination of all HIV/AIDS prevention and care activities in the district
2 Level of intervention	District
3 Prospective users of the practice	District level organisations that want to increase co-ordination, community level organisations
4 Problem addressed	• Many organisations are active in the district but a focal node is needed for co-ordination and sharing of experiences of groups and organisations active in the field of HIV/AIDS care and prevention • Information, education and communication activities for awareness raising are carried out by many organisations but need to be consistent
5 Purpose of intervention	• Promotion of co-ordination of resources and services of organisations involved in HIV/AIDS activities • Coordination of support and care to clients • Coordination of provision of counselling services to clients and their families • Coordination of promotion of safer sex methods through general HIV/AIDS awareness campaigns
6 Context	The centre services the district of Livingstone and part of Kazulunga district with a population of about 180.000. The HIV/AIDS prevalence is 31% in 2002. Unemployment levels are very high and many young adults coming out of school are unemployed. Poverty is widespread. The health system is unable to cope with demand for services and therefore links up with NGOs and CBOs to reach the population. Stigma and discrimination of PLWHA is high, leading to continuing spread of the virus
7 History and process	• SEPO centre was established in 1994 as an initiative of the District Health Management Board in partnership with Norad and UNDP. Initially it was started as a counselling and drop-in centre for patients that were discharged from the hospital. With more patients coming, home based care services were started from the hospital with hospital staff visiting the patients: the hospital determined the level of care • In 1995, a new approach was developed that had the needs of the patient as a starting point and help of care volunteers in the communities. Links were established with ongoing HBC activities from the mission hospital, resulting in multi-sectoral Care and Prevention Teams (CPT). The activities that are carried out or supported by SEPO are mentioned below because they are part of the coordination mechanism • Volunteers are now trained by SEPO centre (care, prevention, counselling, awareness raising, information and behaviour change communication), supervision and drug replenishment is done by the mission, from the local health centres, and from SEPO centre. To facilitate the care given by the teams, income-generating activities were started for the volunteers • It was realised that for prevention efforts to reach beyond the CPT, peer education activities were needed and a programme to mobilise, train and facilitate peer educators (mostly young adults) was started in 1996. The CPT and peer education efforts resulted in the formation of a Widows Association and an Orphan Support Group in 1997 and the formation of a Support Group of PLWHA in 1998 • In 1999, a VCT centre was established at SEPO Centre, and other 12 health centres but uptake was very low because of stigma, fear of lack of confidentiality, and lack of information on VCT. It was then decided to develop a strategy for VCT community mobilisation involving all groups to sensitise for VCT in their ongoing activities (CPT, peer educators, NGOs, CBOs, health systems, public services etc.), including a one day training and monthly reviews with support from AIDS Alliance. Uptake has doubled in a year

Section	Content
	• In 2000, SEPO centre was asked to carry out awareness training for local businesses. This was done and as a result workplace education was added to the activities
8 Steps in implementation	1 Establishment of SEPO centre for counselling and as a drop-in centre 2 HBC services from the hospital, training of its staff in counselling and care 3 Review of activities and development of a new strategy in co-operation with St Francis Mission Hospital 4 Identification and training of care and prevention volunteers by SEPO centre 5 Supervision of care and prevention activities by volunteers (health talks, focus group discussions on specific issues such as stigma, gender, sexuality, HIV/AIDS, STI awareness, basic counselling of patients and families, training of household members in care) 6 Supervision of volunteers by St Francis and the Home Based Care focal point persons in the health centres and SEPO centre, monthly review meetings with all volunteers at local health centres 7 Continuous acquisition of funding through proposals and by showing effectiveness of activities 8 Development and implementation of income generating activities in 4 areas 9 Identification and training of youth peer educators, acquisition of materials for drama, song and dance 10 Peer education activities developed, planned and reviewed during monthly meetings at SEPO centre 11 Ongoing training for care volunteers and peer educators to address newly emerging issues (such as sexual cleansing of widows, dry sex) 12 Coordination of training and support for new community groups involved in HIV/AIDS care and prevention (including youth groups, widows, PLWHA)
9 Duration	Started in 1994, ongoing
10 Resources required	• Donor funding (AIDS Alliance, SAT, NORAD, WFP- material support). The total budget is about $ 40.000 per year from SAT and AIDS Alliance, and a multi year grant from NORAD of $ 15.000 • Staff in SEPO Centre (5 paid: clinical officer, 2 nurses (trained in counselling), 2 support staff; 4 volunteers: secretary, accounting, PLWA and IEC coordinator) • Groups linked to SEPO centre: peer educators (40), CPT volunteers (84), school based educators (21), workplace educators (30), psycho-social counsellors (90) that are mostly health workers, teachers and church leaders, traditional healers (20), PLWHA support group (60) • The peer CPT volunteers and peer educators receive an incentive of $ 7 per month. The counsellors do not receive any incentive
11 Indicators for monitoring	• Supervision and monthly review of CPT volunteers • Supervision and monthly review of plans of peer educators • Income generating activities started and sustained • VCT uptake • Mobilisation activities carried out by different groups, monthly reviews • New community groups started • Reports to donors and District Health Management Team • Mid year reviews and planning meetings with collaborative partners • Annual meeting with partners
12 Impact	• AIDS patients get more and continuing care and their households are involved as well. The integration of care and prevention in the CPT teams leads to greater awareness and less stigma and discrimination. The care system is building on the strengths and relative advantages of the different organisations, thus becoming more efficient • The multi-sectoral approach and co-ordination from SEPO centre makes prevention and care efforts more effective because many different channels are used • The monthly meetings result in better sharing of experiences • Increased number of project sites • Increase in membership of PLWHA in support groups from 12 people in 1999 to 60 in 2002 • VCT uptake has doubled and this may lead to behaviour change
13 Challenges and pitfalls	• Keeping the many volunteers interested in continuing their work. Because of the high unemployment and poverty, the income generating activities were started as an incentive for the volunteers. But the majority of these programmes has failed. There are insufficient

Section	Content
	funds to pay the volunteers even a small token. Peer educators are likely to stop if they find a job • Keeping the VCT councillors motivated. They are not paid for this work, but only for their regular jobs as nurse or midwife • There are inadequate IEC materials available in local languages • Stigma and discrimination still affects all activities in support and care as well as in prevention, this includes self stigma among PLWHA • More transport is needed to support CPT teams and facilitate blood testing
14 Critical issues and lessons learnt	• SEPO centre falls under the District Health Management Team, but operates as a separate entity. This works very well because the roles and responsibilities are clearly defined and because the DHMT is very supportive • The current home-based care volunteers are basically care supporters, the households are the care givers. But this system needs reliable and coordinated support from the health system. Because SEPO centre is part of the district health services this is no problem • The monthly meetings held for all separate HIV/AIDS activities function as a forum for learning and sharing and at the same time increase efficiency and effectiveness of HIV/AIDS activities carried out in the district • The sensitisation and mobilisation for VCT through multi-sectoral channels and integration in all activities has resulted in an increase in VCT uptake
15 Source of practice and dialogue	SEPO centre (att. Mr. Ronald Akakulubelwa), P.O. Box 60545, Livingstone, Zambia. Tel: 321846 E-mail: hope1994@zamnet.zm
16 Editor's note for learning	The efforts to coordinate are very effective. The SEPO centre has become the 'node' for information not only of the public but also for NGOs and CBOs that are involved in HIV/AIDS activities. The stimulating role of the centre leads to increased efforts and not to competition as is often seen in other places

50 Soroti Network of AIDS Service Organisations, Uganda

Developed by: Sonaso, Uganda
Key words: NGO network, advocacy, district coordination, collaboration, Uganda

Section	Content
1 Summary of the practice	NGOs and faith-based organisations in Soroti district have formed a network to promote cooperation and coordination through sharing of information and expertise
2 Level of intervention	District level
3 Prospective users of the practice	NGOs and local governments at district and sub-district level
4 Problem addressed	• NGOs are carrying out activities in HIV/AIDS prevention and care, but because of lack of coordination, activities may be duplicated, distribution over the district may be uneven and experiences and knowledge are not shared • NGOs are competing for funds and there is limited integration between NGO programmes and local government programmes • Policymaking bodies are not informed effectively on practices that are successful or on needs that are identified at community level
5 Purpose of intervention	• To create a network of innovative organisations that can share information and lend support to one another as they pursue their individual efforts and/or objectives • To promote and strengthen collective interventions among members of the network • To give feedback on experiences and needs to policy making bodies
6 Context	• Although the HIV prevalence in Uganda has declined from 23% in the early ninety's to 6% in 2001, many people have died and about 1.4 million Ugandans are currently HIV positive • There is a high political commitment in the fight against HIV/AIDS in Uganda and the National Strategic Framework includes a specific focus on the mitigation of impact at individual, household and community level. The guiding principles include openness, participation and a multi-sectoral approach. Thus the government of Uganda has created a conducive environment for NGOs and a significant number of civil society and faith based organisation offer services in the area of HIV/AIDS • A process is now underway to improve co-ordination, collaboration and learning between these NGOs and CBOs and the local governments, greatly helped by the decentralisation of government planning and services to the districts
7 History and process	• The Soroti Network of AIDS Service Organisations (SONASO) was formed in 2002 by a number of NGOs operational in Soroti district. The initiative was supported by UNASO, the Uganda Network of AIDS Service Organisations that operates at national level, established in 1997. All NGOs in Soroti that are part of SONASO are also members of UNASO and pay an annual membership fee that varies between Ugandan Shilling 50.000 for small starting NGOs and U.Shilling 100.000 for well established NGOs. SONASO receives 60% of these fees for its operations in the district (1 Ugandan Shilling = 0.0005 USD) • There are currently 24 member organisations in SONASO. The strategies of the network are to: 1 Distribute guidelines and case studies on best practices (also received from UNASO) and document good practices in the district 2 Manage a resource centre with training materials and documents 3 Bring together existing expertise within the member organisations in order to improve the capacity of individual organisations and the district government to respond to the epidemic 4 Establish a collective voice to bring about a desired change in policies, programmes and practices • The network works in partnership with the District AIDS Task Force to facilitate the development of appropriate actions consistent with good practice in the district • A small building is constructed for the secretariat on the premises of one of the NGO members (HealthNeed Uganda). HealthNeed also facilitates access to computers and furniture and ad hoc funding for learning meetings etc.

Section	Content
	• Because of the differences in capacity, expertise and experience between the NGOs (including small CBOs and faith based organisations), NGOs are supporting each other on demand
8 Steps in implementation	1 Identify all NGOs active in HIV/AIDS in the district. This includes NGOs not specifically working in HIV/AIDS, but wanting to integrate HIV/AIDS in their ongoing activities 2 Hold a meeting to establish the network and select a secretariat (5 people on a voluntary basis) 3 The secretariat develops a mission statement, objectives and proposes a strategy and principles for working together. This is endorsed by the members 4 The secretariat is trained by UNASO in a workshop covering topics such as administrative management of a network, writing proposals, strategic planning and resource mobilisation 5 Establishment of a partnership with the District AIDS Task Force 6 The secretariat is open two days a week 7 Meetings with the network members are held every month. In these meetings issues for advocacy are discussed, experiences are shared, an overview of individual NGO activities is given and opportunities for collaboration are discussed. For instance, a project proposal was submitted by SONASO that included activities to be carried out by large and small NGOs in the district (for funding through the Global Fund or large donor funded programmes such as AIM). This proposal is submitted through the District AIDS Task Force and, if approved, forms part of the district HIV/AIDS plan NGOs support each other on specific issues based on expertise available
9 Duration	Since 2002 and ongoing
10 Resources required	• An office, office equipment, operational funds for administration and communication • Documentation for the resource centre • Skills to operate a network
11 Indicators for monitoring	• Number of active members in the network • Number of meetings held • Number of proposals from the network funded • Support activities between network members
12 Impact	• The NGOs are strengthening each other in their individual activities (for instance faith based NGOs assist other NGOs in spiritual counselling) • Activities are coordinated between the NGOs and with the District AIDS Task Force • A common purpose and a sense of unity has been established • Organisations that are not specific AIDS related have joined the network to make use of the expertise available in the network
13 Challenges and pitfalls	• Expectations on ability to access funding through collective action are too high, especially with the smaller NGOs • Performance, accountability and transparency of programmes of individual NGOs are not always good and this leads to mistrust • Establishing relationships with other networks in the district (such as NGO forum, Soroti Rural development agency) is not very easy • Understanding of roles and responsibilities of individual NGOs and the network is not always sufficiently clear
14 Critical issues and lessons learnt	• From the start the difference between networking and implementation has to be clarified • NGOs should not look at the network as an opportunity for funding mainly, but as a source of strength for the activities of the individual organisations in terms of advocacy, lobbying and mutual support
15 Source of practice and dialogue	SONASO secretariat, P.O. Box 180, Soroti, Uganda Tel: 256 (045) 61222; E-mail: hnu@infocom.co.ug
16 Editor's note for learning	• A network like SONASO is an excellent way to effectively share knowledge and learn from experience. The mutual support of NGOs increases the capacity of all organisations concerned with HIV/AIDS in the district and the development of joint project proposals enables the NGOs to build on each other's strengths. • The good links with the district administration ensure that coordination of HIV/AIDS activities in the district is taking place • District networks like this are now established in ten other districts. At national level, sharing of knowledge and experience is supported and coordinated by UNASO

Picture: SONASO members discussing experiences

Annex 1:
Guideline on how to write a practice

What is a practice

A practice describes a process that has been carried out by an organisation/ institution/ community to address one or more specific problems. It can serve as an example and/or inspiration for others that are confronted with a similar problem. The practice describes in a practical way the whole process of implementation as it has taken place. In the section on 'critical issues and lessons learnt' the writers can analyse what they would do different next time or can suggest alternative options in any of the sections covered in the practice. The source of information is included to ensure that more details on the process can be obtained if necessary. A practice usually has a longer time frame and it must be sustainable in the context in which it is applied. For instance, if the practice describes an income generating activity, it also needs to address the sustainability of this. If a (donated) grinding mill is broken, it also needs to discuss how the cost for repair is organised.

The process of writing down what exactly has happened and why is in itself a learning experience that can be used to evaluate the practice and to adapt approaches that do not work. The process can also be used to determine indicators for monitoring where these had not been formulated before.

Format of a practice

The format outlined below has to be followed in order to produce a clear and standardised description of the practice. The description of the practice should in principle not cover more than 4-6 pages.

Title
The title has to mention first if the description is a practice or a technique. This has to be followed by a short title. The title should be catchy and appealing and should give an indication on the content of the practice. For instance: Practice: Communities generate income for orphan support. The title should also mention the country in which the practice is situated.

1 Summary of the practice
Brief description of what the practice is all about. It can describe the goal, but should not include the context and the who, when, where, how. It is needed so people can see in an instant if the practice addresses a problem that they also face.

2 Level of intervention
This describes at what level the practice has been carried out. This does not automatically imply that it can only be applied at this level. In some instances practices can be transformed to suit a different level.

3 Prospective users of the practice

This describes who could apply or modify this practice. This can be individuals, groups, facilitators, organisations (NGOs, government) at different levels of intervention.

4 Problem addressed
Describes the problem that was addressed and that has instigated the practice. This section should be relatively short and not describe circumstances that led to the problem. It is possible that more than one problem is addressed at the same time. However, in the description of the implementation, the different problems may have to be described separately.

5 Purpose of intervention
This describes the concrete end result that is expected by using the practice. This may be a one time result (for instance raising funds for a building) but may also be an ongoing activity (income generation to cover the cost of supporting orphans in the community).

6 Context
The context needs to describe the circumstances that were of influence on the development, implementation and impact of the practice. This may pertain to the stage of the epidemic

(prevalence), the trend of the epidemic and the role of the different actors involved. Further it may cover cultural, social, religious, economic, geographical, political, environmental and institutional factors. It may also pertain to demographic factors such as size of the population. This context is essential for readers because it will explain if a practice could be applied in their own setting. It should however not be too extensive: not all issues mentioned above have to addressed.

7 History and process
This describes the overall process from the moment the problem was identified and the decision to address the problem was taken. It includes priority setting, conceptualisation, planning, implementation and monitoring. Where relevant, it also describes the background or history of the organisation, the practice may be a result of earlier activities that the organisation has undertaken. It also addresses measures taken to ensure sustainability of the practice. It also gives an overview of main actors involved in the different stages of the process.

8 Steps in implementation
Chronological sequence of activities taken by the different actors involved during the whole process. This description should be as concrete as possible. For instance, "joint planning" does not describe how the planning was done and who was involved. It should be described as "the six actors (identified) carried out action planning with the help of an action planning matrix (name of technique used)".

9 Duration
When a practice has a clear starting and ending point, these dates should be mentioned. Often a practice will be ongoing. In this case, at least the starting date of the practice should be mentioned as well as those of different phases in the practice, where applicable.

10 Resources required for the practice
This section has to cover:
- Skills needed (for example, being able to cook if you set up a commercial kitchen; different expertises needed)
- Infrastructure/materials required (having a stove to cook on, bicycles to deliver food, telephone)
- Financial resources (think of salaries, fuel, running costs) where possible the costs should be given in US$ to give a clear indication (but this may not be relevant in all cases).
- Training required (for instance book keeping)
- Human resources required (number of people/person months)

11 Indicators for monitoring
Ideally, at the start of a practice a goal is set as well as an overview of activities to be undertaken. Indicators are included for measuring results of the different activities. Such indicators can be mentioned and also how and by whom they are collected. Where this has not been done, the establishment of indicators afterwards with the stakeholders involved in the practice can be a good learning tool. Examples of indicators are: numbers of volunteers involved in home based care, frequency of visits, referrals to and from health posts, reports of meetings, number of products sold, indicators measuring expected results etc.

12 Impact
These may be anticipated impacts (the goal to be reached) but also include not anticipated impacts that have occurred as a result of the practice. For instance increased acceptance of HIV/AIDS in the community, reduced stigmatisation. These may be difficult to measure, but further indications can be given such as more people volunteered for home based care, more self referrals came in etc.

13 Challenges and pitfalls
Here the problems encountered in the process of the practice need to be mentioned. Describing what went wrong in relative detail enhances the capacity to avoid the same problems by those who would like to adapt the practice. For instance sustaining voluntary work needs incentives (bicycle, workshop, visits to other communities etc.)
It also includes non-anticipated negative impacts such as increased stigmatisation as a result of being open about HIV/AIDS.

14 Critical issues and lessons learnt
Reflection and analysis of the practice. Often in retrospect you realise that certain circumstances were very important for the development of the practice. You also realise which parts are crucial for success and should be taken into account by other people who want to adapt/adopt the

practice. The analysis in itself is a good learning activity. Lessons learnt may also address preconceived notions that turned out not to be true (for instance the (im)possibility of formal and informal services working together). Issues of sustainability have to be included here. In case a programme has been set up with outside funding, what is going to happen when the funding ceases; how are funds for operation and maintenance collected.

15 Source of practice and dialogue
Here the name of the organisation and/or contact person that has carried out the practice is mentioned. Sufficient details should be included for readers to be able to contact this person/organisation. In case there are more organisations carrying out a similar practice, these details may be included. It is also useful to refer to documentation in which the same or similar practices are mentioned (both virtual and/or hard copy).

16 Editors note for learning
This is done by the editors (KIT) and will include a reflection on the practice, its connection to techniques that are included in the catalogue and current application/adaptation of a similar practice in other countries for global learning.

17 User feedback
When the practices have been adapted and implemented by others, it will be good if users give a feedback on the use of the practice. This will enrich the learning from experiences and will be included in the practice description. The forum for such an exchange is the e-workspace located at ews@unaids.org.

Annex 2:
Index by category of practice

No.	Practice	Key words
Prevention		
1	Buddhist approach to prevention and care	Faith based organisations, community, training, prevention, care, Thailand
2	Club Cool	Youth, sexual and reproductive health, income generating activities, Haiti
3	Community Art vs. AIDS	Youth, community, contest, prevention, care and support, arts, Togo
4	Community Centre for IDUs	IDU, prevention, syringe exchange, counselling, Ukraine
5	Condom 'Krew'	Youth, sexual and reproductive health, condom promotion, carnival, Trinidad, The Caribbean
6	Cross Border project	Truck drivers, prevention, condom promotion, Hong Kong
7	'De Living Room'	Youth friendly clinic, sexual and reproductive health, Trinidad, The Caribbean
8	Drop-in centre for sex workers	Commercial sex workers, prevention, skills training, social and legal protection, Thailand
9	Each one, teach one	MSM, prevention, safer sex practices, Hong Kong
10	'Jus Once' an interactive HIV/AIDS awareness production	Community, prevention, myths, sexuality, drama and arts, Trinidad, The Caribbean
11	Life skills education in a poor suburb in São Paulo	Prevention, life skills education, teacher training, Brazil
12	Meakaotom Youth Group	Youth, peer education, prevention, Thailand
13	Migrant workers prevention and care	Migrant workers, prevention, care, Brazil
14	Mobile VCT clinic	Voluntary counselling and testing, prevention, India
15	Prison setting prevention and care	Prison, care, prevention, Zambia
16	Protection of young male prostitutes against HIV/AIDS	Street boys, prevention, Brazil
17	Rap against silence	Youth, prevention, music contest, radio, arts, Togo
18	Resource centre for youth	Youth, peer education, prevention, Uganda
19	Sang Phan Wan Mai Youth Group	Youth, prevention, peer education, puppet shows, radio, schools, Thailand
20	Sex industry outreach	Sex workers, clients, sex industry, prevention, Hong Kong
21	Toco Youth Sexuality Project	Youth, community, prevention, peer education, Trinidad, Caribbean
22	VCT at MSM saunas	MSM, voluntary counselling and testing, Hong Kong
23	Voucher scheme	MSM, IDU, sex workers, sexual and reproductive health, access to services, Nicaragua
24	Wear to care	Youth, schools, prevention, social mobilisation, arts, Togo
25	Young people's movement	Youth, peer education, prevention, Nepal
26	Youth learning to take care in a poor neighbourhood in São Paulo	Youth, prevention, peer education, Brazil
27	Video Documentary of HIV/AIDS Projects, 'Choice or Chance'	Youth organisations, documentation, Trinidad, The Caribbean
Care and Treatment		
28	Group Therapy, 'Show you care, Take care of yourself and others'	PLWHA, group therapy, care and support, Trinidad, The Caribbean
29	Macha mission home based care and prevention	Home based care, prevention, Zambia
30	Maramba home based care and prevention	Home based care, prevention, Zambia
31	Masaka ARV provision	ARV treatment, Uganda
32	Mpigi home based care	Home based care, Uganda
33	Nursery for Orphans and Children affected by AIDS	Orphans, faith-based organisations, care and support, ARV treatment, Trinidad, The Caribbean
34	Psycho-social and home care for PLWHA	PLWHA, home based care, psycho-social support, Ukraine
35	Sai Samphan management of ARV treatment by PLWHA group	PLWHA, counselling, ARV treatment, Thailand

No.	Practice	Key words
Support and mitigation		
36	Access integrated child support	Children, orphans, care takers, counselling, treatment, support, Thailand
37	Balcão de direitos (Rights Corner)	Legal advice, law, human rights, partnerships, Brazil
38	"Child is Life" project	PLWHA, adolescents, orphans and vulnerable children, psychosocial support, skills training, Brazil
39	PLWHA Health and Income generating activities	PLWHA, community, income generating activities, Thailand
40	Co-operative of PLWHA for producing school uniforms	PLWHA, municipality, income-generating activities, Brazil
41	Farm school for orphans	Orphans, education, start-up assistance, income generating activities, Uganda
42	Counselling and skills training in Kara Hope House	PLWHA, counselling, skills training, Zambia
43	Support to orphan girls in Kara Umoyo	Orphans, counselling, skills training, employment, Zambia
44	Orphan feeding scheme	Orphans and vulnerable children, nutrition, psycho-social support, South Africa
45	Support from monks to HIV positive women group	Faith based organisations, PLWHA, income generating activities, Thailand
Partnerships and coordination		
46	NGO and Local Government cooperation	District, multi-sectoral cooperation, Uganda
47	People Living with HIV/AIDS Coming Together in the Caribbean	PLWHA, networking, leadership, Trinidad, Caribbean
48	Networking and training of MSM NGOs: Projeto Somos	MSM, community, mobilisation, training, scaling-up, Brazil
49	SEPO Centre, district coordination	District, coordination, prevention, care, Zambia
50	Soroti Network of AIDS Service Organisations (SONASO)	NGO network, advocacy, district, coordination, Uganda

Annex 3:
Index by domains of the Self Assessment Framework

No.	Practice	Key words
Acknowledgement and Recognition		
3	Community Art vs. AIDS	Youth, community, contest, prevention, care and support, arts, Togo
9	Each one, teach one	MSM, prevention, safer sex practices, Hong Kong
10	'Jus Once' an interactive HIV/AIDS awareness production	Community, prevention, myths, sexuality, drama and arts, Trinidad, The Caribbean
17	Rap against silence	Youth, prevention, music contest, radio, arts, Togo
20	Sex industry outreach	Sex workers, clients, sex industry, prevention, Hong Kong
24	Wear to care	Youth, schools, prevention, social mobilisation, arts, Togo
28	Group Therapy, 'Show you care, take care of yourself and others'	PLWHA, group therapy, care and support, Trinidad, The Caribbean
37	Balcão de direitos (Rights Corner)	Legal advice, law, human rights, partnerships, Brazil
39	PLWHA Health and Income generating activities	PLWHA, community, income generating activities, Thailand
44	Orphan feeding scheme	Orphans and vulnerable children, nutrition, psycho-social support, South Africa
45	Support from monks to HIV positive women group	Faith based organisations, PLWHA, income generating activities, Thailand
47	People Living with HIV/AIDS Coming Together in the Caribbean	PLWHA, networking, leadership, Trinidad, Caribbean
Inclusion		
1	Buddhist approach to prevention and care	Faith based organisations, community, training, prevention, care, Thailand
4	Community Centre for IDUs	IDU, prevention, syringe exchange, counselling, Ukraine
16	Protection of young male prostitutes against HIV/AIDS	Street boys, prevention, Brazil
28	Group Therapy, 'Show you care, take care of yourself and others'	PLWHA, group therapy, care and support, Trinidad, The Caribbean
35	Sai Samphan management of ARV treatment by PLWHA group	PLWHA, counselling, ARV treatment, Thailand
36	Access integrated child support	Children, orphans, care takers, counselling, treatment, support, Thailand
37	Balcão de direitos (Rights Corner)	Legal advice, law, human rights, partnerships, Brazil
38	'Child is Life' project	PLWHA, adolescents, orphans and vulnerable children, psychosocial support, skills training, Brazil
39	PLWHA Health and Income generating activities	PLWHA, community, income generating activities, Thailand
40	Co-operative of PLWHA for producing school uniforms	PLWHA, municipality, income-generating activities, Brazil
45	Support from monks to HIV positive women group	Faith based organisations, PLWHA, income generating activities, Thailand
47	People Living with HIV/AIDS Coming Together in the Caribbean	PLWHA, networking, leadership, Trinidad, Caribbean
48	Networking and training of MSM NGOs: Projeto Somos	MSM, community, mobilisation, training, scaling-up, Brazil
Care and prevention: all practices under the heading prevention and care and treatment (practices 1-35) and		
36	Access integrated child support	Children, orphans, care takers, counselling, treatment, support, Thailand
42	Counselling and skills training in Kara Hope House	PLWHA, counselling, skills training, Zambia
43	Support to orphan girls in Kara Umoyo	Orphans, counselling, skills training, employment, Zambia
44	Orphan feeding scheme	Orphans and vulnerable children, nutrition, psycho-social support, South Africa

No.	Practice	Key words
Access to treatment		
7	'De Living Room'	Youth friendly clinic, Sexual and reproductive health, Trinidad, The Caribbean
13	Migrant workers prevention and care	Migrant workers, prevention, care, Brazil
23	Voucher scheme	MSM, IDU, sex workers, sexual and reproductive health, access to services, Nicaragua
31	Masaka ARV provision	ARV treatment, Uganda
33	Nursery for Orphans and Children affected by AIDS	Orphans, faith-based organisations, care and support, ARV treatment, Trinidad, The Caribbean
35	Sai Samphan management of ARV treatment by PLWHA group	PLWHA, counselling, ARV treatment, Thailand
Identify and address vulnerability		
2	Club Cool	Youth, sexual and reproductive health, income generating activities, Haiti
4	Community Centre for IDUs	IDU, prevention, syringe exchange, counselling, Ukraine
5	Condom 'Krew'	Youth, sexual and reproductive health, condom promotion, carnival, Trinidad, The Caribbean
6	Cross Border project	Truck drivers, prevention, condom promotion, Hong Kong
8	Drop-in centre for sex workers	Commercial sex workers, prevention, skills training, social and legal protection, Thailand
11	Life skills education in a poor suburb in São Paulo	Prevention, Life skills education, teacher training, Brazil
12	Meakaotom Youth Group	Youth, peer education, prevention, Thailand
13	Migrant workers prevention and care	Migrant workers, prevention, care, Brazil
15	Prison setting prevention and care	Prison, care, prevention, Zambia
16	Protection of young male prostitutes against HIV/AIDS	Street boys, prevention, Brazil
18	Resource centre for youth	Youth, peer education, prevention, Uganda
26	Youth learning to take care in a poor neighbourhood in São Paulo	Youth, prevention, peer education, Brazil
38	'Child is Life' project	PLWHA, adolescents, orphans and vulnerable children, psychosocial support, skills training, Brazil
41	Farm school for orphans	Orphans, education, start-up assistance, income generating activities, Uganda
43	Support to orphan girls in Kara Umoyo	Orphans, counselling, skills training, employment, Zambia
Learning and transfer		
1	Buddhist approach to prevention and care	Faith based organisations, community, training, prevention, care, Thailand
25	Young people's movement	Youth, peer education, prevention, Nepal
27	Video Documentary of HIV/AIDS Projects, 'Choice or Chance':	Youth organisations, documentation, Trinidad, The Caribbean
29	Macha mission home based care and prevention	Home based care, prevention, Zambia
34	Psycho-social and home care for PLWHA	PLWHA, home based care, psycho-social support, Ukraine
39	PLWHA Health and Income generating activities	PLWHA, community, income generating activities, Thailand
41	Farm school for orphans	Orphans, education, start-up assistance, income generating activities, Uganda
47	People Living with HIV/AIDS Coming Together in the Caribbean	PLWHA, networking, leadership, Trinidad, Caribbean
48	Networking and training of MSM NGOs: Projeto Somos	MSM, community, mobilisation, training, scaling-up, Brazil
49	SEPO Centre, district coordination	District, coordination, prevention, care, Zambia
50	Soroti Network of AIDS Service Organisations (SONASO)	NGO network, advocacy, district, coordination, Uganda
Measuring change		
1	Buddhist approach to prevention and care	Faith based organisations, community, training, prevention, care, Thailand
7	'De Living Room'	Youth friendly clinic, Sexual and reproductive health, Trinidad, The Caribbean
33	Nursery for Orphans and Children affected by AIDS	Orphans, faith-based organisations, care and support, ARV treatment, Trinidad, The Caribbean

No.	Practice	Key words
34	Psycho-social and home care for PLWHA	PLWHA, home based care, psycho-social support, Ukraine
35	Sai Samphan management of ARV treatment by PLWHA group	PLWHA, counselling, ARV treatment, Thailand
41	Farm school for orphans	Orphans, education, start-up assistance, income generating activities, Uganda
43	Support to orphan girls in Kara Umoyo	Orphans, counselling, skills training, employment, Zambia
Adapting our responses		
19	Sang Phan Wan Mai Youth Group	Youth, prevention, peer education, puppet shows, radio, schools, Thailand
21	Toco Youth Sexuality Project	Youth, community, prevention, peer education, Trinidad, Caribbean
22	VCT at MSM saunas	MSM, Voluntary counselling and testing, Hong Kong
23	Voucher scheme	MSM, IDU, sex workers, sexual and reproductive health, access to services, Nicaragua
33	Nursery for Orphans and Children affected by AIDS	Orphans, faith-based organisations, care and support, ARV treatment, Trinidad, The Caribbean
39	PLWHA Health and Income generating activities	PLWHA, community, income generating activities, Thailand
41	Farm school for orphans	Orphans, education, start-up assistance, income generating activities, Uganda
46	NGO and Local Government cooperation	District, multi-sectoral cooperation, Uganda
49	SEPO Centre, district coordination	District, coordination, prevention, care, Zambia
Ways of working		
8	Drop-in centre for sex workers	Commercial sex workers, prevention, skills training, social and legal protection, Thailand
19	Sang Phan Wan Mai Youth Group	Youth, prevention, peer education, puppet shows, radio, schools, Thailand
25	Young people's movement	Youth, peer education, prevention, Nepal
34	Psycho-social and home care for PLWHA	PLWHA, home based care, psycho-social support, Ukraine
35	Sai Samphan management of ARV treatment by PLWHA group	PLWHA, counselling, ARV treatment, Thailand
46	NGO and Local Government cooperation	District, multi-sectoral cooperation, Uganda
47	People Living with HIV/AIDS Coming Together in the Caribbean	PLWHA, networking, leadership, Trinidad, Caribbean
49	SEPO Centre, district coordination	District, coordination, prevention, care, Zambia
50	Soroti Network of AIDS Service Organisations (SONASO)	NGO network, advocacy, district, coordination, Uganda
Mobilising resources		
1	Buddhist approach to prevention and care	Faith based organisations, community, training, prevention, care, Thailand
5	Condom 'Krew'	Youth, sexual and reproductive health, condom promotion, carnival, Trinidad, The Caribbean
35	Sai Samphan management of ARV treatment by PLWHA group	PLWHA, counselling, ARV treatment, Thailand
38	'Child is Life' project	PLWHA, adolescents, orphans and vulnerable children, psychosocial support, skills training, Brazil
39	PLWHA Health and Income generating activities	PLWHA, community, income generating activities, Thailand
40	Co-operative of PLWHA for producing school uniforms	PLWHA, municipality, income-generating activities, Brazil
45	Support from monks to HIV positive women group	Faith based organisations, PLWHA, income generating activities, Thailand
46	NGO and Local Government cooperation	District, multi-sectoral cooperation, Uganda
47	People Living with HIV/AIDS Coming Together in the Caribbean	PLWHA, networking, leadership, Trinidad, Caribbean
49	SEPO Centre, district coordination	District, coordination, prevention, care, Zambia

Annex 4: Index per country

No.	Practice	Key words
Brazil		
11	Life skills education in a poor suburb in São Paulo	Prevention, Life skills education, teacher training, Brazil
13	Migrant workers prevention and care	Migrant workers, prevention, care, Brazil
16	Protection of young male prostitutes against HIV/AIDS	Street boys, prevention, Brazil
26	Youth learning to take care in a poor neighbourhood in São Paulo	Youth, prevention, peer education, Brazil
37	Balcão de direitos (Rights Corner)	Legal advice, law, human rights, partnerships, Brazil
38	'Child is Life' project	PLWHA, adolescents, orphans and vulnerable children, psychosocial support, skills training, Brazil
40	Co-operative of PLWHA for producing school uniforms	PLWHA, municipality, income-generating activities, Brazil
48	Networking and training of MSM NGOs: Projeto Somos	MSM, community, mobilisation, training, scaling-up, Brazil
Haiti		
2	Club Cool	Youth, sexual and reproductive health, income generating activities, Haiti
Hong Kong		
6	Cross Border project	Truck drivers, prevention, condom promotion, Hong Kong
9	Each one, teach one	MSM, prevention, safer sex practices, Hong Kong
20	Sex industry outreach	Sex workers, clients, sex industry, prevention, Hong Kong
22	VCT at MSM saunas	MSM, Voluntary counselling and testing, Hong Kong
India		
14	Mobile VCT clinic	Voluntary counselling and testing, prevention, India
Nepal		
25	Young people's movement	Youth, peer education, prevention, Nepal
Nicaragua		
23	Voucher scheme	MSM, IDU, sex workers, sexual and reproductive health, access to services, Nicaragua
South Africa		
44	Orphan feeding scheme	Orphans and vulnerable children, nutrition, psycho-social support, South Africa
Thailand		
1	Buddhist approach to prevention and care	Faith based organisations, community, training, prevention, care, Thailand
8	Drop-in centre for sex workers	Commercial sex workers, prevention, skills training, social and legal protection, Thailand
12	Meakaotom Youth Group	Youth, peer education, prevention, Thailand
19	Sang Phan Wan Mai Youth Group	Youth, prevention, peer education, puppet shows, radio, schools, Thailand
35	Sai Samphan management of ARV treatment by PLWHA group	PLWHA, counselling, ARV treatment, Thailand

No.	Practice	Key words
36	Access integrated child support	Children, orphans, care takers, counselling, treatment, support, Thailand
39	PLWHA Health and Income generating activities	PLWHA, community, income generating activities, Thailand
45	Support from monks to HIV positive women group	Faith based organisations, PLWHA, income generating activities, Thailand
Togo		
3	Community Art vs. AIDS	Youth, community, contest, prevention, care and support, arts, Togo
17	Rap against silence	Youth, prevention, music contest, radio, arts, Togo
24	Wear to care	Youth, schools, prevention, social mobilisation, arts, Togo
Trinidad and Tobago		
5	Condom 'Krew'	Youth, sexual and reproductive health, condom promotion, carnival, Trinidad, The Caribbean
7	'De Living Room'	Youth friendly clinic, Sexual and reproductive health, Trinidad, The Caribbean
10	'Jus Once' an interactive HIV/AIDS awareness production	Community, prevention, myths, sexuality, drama and arts, Trinidad, The Caribbean
21	Toco Youth Sexuality Project	Youth, community, prevention, peer education, Trinidad, Caribbean
27	Video Documentary of HIV/AIDS Projects, 'Choice or Chance':	Youth organisations, documentation, Trinidad, The Caribbean
28	Group Therapy, 'Show you care, take care of yourself and others'	PLWHA, group therapy, care and support, Trinidad, The Caribbean
33	Nursery for Orphans and Children affected by AIDS	Orphans, faith-based organisations, care and support, ARV treatment, Trinidad, The Caribbean
47	People Living with HIV/AIDS Coming Together in the Caribbean	PLWHA, networking, leadership, Trinidad, Caribbean
Uganda		
18	Resource centre for youth	Youth, peer education, prevention, Uganda
31	Masaka ARV provision	ARV treatment, Uganda
32	Mpigi home based care	Home based care, Uganda
41	Farm school for orphans	Orphans, education, start-up assistance, income generating activities, Uganda
46	NGO and Local Government cooperation	District, multi-sectoral cooperation, Uganda
50	Soroti Network of AIDS Service Organisations (SONASO)	NGO network, advocacy, district, coordination, Uganda
Ukraine		
4	Community Centre for IDUs	IDU, prevention, syringe exchange, counselling, Ukraine
34	Psycho-social and home care for PLWHA	PLWHA, home based care, psycho-social support, Ukraine
Zambia		
15	Prison setting prevention and care	Prison, care, prevention, Zambia
29	Macha mission home based care and prevention	Home based care, prevention, Zambia
30	Maramba home based care and prevention	Home based care, prevention, Zambia
42	Counselling and skills training in Kara Hope House	PLWHA, counselling, skills training, Zambia
43	Support to orphan girls in Kara Umoyo	Orphans, counselling, skills training, employment, Zambia
49	SEPO Centre, district coordination	District, coordination, prevention, care, Zambia

Annex 5:
List of Abbreviations

AIC	AIDS Information Centre (Uganda)
AIC	Appreciate, influence, control (Thailand)
AIDS	Acquired Immunodeficiency Syndrome
ARV (ART)	Antiretroviral (Antiretroviral Treatment)
BBS	Bulletin board systems
CAO	Chief Administrative Officer (Uganda)
CAREC	Caribbean Epidemiology Centre
CBO	Community-based organisation
CDC	Communicable Disease Control (Thailand)
CHAYN	Caribbean HIV/AIDS Youth Network
CHE	Community based health educators
CNLS	Conseil National de Lutte contre le SIDA
CPT	Care and Prevention Teams (Zambia)
CSW (SW)	Commercial Sex Workers
Empower	Education Means Protection Of Women Engaged in Recreation
DDC	District Development Committee
FBO	Faith-based organisation
FPATT	Family Planning Association of Trinidad and Tobago
GASD	Groupe d'Action et de Solidarité pour le Développement
GLBT	Gays, Lesbians, Bisexuals and Transvestites
GTZ	German Technical Cooperation
HAART	Highly Active Antiretroviral Treatment
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
HNU	HealthNeed Uganda
ICAS	Instituto Centroamericano de la Salud (Central American Health Institute)
IDU	Injecting Drugs Users
IEC	Information, Education and Communication
IGA	Income Generating Activities
KAP	Knowledge, attitudes and practices
MoH	Ministry of Health
MoU	Memorandum of Understanding
MPINASO	Mpigi District Network of AIDS Service Organisations (Uganda)
MSF	Médecins Sans Frontières
MSM	Men who have sex with other men
NGO	Non-governmental organisation
NORAD	Norwegian Aid
NOVIB	Oxfam Netherlands
OI	Opportunistic Infections
PAHO	Pan American Health Organization
PCE	Public Cruising Environments
PHC	Primary Health Care
PHO	People's Health Organisation (India)
PLWHA	People Living with HIV or AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PRA	Participatory Rural Appraisal
PSI	Population Service International
RDC	Resident Development Committee (Uganda)
SAT	Southern Africa Training Centre
SIDA	Syndrome d'Immunodeficience acquise
SONASO	Soroti Network of AIDS Service Organisations
SRH (SRHR)	Sexual and Reproductive Health (and Rights)
STI (STD)	Sexually Transmitted Infections (Diseases)
TASO	The AIDS Service Organisation (Uganda)
TB	Tuberculosis
TBA	Traditional Birth Attendant
TNP+	Thai Network of Positive People

UNAIDS	United Nations Joint Programme on AIDS
UNASO	Uganda Network of AIDS Service Organisations
UNDP	United Nations Development Programme
UNFPA	United Nations Family Planning Association
UNHCR	United nations High Commission for Refugees
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VDC	Village Development Committees
WFP	World Food Programme
WHO	World Health Organization
YMCA	Young Men's Christian Association

Conversion Rates

Currency	**USD**
1 Trinidad and Tobago Dollar (TTD)	0.162602
1 Thai Baht (THB)	0.03
1 Indian Rupee (INR)	0.02
1 Ugandan Shilling (UGX)	0.0005
1 Hong Kong Dollar (HKD)	0.13
1 British Pound (GBP)	1.84
1 South African Rand (ZAR)	0.14