HEALTH DIVISION DOCUMENT 2002:5

Report on

The Mekong Partnership and Beyond

A follow up of the components for Swedish support in Burma/ Myanmar, Cambodia, China (Yunnan Province), Laos and Vietnam

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Contents:

Some remarks by the consultants on the mission, the team and the report

The team consisted of two consultants Mr Anders Nyman, child psychologist with an expertise on vulnerable children and children in need of special protection and Mrs Viveca Urwitz, MSW with an expertise in HIV/AIDS with a focus on prevention and health promotion for youth. Youth Representatives were attached to the team, Ms Ida Strasser and Mr Jakob Strasser, with a background in HIV/AIDS-prevention and peer-education. The purpose their participation was to give input to Sida on possible conditions for youth participation in missions concerning development work for youth in general. The youth representatives have written a separate report on that specific topic. The report is also included as an Appendix in this report *(Appendix V)* However they have also contributed with their points of view to this report. We are convinced that their presence and their questions helped obtain an open and informal atmosphere that benefited the mission. Their experiences from similar interventions in Sweden gave valuable information for the conclusion and suggestions.The consultants want to thank the staff of UNICEF and their partners who all helped us obtain the information we needed with the utmost patience. The facilitation of our mission was done with, what appears to us, as impressive commitment and ambition often through using evenings as well as weekends. We have been well received and our mission has been treated with respect, sincerity and patience. We have been allowed to ask all questions and make all interviews and study all materials we wanted. Language difficulties, cultural circumstances, lack of time and patience on our side might have resulted in misconceptions and mistakes. The initiated reader will probably find incorrect facts and figures as well as incorrect spelling of names. We apologize for all of this and appreciate if significant mistakes could be communicated to us. We have tried to present our reference materials whenever we cite facts or quote directly. However the documents related to field visits and meetings are only found in Appendix VI. In the report we refer to ourselves as the consultants, the consultancy team or simply "we".The mission took place within a very short time span, between the 1st of June and 30th of June, travel included. The consultants therefore had limited time in most countries. Burma/Myanmar and Cambodia were prioritised by Sida.

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List of abbreviations

AIDS Acquired Immune Deficiency Syndrome
BDCC Behaviour Development Change Communication
CASD Community Action for Social Development
CEDC Children in Especially Difficult Circumstances
CNSP Children in Need of Special Protection
CRC Child Rights Committee
CSW Commercial Sex Worker
FPA Family Planning Association
HIV Human Immunodeficiency Virus
IDU Infected (Injection) Drug Users
IEC Information Education and Communication
IMR Infant Mortality Rate
KAB Knowledge Attitudes Behaviour
M&E Monitoring and Evaluation
MCH Mother and Child Health
MMA Myanmar Medical Association
MoE Ministry of Education
MoEYS Ministry of Education Youth and Sports
MP Mekong Project
MPB Mekong Partnership and Beyond Project
MSM Men who have sex with men
NAP National AIDS Program
NCCA National Coordination Committee for AIDS
NGO Non Governmental Organisation
PLWHA People Living With HIV/AIDS
PMTCT Prevention of Mother to Child Transmission
PSI Population Service International
PTA Parent Teacher Association
RHAC Family Planning Association of Cambodia
SCUK Save the Children United Kingdom
SHAPE School based healthy living and HIV/AIDS prevention education
SRHR Sexual and Reproductive Health and Rights
STI Sexually Transmitted Infection
ToT Training of Trainers
TRIMAX Name of Textile Company in Laos
UNAIDS Joint United Nations Program on HIV/AIDS
UNICEF United Nations Childrens fund
UNICEF/EAPRO UNICEF East Asia Programme Office
UNJPO United Nation Joint Program of Action
USAID United States Authority for overseas development aids
VCCT Voluntary and Confidential Counselling and Testing
VCT Voluntary Counselling and TestingYSRHR Youth Sexual and Reproductive Health

Executive summary

In 2001 Sida entered into an agreement with UNICEF to support the Mekong Partnership Program and Beyond (MPB). This is a regional program in support of HIV/AIDS work for youth, children and their families in Southeast Asia. The agreement focuses on the following countries in the Mekong sub-region: Burma/Myanmar, Cambodia, China (Yunnan province), Laos and Vietnam. All the countries have had an earlier or initiating phase of the Mekong Partnership program, the phase 1. The purpose of the present phase is on strengthening components and up-scaling.

The consultant visited all 5 countries during the 2nd and 29th of June. The consultants met with around 200 persons in over 45 field visits and a large number of meetings with UNICEF program officers and national policymakers. (appendix V) The consultants have read over 100 documents (Appendix VI).

The rationale for Sida's agreement is the Swedish adopted policy for its international response to HIV/AIDS. The policy is very much in line with the objectives for the MPB. Sida also emphasises Children in Extremely Difficult Circumstances and Child Rights. The purpose of the mission is to monitor the MPB in the 5 countries relevant for Sida support. The emphasis on the mission is giving Sida an opportunity to learn more on the following areas: the regional approach, the different areas of activity covered by the agreement, best practices for youth sexual and reproductive health and rights, gender and CEDC. The report should also give Sida an input for the annual review meeting.

HIV/AIDS is spreading rapidly through the Mekong sub-region. Youth are increasingly becoming infected. Children are also increasingly infected through mother-to child transmission. In Cambodia, Myanmar and Thailand more than 2% of the women between 15 and 24 are infected. Beside commercial sex, intravenous drug use and trafficking/large mobile young workforces play an important role in fuelling the epidemic. Poverty, lack of education and gender-inequalities are root-causes. Most risk groups are young

The Mekong Partnership and Beyond program (MPB) – an outline

The MPB is a regional project/programme whereby UNICEF operates on a number similar HIV/AIDS related interventions in the countries. The regional office, EAPRO, serves as *change agent.* EAPRO initiates programs together with country offices, gives technical support, facilitates exchange for the spread of best practices and takes part in regional meetings for co-ordination and advocacy purposes. The aim of the regional approach is to speed up and improve the quality of UNICEFs response as well as its partners. The MPB consists of 5 components:

1. Prevention for youth
2. Care and support
3. Prevention of mother to child transmission (PMTCT)
4. Capacity building
5. High level advocacy

The Regional Approach

The consultants have the overall impression that the MPB is a project with a lot of commitment and energy. The program has managed to mobilise country offices and partners. This has undoubtedly speeded the response to HIV/AIDS in the region. The structure of UNICEF is suitable for serving as a "change-agents structure" at different levels in the region when it comes to youth and children. The MPB tries to use existing UNICEF programs and partnerships and develop them towards HIV/AIDS preventive or mitigating programs. The report points to the possibility that the phase of sustainability and scaling up might affect the role of the EAPRO as well as country programme officers for HIV/AIDS. This has to be further analysed and reflected in the program. Furthermore there is a need to highlight the main objectives and tasks at different levels.

The areas of activity covered by the agreement and best practices

Components numbers 1–3 above constitute the main elements of the activities: Prevention for youth, care and support and PMTCT. Capacity building is integrated into them. High level advocacy is also partly integrated. The consultants maintain that this component could be strengthened and developed into an activity in itself, focussing on policymakers changing attitudes towards young people as well as best practices in the care of orphans.

Prevention for youth

There are three main activities: a) Life skills curricula in the school b) peer-education for out of school youth c) media activities.

The MPB is putting a great emphasis on installing general health promoting life-skills curricula with HIV/AIDS included as regular parts of the education from grade 1–9. The consultants find this to be a relevant and successful strategy. The HIV/AIDS component might need some strengthening and teachers some more training. There needs to be special development on how to reach the youth in countries with large populations.

The peer-education programs are very good in some countries but needs strengthening in others. Research on the lives of youth might improve them and customise them to different groups. They need to be reinforced by better condom promotion. The consultants would suggest a review of possible condom

promoting strategies within the present areas of activity. There is also a need for method development to take the necessary leap from awareness to behaviour change. The gender strategies need some development concerning male approaches. There is also a need for method development and exchange on media strategies. Finally further development of the drug component is of utmost importance.

Care and support

The MPB has developed 4 strategies: a) partnership with the Buddhist community and some other religious communities b) working through UNICEF area focused activities- the community based approach c)partnership with NGOs d) supporting self help groups.

In most countries this part of the MPB is still at an early stage. There is a considerable need to develop counselling skills to move the programs forward. However it is obvious that the partnership with the Buddhist community has a large potential for ownership, for scaling up and for sustainability. The community based approach has proven viable in other parts of the world. A crucial issue is how to get local government support in the long run. Within this strategy there is a need to explore how to move from awareness to action through the "Hope-and Help –package" Furthermore there is a need for exchange on small scale and replicable NGO initiatives for support of widows and orphans in some countries.

PMTCT

These programs have just started. The one demonstrated to the consultants seemed very well organised. The consultants hold the view that UNICEF is in a good position to develop this component and that it can have a general impact on the understanding of how to operate programs for Voluntary Counselling and Testing.

Children in extremely difficult circumstances and children in need of special protection

The MPB is not a specific CEDC or CNSP program. If Sida wants to support comprehensive programs for CNSP other mechanisms have to be found. However street children are especially vulnerable to HIV/AIDS. The numbers of orphans are increasing. UNICEF runs special programs for CNSP. The consultants find a need for better integration of YSRHR and HIV/AIDS prevention and a strengthening on counselling skills. The MBP certainly is in a good position for advocacy on community based responses to the increasing number of orphans as well as supporting research for more knowledge into their present situation.

1 Background

1.1 The Swedish HIV/AIDS Policy

In 1999 Sweden adopted a policy for its international response to HIV/AIDS, " Investing for Future generations".[1] The strategic framework contains the following components:

Fig. 1 Strategic Framework for Sweden's International Response

Addressing immediate causes:
Strategic goal: To enable people to protect themselves against HIV infection (prevention)

- Greater acceptance of safer sexual behaviour, especially among young people, with an emphasis on gender equality
- Provisions of condoms and other forms of protection against HIV
- Enhanced access to treatment for STIs
- Enhanced access to voluntary counselling and testing
- Development and availability of safe, effective and affordable vaccines against HIV

Addressing immediate effects:
Strategic goal: To allow people infected and affected by HIV/AIDS to pursue their lives with quality and dignity (care and support)Specific objectives:

- The provision of social support to poverty effected households
- The provision of social ad educational support to affected children
- Improved availability and quality of health care services and home. Based care for PLWHA

Addressing underlying causes:
Strategic goal: To encourage greater political commitment to HIV prevention programmes (Political Commitment)

Specific objectives:

- greater recognition by policy and decision makers of HIV and AIDS as major development and political issues
- greater respect for human rights to protect PLWHA
- good surveillance and information systems, and well co-ordinated policies on HIV/AIDS

[1] Investing for Future Generations, Sweden's International Response to HIV/AIDS, Sida and Swedish Ministry for Foreign Affairs, March 1999.

[2] Agreement Between the Government of Sweden and UNICEF on Support to the Mekong Sub region HIV/AIDS Program phase II, The Mekong Partnership and Beyond, HIV/AIDS/STD Prevention and Care in Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam, 2001–2003.Sida ref 2000-04618

Addressing long-term effects:
Strategic goal: To develop coping strategies to alleviate long-term effects (Coping Strategies)Specific objectives:

- development of sectoral capacities to respond to HIV/AIDS
- Application of a national multi-sectoral approach to mitigate the impact on society

In 2001 Sida entered into an agreement with UNICEF to support the Mekong Program phase II, also called *The Mekong Partnership & Beyond (MPB)*. This is a regional programme for HIV/AIDS prevention, care and support that emphasises many of the main elements of The Sida framework with youth, children and families as main target groups. Sida's support is for the following countries; Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam and for the period of 2001–2003. The support is 30 million SEK. The Swedish policy emphasises children and youth as well as the SRHR (Sexual and Reproductive Health) component of HIV/AIDS. Although the contribution from the Sida is for the entire MPB in the listed countries Sida strategic framework is reflected in the agreement by a special emphasis on youth, children and SRHR [2]. Therefore the follow up is focussed on these issues. Furthermore Children in Especially Difficult Circumstances (CEDC) is an area to which Sweden give high priority are these children are seen as especially vulnerable to HIV/AIDS.

1.2 Terms of Reference and the Purpose of the Mission

Since the discovery of HIV/AIDS almost 20 years ago Sida realised the close connection to development. Thus Sida has contributed actively both to the creation of the earlier Global Programme on AIDS and the current UNAIDS as well as other active multilateral, regional and bilateral support for HIV/AIDS work and related issues, especially SRHR, gender and HR. The current development of HIV/AIDS in South and SE Asia is of great concern to Sida and there is an increased awareness of the need to give HIV/AIDS a higher priority in the region. Entering an agreement with the MPB will permit Sida to support a multitude of interventions that are in line with the framework for Sweden's international response to HIV/AIDS and at the same time learn more about the specific regional possibilities and constraints for successful intervention. The emphasis on the follow up mission is on learning. (the terms of reference can be found in *Appendix II*)

The purpose of the mission is:
To give Sida an opportunity to learn more. Three areas for learning are specifically mentioned in the terms of reference:

- The regional approach
- The different areas of activities covered by the agreement

– Best practices for adolescent sexual and reproductive health and rights and for children in especially difficult circumstances

To give input to Sida for the Annual Review meeting between UNICEF/ EAPRO and Sida through:

– reviewing the ongoing activities in relation to the stated objectives
– giving recommendations on the plan of activities and the scope of strengthening the service
– giving recommendations on the scope and rate of expansion of the project, taking account of quality control.

Special issues of concern are the gender perspective and the potential for scaling up and sustain the ongoing interventions. The team focused the following issues:

– quality and capacity of ongoing interventions from an evidence based perspective
– shortcomings or gaps to be filled in the future
– the systems and the systematic approaches for the purpose of scaling up
– long term sustenance of activities
– the co-ordination, co-operation and partnerships

This report takes at its departure the Sida focus on youth and children and will not describe the entire UNICEF Mekong Partnership and Beyond. The youth and child period of life is the object of the report rather than specific occupational or other situations that have been the focus of some MP/MPB interventions. Neither has the monitoring team looked into operations in countries not partaking of the Sida funding. Although Thailand originally was included in the Sida funding it seems UNICEF currently isn´t funding any intervention for youth and children in Thailand. As a result of this the monitoring team has not included Thailand in the mission.

2.HIV/AIDS in the Mekong Region

Although established in Asia since the 1980s the spread of HIV/AIDS seemed relatively slow during the 1980s and 1990s, compared with other regions such as Africa and the Caribbean also in populations with high-risk behaviour. Even in the late 1990s reports maintained only Thailand, Cambodia and Myanmar and some pockets in China and India had established epidemics[3]. In the last two years this picture has changed dramatically.[4] While sentinel surveillance seems weak in some countries, a number of directed behavioural surveillance studies[5] combined with existing surveillance data will explain some risk factors as well as of the current trends through which we can see a spread from high risk- groups into what is sometimes called " the general population". Analysing the data a complex pattern emerges whereby it is clear that there are no real boarders between these groups. The pattern of risk factors might be somewhat different from Sub Saharan Africa but nevertheless fuelling the spread of the epidemic and the epidemic could spread with the same speed. Main risk factors are:

- Trading sex for money (a large and growing commercial sex "sector")
- Intravenous drug use – a growing problem among youth
- Large voluntary or trafficked mobile workforces
- Discrimination of MSM (men who have sex with men) leading to lack of information, knowledge and denial
- Mother to child transmission

In *Appendix 1* is a more thorough account for HIV/AIDS, risk factors and effects in the Mekong region.

5 important aspects can be highlighted:

- There are more risk factors in Asia than in Africa
- There are more people in Asia than in Africa
- Young people are the most vulnerable – most risk groups are young
- Risk populations /risk behaviours are interlinked and overlapping. This speeds the spread. HIV is moving from so called risk populations into the general population.
- There is little exact knowledge on prevalence in many of the countries in the Mekong region.

[3] MAP – Monitoring the Aids Pandemic. Status and Trends in Asia and the Pacific. 1999.

[4] MAP- The Status and Trends of HIV/AIDS/STI epidemics in Asia and The Pacific. Oct 4 2001. Melbourne. Australia,

[5] What Drives HIV in Asia. FHI. HIV/AIDS Prevention and Care Department. 2001

Table 1. HIV in East Asia (Sub- Mekong Region) 2000[67]

	Prevalence 15–49	Number	Proportion fem. 15–49	Proportion fem.15–24	Proportion male15–24	Est. number HIV+ children
Cambodia	4.04%	210.000	34%	3.5%	2.4%	5.400
China	0.1%	600.000	12%	0.02%	0.01%	4.500
Laos	0.05%	1.300	50%	?	?	Under 100
Myanmar	1.99%	510.000	35%	2.30%	1.20%	14.000
Thailand	2.14%	740.000	41%	2.30%	1.20%	13.900
Vietnam	0.24%	99.000	20%	0.10%	0.3%	2.500

The table above gives the official view of the HIV epidemic in the Sub-Mekong Region. Please note that the sentinel surveillance is deficient in many of the countries and that UNAIDS warns that the numbers could be much higher. The Consultants would also like to underscore that the number of children affected is more than 10 times higher than the number of children infected.

[6] Every Last Child. UNICEF EAPRO (Source: UNAIDS 2001)

[7] The figures for China are adjusted to newer numbers from UNICEF

3. The Mekong Partnership and Beyond – a regional UNICEF program for HIV/AIDS prevention and mitigation in SE Asia and the Pacific.

3.1 Background

The Mekong Project (called MP in this report) was developed during 1994–95 by EAPRO (UNICEF's program office for Eat Asia). Already at that time the threat of a fast growing epidemic became more evident At that time only a few governments in the region had aimed at or had capacity for comprehensive programs.

The similar problems faced by the countries in the Mekong region, the movement of people through the region, and the economic and social interaction between countries suggested that an inter-country approach could be of use and add value to the country programs. It is not usual for UNICEF to operate such regional programs. An exception was made because of the dignity of the problem and because UNICEF with its country offices, its focus on youth and children and its more operational status could serve as a network for change in the region addressing different levels of society. At the time UNAIDS was being restructured and there was a need to fill the gap for co-ordination and formation of partnership. The Dutch government funded the first MP. An external review of the MP was made in 1999. The review concludes that the MP has given a major contribution to HIV/AIDS work on different levels and managed to mobilise and coordinate a number of actors and levels. Their conclusion was that the sub- regional approach had been valuable and should continue. A number of recommendations were made for the continuing work [8](see appendix IV).

3.2 The Mekong Partnership and Beyond – the program

On the basis of the review a new program was developed and a new phase, phase II, was entered. This new phase had as its main vision, on the one hand to include more countries in the region into the program and, on the other hand to improve and scale up operations in the countries that had undergone phase 1 and were already included in the program.[9] The new program was called the Mekong Partnership & Beyond (MPB in this report).

For the Mekong sub-region the following overall objective is stated in the MPB proposal to Sida in 2001:

[8] External review, Mekong Sub regional STD/HIV/AIDS project. March 1999. Regional Report UNICEF

[9] The Mekong partnership and Beyond. HIV/AIDS/STD prevention and care in Cambodia, China, Indonesia, Lao PDR, Mongolia, Myanmar, Pacific Island Countries, Papua New Guinea, The Philippines, Thailand & Vietnam 2001/2003. Project Proposal. UNICEF East Asia and Pacific Regional Office, Bangkok October 2000.

– to reduce the impact of the epidemic on children, young people and families through increasing effectiveness of national and inter-country response to the HIV/AIDS epidemic in the Mekong sub-region and providing practical support at community level, encouraging full participation of people affected.

In the light of this overall objective the objectives for the work of the team at EAPRO (the East Asian Program Office) are specified (The specific objectives for 2002–2003 can be found in Appnedix IV):

– to assist countries in reaching their own objectives
– to facilitate multi-country and multi-agency initiatives
– to keep country offices and partners informed and facilitate exchange
– to participate and help co-ordinate new regional and country initiatives and to reduce overlapping of trafficking initiatives with HIV/AIDS initiatives

The work still focuses on the 5 main elements of the first program: Behavior development and change, Reproductive health, Care and support, High-level advocacy and Capacity building. Priority populations are children, youth and young people, women of reproductive age, people considered vulnerable (the poorest, migrants, ethnic minorities, men who have sex with men, drug users etc) but also policy makers and government officials and implementing organizations. Below is an attempt by the consultants to describe the complex MPB-project based on the presentation at EAPRO and the list of documents in Appendix VI from the perspective of the Sida terms of reference..

The MPB is a project whereby UNICEF Country Offices are running the MPB 5 main components through similar programs in each country. The regional office staff serves as *change agents* for the components and as *technical experts for program development*. They can also be *initiators of new initiatives* or *agents for co-ordination and/or for exchange between countries*. They also serve as *fundraisers and coordinators at a regional level* with UNAIDS and other important players. Thus the country offices together with the regional office actually becomes a regional "change-agent structure (or infrastructure)" combining regional, national and sub-national levels.

The basis of the MPB are to a large extent the already ongoing UNICEF programs and partnerships. They are all focusing on children and their environment. The different components of the MPB are often integrated in or merged with these programs to form new HIV/AIDS adopted efforts. However, in some cases totally new efforts and projects are actually developed. It is important to understand that the MPB –team at the Regional Office mainly is a technical support and a co-ordination body. Each country office is free to take on its own programs and projects. Each country office is also subject to the variations in culture, political leadership, infrastructure, possible partners and resources in the country. In some countries there were already ongoing projects on AIDS-education for youth when the MP and MPB started. The implementation of the 5 components will vary according to all these factors. Another important determinant for the work is how the office sees its role in HIV/AIDS work and which type of interventions and programs that already have a strong standing in the particular country office. If for example co-operation with the school system is

good it will be easier to develop the co-operation and implementation on Life-skills education.

The HIV/AIDS – team at EAPRO described the ongoing and future regional to the consultants. In this description lies the ambition for the similar country programs as well as the tasks for the regional officer. Three components seem to be the most important for program and project development as well as technical support: *Prevention for youth, Care and support, Prevention of mother to child transmission (PMTCT).* The component *Capacity building* is included in all the three themes. The staff at EAPRO undertakes a lot of training for country office staff and their partners. Likewise country offices organize training even themselves. The three main components are described below.

When it comes to the component *High Level* Advocacy the consultants could not distinguish any specific structured program or a systematic approach to be described. To a certain extent advocacy is also included in the three main components mentioned above. In the UNICEF/EAPRO workplan the development of specific advocacy strategies is mentioned as a target objective for 2002[10] (for the full work-plan see appendix IV) UNICEF also tries to be a part of regional and national strategic and policymaking groups. Through our interviews in the countries we later learned that there had been capacity building activities for UNICEF Representatives as well as other higher management of all country offices. Such activities were undertaken by EAPRO so that HIV/AIDS is put high on the office agenda and that the representatives could fulfill an advocacy role within their diplomatic tasks.

Component 1 Prevention for youth

According to the UNICEF presentation at EAPRO there should be 5 main structured programs or approaches: 1.*Life skills education in school, 2. Life-skills education for out of school, 3.Awareness raising activities in the media, 4.Voluntary testing and counseling and 5.Condom promotion through social marketing.* As far as the consultants could judge, and as can be seen in the account from the field visits, UNICEF activities mainly focus the first 3 on this agenda. The technical support from EAPRO focuses on life-skills and care and support programs/PMTCT.

UNICEF has analyzed its role in relation to VCT for youth[11]. Since UNICEF cooperates with the MCH on child health UNICEF has a position to support VCT as can bee seen in the PMTCT program below. The document concludes a number of items where UNICEF country staff could be active in relationship to VCT. Besides PMTCT making VCT more youth and child friendly is among these tasks. However a critical appraisal of the youth friendly services currently supported by UNICEF and other donors (UNFPA) seems among the most important. At the initial and very short EAPRO meeting this issue was not discussed. Neither did we have time to discuss the issue of children and VCT. Some of the country offices (notably Cambodia) has VCT in general on the agenda. The consultants have not found any similar analysis on condom promotion.

[10] EAPRO HIV/AIDS Information Note Nr 3 April 2002: UNICEF EAPRO Regional HIV/AIDS workplan –2002.

[11] Executive summary on UNICEF´s role in voluntary counselling and testing (VCT) for young people, children pregnant women. Undated document from EAPRO

1. *Life skills education in school*: UNICEF supports implementation of Life Skills (LS) curricula throughout the whole school system LS aims at building a healthy life style though a combination of knowledge, cognitive and emotional development and decision-making skills. It is based on participatory learning techniques. The main objective of Life-skills education is not HIV/AIDS prevention only. But both sexuality education and education on drugs and alcohol is a part of life skills education and therefore HIV/AIDS education can also easily be included.
2. *Life skills education for out of school youth* Not all children go to school and some leave it early. In order to reach out to all youth the LS activity is complemented by outreach projects together with NGOs and popular movements (women's union, youth union). Life skills methodology is applied in these projects /programs and often through a "peer-to peer" approach. These operations are usually more focused on HIV/AIDS. The basis often is the Thai Friend-Tell Friend Initiative.[12] Young college students or young workers are trained to educate their peers on a one-to one basis or in small groups.
3. *Media.* No structured program or project for the media was described at the visit to the EAPRO office. However all country offices do work with the media. In most countries there are close co-operation with the media as well as regular projects for the radio.

EAPRO wants to shift the technical support from focussing on *risk factors* to *vulnerability*. By this UNICEF means: *A person's ability to act on the decisions they make*. A lot of people know about AIDS but do not seem to act upon it. The factors that are reducing the ability to act are focussed and the life skills education is customised to address them. Such factors are: Information, Past experiences, Social pressure, Risk perception and Personal concerns and motivation. It seems this development is yet at an early stage. It still has to be operationalised.

Efforts are also made to build supportive environments. Raising awareness of young peoples needs stakeholders and adult support etc. A prime concern is that young people are seen as troublesome and "deviant". Meanwhile they are in a very difficult position being the target of many dangers.

Component 2. Care and support

The main task is to find models to support families and models to support orphans.

4 main approaches have been developed:

Mobilisation of the Buddhist community. Monks are trained to go out in wards and villages to visit the families infected and affected. They support them with food but also through spiritual guidance. The monks are trained and there are ToT – programs (Training of Trainers). In some countries a special "clerical" vocabulary. is developed. The monks also engage in prevention. Monks also follow the situation of orphans in their catchment area. Some pagodas let children stay in the pagoda.

[12] Friends Tell Friends. A peer-based HIV/AIDS curriculum for blue collar workers and white collar workers. Thai Red Cross for The Working Partners Project. Coordinated by Thailand Business Coalition on AIDS. Sept 1996.

The Area Focused Activities. The AFAs are UNICEF Community Development programs for strengthening village and neighbourhood initiatives in relation to decentralisation efforts in the respective countries. Now these programs are also used for awareness rising on HIV/AIDS and finding models for care and support. Through a peer–education approach local resource persons are trained to use a video, *With Hope and Help*, to strengthen community awareness and capacity to deal with HIV/AIDS and its effects. Each country has produced its own video.

NGOs are mobilised to work with acceptance campaigns also often through the video "With Hope and Help"

Building and supporting self help groups. This is relatively recent in all countries except Thailand. For practical reasons such initiatives only grow when there is a sufficient number of PLWHA in the area or within transport reach. In Thailand where they exist since long, they do a good job and now even distribute anti-retrovirals. The aim of EAPRO is to tap into this experience.

A big problem is that there are few good models for supporting orphans in consistency with best practices. EAPRO has summarised the best practises in fact sheets[13]. In consistency with general knowledge base on orphans it is no surprise that the best practises point towards letting orphans stay in their home environment and support relatives and neighbours to take them in. Most governments however, believe in orphanages and there is some way to go before finding a model that can be up-scaled and used in many countries

PMTCT

The morbidity in AIDS is relatively high through MTCT (Mother To Child transmission) and it can be reduced by the minimum package of treatment and education on breastfeeding. The regional office tries to implement best practices through technical assistance and exchange between countries. They have mobilised funds, and have set up an Internet discussion forum for the operations. PMTCT is seen as a major tool to reach vulnerable women. If they come to test this is seen as an occasion for counselling. There is a general growing concern for VCT in the region. The structured initiatives on PMTCT can be seen as an entry point for quality VCT.

There are some important obstacles for successful implementation to be tackled. PMTCT hold many ethical and politically sensitive issues. In many countries there has to be policy development even before pilot studies. The testing requires technical skills, equipment and logistics that might be a challenge for the health care system, which is in a very poor state in some of the countries. In some countries confidentiality is lacking and sometimes not even understood. VCT should be VCCT – *voluntary and confidential counselling and testing.* In some countries the health care adopts an authoritarian attitude towards the patients which might be an obstacle to counselling.

7 sites have started in China, before starting in Vietnam policy has to be developed, Laos is starting, Myanmar has 7 sites, Cambodia 2 sites and Thailand a national program

[13] Growing up alone. EAPRO, UNICEF. Undated

Some important general concerns and obstacles

The MPB team also highlighted some important general obstacles for successful work: Efforts are made to have a uniform approach by all donors towards a sector so that not so many parallel programs come through a sector. UNICEF tries to co-operate with a multitude of partners to this purpose. Another concern is the lack of decentralised funds in most countries. This impedes necessary local empowerment and decision-making. On the advocacy level it is important change attitudes towards youth who are often depicted as behaving badly and not seen as a resource in the fight against HIV/AIDS. Finally manageable monitoring and evaluation is lacking.

4 Cambodia

4.1 Country presentation

4.1.1 Some facts and figures[14] [15]

Country: 24 provinces, 183 districts, 1609 communes, 13406 villages

Population (millions)	**13 (2001)**
% Population under 15	40
% of population in rural areas	85
Total fertility rate (per women)	4 (2000)
Life expectancy (male/female)	54/59
% reaching grade 5 at prim level boy/girl	48/43 (1997–1998)
% illiterate of total	32 (2000)
% access to safe water	32
% households under the poverty line	38
infant mortality rate IMR	115

4.1.2 HIV prevalence

The first HIV/AIDS case in Cambodia was discovered in 1991. Today according to UNICEF presentation 03-06-02 the Cambodian HIV epidemic is the most serious and fast growing in Asia. Infection rates are much higher in urban than in rural areas. Primary prevention for women and pregnant women, the risk of mother to child transmission are growing concerns. A hopeful sign is that the latest data indicate that the epidemic has reached a plateau. In Cambodia today there are:

- 170 000 infected people
- 100 new infections per day
- 8000 deaths in 2000 = 20 people per day
- 3,500 HIV+ babies born each year

Among the general population HIV/prevalence levels are about 50% higher in men than in women. The infection rate among pregnant women tested in antenatal care clinics was 2,3% in 2000[16].

[14] A situation and Response Analysis of the HIV/AIDS epidemic in Cambodia, National AIDS Authority 2001

[15] Country Profile, UNICEF, April 2002

[16] A situation and response Analysis of the HIV/AIDS epidemic in Cambodia, National Aids Authority 2001

4.1.3 Vulnerability and risk factors

Heterosexual sexual intercourse is the major mode of HIV transmission in Cambodia. Increasingly, men are bringing HIV-infection from sex workers to their wives and girlfriends who then pass the virus to their babies[17]. It is believed that 10 000–20 000 men buy sex each day in Cambodia. Vulnerability, especially for women is also related to socio cultural economic and political factors. These factors include discrimination and marginalisation of certain groups such as sex workers, persons living with HIV/AIDS, illiteracy and ignorance about STI/HIV/AIDS.

Beside the increasing commercial sex it is believed that there is an increase in extra-and premarital sexual contact in Cambodia today. This is considered to be related to weakening family bonds as a result of the civil war and the fact the shift to a free market economy made large number of young migrant workers move inside the country and across the borders to seek jobs. Young seafarers and fishermen have proven to be a risk group as well as garment factory workers and girls working in bars. There are some risks of renewed armed conflict and some border areas have not come yet under complete control of national or local authorities. Such instability is always connected to increased risk of spread through lack on information, poverty and the mobility of armed forces. It can also contribute to problems with unchecked migration and the trafficking of women, children and drugs[18] As a result from the epidemic the number of young orphans is increasing. Young orphans are at risk of becoming street children; trafficked for sexual purposes, end up in child prostitution under considerable risk of being HIV-infected. There is a "missing generation of grand parents" due to the earlier traumas of the country. This will increase the problems of orphans. General problems of infrastructure in the country can contribute to the problems of curbing the epidemic.

4.1.4 Protective factors

The most important protective and HIV-preventive factor is that the HIV epidemic now seems to be described, analysed, acknowledged and well recognised on official political levels nationally and locally where media, the educational system and work life are becoming more and more included. NGO's and INGO's and organisations like UNICEF are encouraged to take measures and initiate programs and campaigns. Awareness raising efforts seem to be well-aimed and designed and step-by-step challenge and weaken the defence and the denial around these sensitive issues. The impact of the commitment of the religious society in this work through the Buddhist monks should not be underestimated as a protective factor since Buddhist values and traditions still is imprints large parts of Cambodian society. An impressive, important, protective and highly preventive effect of straightforward and targeted efforts towards high risk groups is that the use of condoms is shown to be much more frequent during last years. The infection rate has flattened. Positive and shared experiences from preventive work might also be regarded as a considerable preventive factor strengthening the "self efficacy" of the population as well as its leaders.

[17] A situation and Response Analysis of the HIV/AIDS epidemic in Cambodia, National AIDS Authority 2001

[18] The Mekong Partnership & beyond, project proposal UNICEF EAPRO, Bangkok October 2000

4.2 UNICEF approach

4.2.1 Strategic approach

UNICEF in Cambodia has some strong programs into which HIV/AIDS work is integrated. UNICEF is advocating a multi sectoral approach through direct cooperation with provincial administration and local institutions[19]. Through the CASD (Community Action for Social Development program) UNICEF aims at strengthening the "building from below" – approach which implies community ownership, local sustainability and utilization of existing resources. This requires the formation of, and a close cooperation with, VDC: s (Village Development Committees). Members of VDC: s ideally are meant to be involved in and responsible for most of the decisions on village level, including school and local health issues. With the purpose of integrating HIV/AIDS committee members participate in HIV/AIDS training workshops. The work with the VDCs are done by multi sectoral teams The involvement of the Buddhist monks in the HIV-prevention work, care and support of already infected is also included in the CASD program. At the Seth Koma level (district/municipality level).

Parallel to this community strategy UNICEF also supports national actors for policy development. The MoE and the Ministry for Religious Affairs are close co-operation partners. for development of guidelines, ToT -training on resource materials. UNICEF also co-operates and supports pilot interventions from NGOs and media initiatives. UNICEF also has close cooperation with the health care through which they will start PMTCT. Unfortunately the consultants did not have time to look into these operations.

4.2.2 The objectives for UNICEF support

In the project proposal

- Promote positive preventive behaviours and contribute to developing the life skills of youth and people with high-risk behaviour.
- Contribute to building national capacity to respond to the needs of people affected by HIV/AIDS
- Contribute to reduction of HIV transmission among women of reproductive age, pregnant women, and mother to child transmission
- Develop community care and peer support groups for families and children affected by HIV/AIDS

In the memorandum for the Sida-team

- Widespread awareness of HIV/AIDS and general knowledge of its modes of transmission; adoption of protection factors by 60% of all the sexually active population and 80% of adolescents and high risk groups.
- Availability of voluntary and confidential counselling and testing services in all national hospitals and 70% of provincial hospitals.
- Prevention of mother to child transmission of HIV through progressive development of PMTCT protocols in all national hospitals with maternity wards and 50% of provincial hospitals.

[19] Mekong progress report UNICEF EAPRO, October 2000

In the UNICEF presentation for the Sida-team

- Increase awareness on HIV/AIDS and adoption of protective behaviours§ Increase availability of voluntary and confidential counselling and testing services on HIV/AIDS
- Reduce mother to child transmission of HIV/AIDS
- Improve access to recovery, care and support for children and families affected by HIV/AIDS

4.3 Field visits and meetings

4.3.1 Working group of the Inter departmental Committee on HIV/AIDS, Ministry of Education, Youth and Sports (MoEYS)

The Ministry of Education Youth and Sports has an inter-departmental committee for the HIV/AIDS work. All heads of departments are planning and coordination efforts. Every department has its responsibility. Some are still in the pilot stage while others have tested projects for a few years and are now scaling up.

Examples of activities

- Development of different tools for prevention work such as manuals for teachers and workbooks for students have been tested in grade 10. With life skill approach, knowledge can be introduced at earlier stages in primary school.
- Information on condom use (only in secondary school)
- Facilitate for infected children to go to school.
- Fight the discrimination of infected children.
- Sport events are used for awareness raising. 120 sport instructors have been trained. Posters with famous sportsmen have been used in campaigns with positive messages like: "you can protect yourself – use condom" (boxer), "Anyone with AIDS can swim with me" (swimmer)
- Parent-teacher associations are addressed for information
- A newsletter on HIV/AIDS is distributed among responsible and active "key people" on district level to keep them informed and active.

4.3.2 RHAC – The Family Planning association of Cambodia

The organisation has 6 clinics in the country, 130 employees of which 23 are medical doctors. RHAC is targeting the general population including youth. In all clinics they combine FP-activities with STI-activities. They have tried to make their services youth friendly through information rooms where youth can come and seek information. The librarian will connect young people with a counsellor and clinics when they need it. For the moment RHAC discusses how to make their services more "male friendly". Today 85% of their clients are female. RHAC has started co-operation with UNICEF to pilot VCT. Since they are well known trainers they want to develop skills to train other providers. RHAC is running outreach activities. RHAC is funded by many sources among others USAID.

4.3.3 The Women Media Centre of Cambodia

The media centre started as an NGO in 1995 with a focus to promote gender equality and social change in Cambodia. After initial disbelief from the media and the decision-making community the centre now seems to be well recognised. They have their own radio channel, broadcasting 15 hours a day. They also produce TV-programs, which are given to different TV channels. The Centre is used by donors and ministries for IEC or for media input on different issues, like domestic violence, HIV/AIDS, law enforcement, social change, elections.

60% of Cambodia's population has access to the radio station. 32–82% said in a survey that they had changed behaviour in some way because of what they heard or saw in radio/TV. Most of all the listeners had realised that women can do valuable work in society.

4.3.4 Seth Koma – Community Action for Child Rights, Kampong Speu province and visit ti to Chamkar Sleng village.

In the framework of the new programme, cooperation between the Royal Government of Cambodia and UNICEF for the period of 2001–2005, Kampong Speu has been identified as one of the six priority provinces where UNICEF supported programmes will converge. UNICEF has been working in Kampong Speu since the beginning of the 1990s, starting with the women in Development, Water and Sanitation and Family Food Programmes, continued later by the Community Action for Social Development (CASD) Programme. Currently UNICEF supported Seth Koma, Health and Nutrition, Expanded Basic Education, HIV/AIDS Prevention and Care and Children in Need of Special Protection (CNSP) Programmes are present in Kampong Speu. Villagers have selected their leaders to communicate with the local authorities. Selected persons have now been rained to become peer educators for the village. They have been trained by local trainers who in their turn have been trained by UNICEF.

Visit to Chamkar Sleng village

Chamkar Sleng village has 65 families. It has a population of 206 women aged 15–45. There are 49 children under 5. The main income source is from rice. Since 1997 Community Action for Social Development Program (CASDP) has initiated activities in this village. In the beginning of the program CASD working groups visited villagers to introduce the program objectives. An election was held by villagers to vote for the Village Development Committee (VDC) through a democratic process. In the beginning of the program operation many children were skinny from malnourishment. Mothers and families did not know how to feed and take care of their children properly. Today because of education on nutrition conducted by a working group and village Health Volunteers the percentage of skinny children has decreased from 65 to 55%. People also understand the importance of health and hygiene practices. Boiling water for drinking is now the common practice of the local people.

When the team were invited to talk to a group of men and women who just saw the video *Giving a hand* and were discussing the film between them. One women said that she felt sad after seeing the film, thinking of the suffering among people infected by HIV/AIDS. The villagers agreed on the importance of teaching people to use condoms. "People" referred to men who sometimes use to "leave the village". In this village no men use to "leave the village" so in this village there were no need for condoms. Men

in this village were said to make their first sexual experiences when they marry, which they do when they are about 20 years old. It is the parents of the young people who arrange and approve of the partner and the wedding. It is the mother or the mother in law who is giving the son or son in law "the condom message": to stay faithful and if not use the condom. Only one man said he knew someone who died from AIDS.

All children in the village go to school and the team was invited to visit a school and ask some question to the children about their lives. The pupils were between 9 to 11 years of age. They all used to watch television. No one had access to a computer or internet. They all knew, according to the teachers how children are made and some knew what a condom was. The children said that they learn about sex from experiences at home and what they learn at school. All children in this area are sleeping in the same bedroom as the parents. The team also visited a group of teachers who had just been trained on participatory techniques. These teachers were positive to the thought of a more active HIV/AIDS education through such techniques but maintained that this had not been in their training. One of the teachers came up with the idea that teachers could hold condom demonstrations in the school!

4.3.5 Visit to the Salvation Centre in Cambodia (SCC)

UNICEF is working with SCC in awareness raising of the monks and their involvement in prevention and care, counselling and training related to HIV/AIDS at community level.

The team was informed that there are two projects, one in Phnom Phen and one in Battam Bang where the monks collect clothes and rice for poor children and orphans and also provide them with counselling and information. The question was brought up about how the monks do when the condom promoting issues occur and it was said that this part of the information is handled by their associate fieldworkers, as the monks cannot talk about these issues. The team was taken to see how a monk was providing counselling to a homeless family in the slum district, a family who actually was living in the street. While praying with the family he was sprinkling water on them as some sort of symbolic act of giving or blessing. He was doing this with the family three or four times a week.

4.3.6 Inthanou Association

Inthanou Association was established in order to disseminate information on HIV/AIDS/STD and other health issues to people through telephone hotline service. Inthanou provides free and anonymous counselling through two free phone-lines provided by Mobitel Phone Company

This hotline receives about 200 phone calls every day. 6 persons in two teams are answering the calls, all of them doctors. The phone calls are limited to ten minutes except for those who call after having received the information that they are infected. They are allowed to talk much longer. 40% of the callers are between 15 and 24. 25% are female and 75% are male callers. The reason for this has to do with the access to a mobile phone that more men has and that women are not so outspoken about problems. They cannot speak so openly. Most phone calls were from "risk group people" The message from the staff to the callers is to use the condom in all occasions. The hotline is 100% sponsored by UNICEF

4.3.7 Nyemo projects in Phnom Phen and Battambang

Nyemo is an NGO that started 5 years ago. Women with children who have social problems can come to change their lives. Nyemo has a house with 20 sleep-over places, a kindergarten, training rooms and workshops for vocational training. They run a restaurant and a shop and have 17% of their costs covered by this income generation. In Battambang Nyemo was operating in a village which where a lot of women had become widows of HIV/AIDS (Husbands in the army). Similar activities were run.

Nyemo has developed a network and outreach whereby women are referred to them. They receive around 200 women a year of which 50% are HIV+. When the women come their problems are assessed and they get counselling. They can also get medical help and VCT. They then enter into vocational training or any of all the training sessions that are offered. Literacy classes exist as well as training on legal matters, family planning, HIV/AIDS information.

4.3.8 The Peer-educators of The Cambodian Red Cross

UNICEF and UNESCO in partnership have been supporting the Cambodian Red Cross for the training of peer educator at the university level. The peer educators are trained with the purpose of talking on a one to one basis with 10 friends (Friends tell Friends) rather than organising educational events or a consecutive series of meetings covering different aspects.246 peer educators are operative in several universities in Phnom Penh. They were happy about their task and had gradually learned to appreciate it although it felt embarrassing at first. Their friends are interested but the peer educators sometimes feel need more knowledge support. The team got the impression that they did not feel they had the mandate or perhaps the initiative to go beyond the original boundaries of the program and that they had a slightly normative approach in addressing the behaviour of their friends. The peer educators do not do any social marketing of condoms.

4.3.9 Meatho Phum Komah in Battambang, Wat Norea Peaceful Childrens Home

The consultants visited two homes for orphans and street-children in Battambang. The first place was mainly used for children who had been trafficked over the boarder. They co-operated with the local boarder police and many ministries. They currently had 53 children, boys and girls who lived in two large dormitories under simple but clean conditions. Counselling possibilities were there but very rudimentary. The children get shelter, food and education and some health care. The home works with getting the children back into the community. The problem is that they are often re-trafficked over the boarder. They try to work with micro-credits to counter act this. These efforts have yet to be evaluated. The shelter works very systematically with quality control. The shelter increasingly comes into contact with HIV/AIDS infected and affected children an youth. They also think drugs is an increasing problem in the area.

Wat Norea works mainly with orphans in their orphanage. They have taken in orphans since long but has now increased their work through attachment to an Ngo formed by one of their former orphans. Many of the children are affected by HIV/AIDS since the area in general is a high prevalence area, being a boarder community with a lot of vulnerable groups.

4.4 Conclusions

The HIV/AIDS situation in the country seems to be well analysed, described and acknowledged. The impression of the consultancy team is that UNICEF Cambodia puts a slightly greater emphasis on component nr 2 (care and support). The consultancy team had no opportunity to investigate weather this was a result of a specific gap to fill and in relation to other actors. The work of the country office builds partly on already existing country wide systems (school, Buddhist community) which give a potential for sustainability and scaling up.

The consultancy team found the impact of the sex-industry in the country well considered by officials, NGO: s and policymakers and the current interventions extremely successful. Sexual transmission is more emphasised than the transmission through drug use and needle sharing. One issue to consider for the future is if the impact of drug use is underestimated and/or not enough considered or analysed or if this problem is still small in the country in which case preventive efforts should aim to sustain the situation.

Component 1 Prevention for youth

- The CASD programme lacks a more direct youth component. Even the vulnerable group of out of school youth in the countryside has to be reached effectively. At village level it seems that transmission of HIV/AIDS still is perceived as something that "others" should be concerned with. Facts about sexual habits, premarital sex, age of first intercourse, marriage age, visit CSW, seem to be rather denied and/or idealised rather than realistically acknowledged. There might be a need for some survey as far as sexual habits of both youth and grown ups to develop adequate programs for prevention outside the main cities. This could also be useful for development of gender based approaches. There is an obvious need for interventions addressing men. Program development on how prevention knowledge might be transmitted in a village context is needed.
- The methodology used for information and condom promotion during our visit to the village might be developed in a more participatory way. Information strategies and proper pedagogical approaches in HIV education might be addressed through additional training of trainers that especially focuses on participatory techniques and group work. Considering the success of straightforward campaigns for sex workers and clients in Cambodia, the Consultants is of the opinions that even in the village messages could be sharpened in a more open straightforward and outspoken way
- The Consultancy team was impressed by the commitment for HIV/AIDS work among the staff at MoE. Their materials were straightforward, non-judgemental offering positive options for youth and the staff voiced some outspoken gender concerns. *Considerable efforts are needed to implement the policies and curricula currently developed.* The teachers we met at village level had currently undergone training for participatory methodology through the Seth Koma but not specifically on HIV/AIDS. *It seems to us that UNICEF could be in a position to speed up the process from policy level to the implementation level if their different approaches could be combined in a resourceful way.*

– As far as peer education at Phom Phen universities is concerned, the youth representative of the consultancy team found the peer-educators were in need of more or perhaps different training support and supervision. They need to be more independent and self assertive about methods, how their messages could be conveyed to their peers. There seems to be need for more gender-based efforts. We also wonder how out of school youth are reached by education. If this need is filled by other organisations/NGOs.
– The media initiatives seem to have vitality and would probably benefit from exchange with similar initiatives in other countries. A strategy for this could also be a part of advocacy on the attitudes towards youth. The hot line efforts are good but seem to need more knowledge support. This could be arranges easily through e-mail.

Component 2 Care and Support

– One part of the UNICEF supported strategy for care and support is the mobilisation of the Buddhist Community whereby the monks support families and orphans in their "catchment area". This program is now supported from the national level. The outreach-work demonstrated to us (visiting families, supporting orphans in a neighbourhood, co-operation with NGOs) was largely dependent on local resources. *Probably this approach is possible to scale up and sustain in the long run* with a realistic amount of resources from government and or/country partners.
– Cambodia is a country with a high enough HIV/AIDS prevalence to make care and support for families and children a very central issue. It seems that the CASD programme is another avenue for this beside the work of the monks. It has a potential as an area focused intervention in combination with the Hope and help video –programme. We saw commitment among villagers and village leaders. This could be developed to a strong tool for support and home-based care and possibly also for orphan support. *However there needs to be a parallel development of proper decentralised funds and interventions from the Seth Koma to sustain the CASD in the long run.* The consultants know the decentralisation efforts also to be a part of the bilateral support from Sweden and would like to advocate for a concerted effort between UNICEF and Sweden on this point.
– Some of the NGO collaborations for support of families have a good component for female empowerment. It would be interesting to discuss whether these initiatives are possible to scale up

Component 3 PMTCT

– The PMTCT was only presented theoretically to the team as in a very early stage. However as UNICEF has a good network within the health care the, plan to introduce it within the major hospitals seems realistic but with many challenges due to the state of the health care in general.

Children in Extreme Difficult Cirkumstances (CEDC)

– The situation for CEDC, trafficked children, sexually abused children, orphans, HIV-infected and affected children has to be considered to a larger extent, child right issues such as: efforts of protection, counselling, reintegration for these children are not sufficient for many reasons. There is today an estimate of 30 000 children orphaned by HIV/AIDS and 10 000+ street children in Phnom Penh vulnerable of all kinds of sexual exploitation, drugs and HIV. Protective measures to HIV/AIDS have to develop.

5 Burma/Myanmar

5.1 Country presentation

5.1.2 Some facts and figures[20][21]

Country: 14 Divisions/States, 63 districts, 324 townships, 13 762 villages tracts of 5 villages (urban: wards)

8 large population groups but really 135 ethnic minorities many with own language.

Population (millions):	50,1 (2000)
Population under	22 million 2002)[22]
% of population in rural areas:	72
Total fertility rate (per women):	3.1 (2000)
Life expectancy (male/female):	60/62 (1999)
% Reaching grade 5 at prim level:	75 (2000)
% Female illiterate:	15 (2000)
% Access to safe water	72 (2000)
% Households under the poverty line:	around: 25%
Infant mortality rate:	59,8

5.1.3 HIV prevalence

UNAIDS has identified Burma/Myanmar as a priority one country along with Thailand and Cambodia.[23] According to the oral presentation at UNICEF headquarters in Yangon 2002-06-10 the situation is developing at a rapid pace. At last the government has declared it a national priority. Average prevalence of HIV is 2.2%. 13% of pregnant women infected in high prevalence areas. Prevalence among CSW is around 50%. Around 30% of cases transmitted through IDU More than 14 000 children orphaned by HIV/AIDS Sentinel surveillance cover STI-patients, CSW, IDU, pregnant women, blood donors and male conscripts. Figures are uncertain and vary between 500.000–170.000 PLWHA in the country.

[20] Country Profile 2002, Planning M&E Section, UNICEF

[21] Oral presentation at UNICEF Myanmar 2002.

[22] Memorandum. From Robert Bennoun, Eapro Regional Advisor 20020527. (mimeo).

[23] The United Nations and Parners Joint Plan of Action on HIV/AIDS in Myanmar 2002–2003-Overview. Draft 16th of May 2002. UNAIDS.

5.1.4 Vulnerability and risk factors

Heterosexual intercourse is the major mode of HIV transmission in Burma/ Myanmar although intravenous drug use probably is on the increase. Illegal cross-border migration to high prevalent areas for work, as well as trafficking is a major contributor to the spread of HIV. There is also a considerable internal migration for the work, because of the high poverty. Many of the migrants are young and they end up in high-risk jobs, notably sex work, as bar girls, in fishing and seafaring or in sweatshops. An increasing number of youth are illiterate because of poverty. Unlike other countries in the region there are few brothels in B/M however there is a considerable amount of CSW going on either through "free-lance street workers" or hospitality girls in bars[24]

There is only a limited blood safety in B/M. According to UNICEF Headquarters in Yangon the general knowledge on HIV and other STI is still low and condom use as well. Only 10% of women have ever used a condom and only 40% have ever seen one. Active MSM are around.5% of the population and have a condom use around 30%. Furthermore there are boarder areas of armed conflict where it is hard to operate any program. The credibility and capacity for media intervention is small. And as in many countries a profound gender inequality fuels the spread. There was little information on drugs as a risk-factor.

5.1.5 Protective factors

The most positive sign for development of intervention is the fact that the high leadership of the government now have joined the UN Theme Group for HIV/ AIDS on equal basis as all the other members. The positive attitude to education and the still existing infrastructure for education as well as health care gives a good potential for intervention. However the public spending for these purposes is extremely low and gradually weakens these important systems. An evaluation of a pilot project with 100% condom use for sex workers and their clients in 4 townships has proven successful and will be expanded. Condom distribution and use has increased considerably over the last years. In 1997 it was 30% with CSW and has now increased to 60%. The NAP (National Aids Program, MMA (Myanmar medical Association) and UNICEF has launched a STD-management programme.[25]

5.2. UNICEF approach

5.2.1 Strategic approach

UNICEF in Burma/Myanmar has integrated the HIV/AIDS work into the relevant departments. The interventions mainly follow the components of the Mekong Project. The HIV/AIDS co-ordination internally is done from the Health Department. However the education department has included HIV/ Aids work into its programme and are collaborating with the MoE on life-skills

[24] Uhrig J: An evaluation of the Pilot One Hundred Per Cent Condom Use Programme in Myanmar. April 2002, Report to the UN Theme Group on HIV/AIDS.

[25] Sexually Transmitted Disease Care in Myanmar March 1998 (mimeo). This mid term review demonstrate some major shortcomings but nevertheless also some successes.

(The Shape programme). The Health Department of UNICEF in B/M has a general close co-operation with the health care and funds many of the ongoing MCH programs as well as the STI management in the country. Recently they started on PMTCT. The Resident representative heads the UN-theme group and engages in high level advocacy. The HIV/Aids work also forms an important task of the programme for Area Focused Activity at township level (AFA) through which many of the care and support mechanisms are piloted. The UN Theme Groups has adopted a township strategy for further implementation of interventions on HIV/AIDS. The government of B/M has been in denial of HIV/AIDS until quite recently and it has been hard to operate any nation wide programs or specific HIV/AIDS programs on large scale.

5.2.2.The objectives for UNICEF support in Burma/Myanmar

Objectives in project proposal

- To prevent transmission of sexually transmitted diseases and to promote the reproductive health of youth and women of reproductive age
- To reduce HIV transmission and to raise the community acceptance for women, children and families affected
- To provide care and support for people affected by HIV/AIDS and respond to TB and other opportunistic infection

Objectives for 2002–2003 According to me Memorandum for the mission team[26]

- To contribute towards formulation of a communication strategy within the framework of the national response
- To strengthen prevention, management and care of STI and promotion of Adolescent Reproductive Health as primary prevention among young people
- To reach particularly vulnerable and at-risk population, migrants workers and people in poverty with core messages
- To provide care and support for PLWHA with particular emphasis on children affected.

Sida funding will be used specifically to

1. Young men and women have access to information, education and services necessary to develop skills required to reduce vulnerability through religious organisations and work places
2. Youth friendly services

[26] Memorandum. From Robert Bennoun, Eapro Regional Advisor 20020527. (mimeo).

Objectives presented at Consultants visit to Yangoon

Improved policy framework

1. Strengthen national response through UNJPoA
2. High Level Advocacy through World Aids Day events etc.
3. Capacity building in counterparts and partners

Young people develop safe and responsible behaviours for prevention.

1. SHAPE (life-skills in school and communities.)
2. Life-skills and HIV/AIDS training
3. Youth Friendly Services
4. Youth friendly IEC, literature.

Vulnerable groups have access to prevention and care services

1. Collaboration with (I)NGOs to provide IEC, care and counselling including STI care and management
2. Innovative communication to reach ethnic groups for prevention and care

Increased care and support for those infected and affected

1. Policy and guidelines for VCT and PMCTC
2. Care, counselling and support… including home-based Care family skills and psychosocial support.
3. Assess situation of children af fected and infected, provide care

5.3 Field visits and meetings

5.3.1 Monywa AIDS/STD team and co-ordination committee (Area Focused Activity)

Monywa is a middle sized city and township of 350 000 inhabitants and a commercial hub on the road to India We met the entire team. Because of the engaged work of the team leader, who is the Head of disease control the team and committee could give an example of a multitude of activities that can be found in the area focused townships – albeit perhaps not all of them in all places. All the self-evident players such as staff of MCH, school health, and TB-team were part of the work. Other powerful members had been mobilised such as The Myanmar Medical Association and NGOs such as Red Cross and Myanmar Welfare Association. An example of how the team worked is the large-scale social mapping and their clinic. In collaboration with STD-team, Red Cross is tying to reach risk groups. 300 drivers, 1000 Trig-shaw drivers, 500 factory workers and 150 sex workers had been reached. Other activities is syndromatic management in all health centres and the MCH

The team also visited a centre in the urban area where activities were similar to the ones described below in Kyewa. The team was also made familiar with peer-education awareness project run by Care and Myanmar Welfare Association. Care also runs a care and support project for high-risk groups aiming at reach-

ing 25 000 persons in 3 years. Finally the team was taken to a so-called user friendly or youth friendly clinic. It was situated near the university and had reduced costs for STI treatment but unfortunately lacking everything else that might attract a younger crowd.

5.3.2 Health Centre, Kyewa (Monywa)

The health centre is a typical rural health centre situated in a typical village area with a perhaps somewhat higher affluence than average. The health centre covers a population of about 43 000 people. It has 4 sub centres with one midwife/nurse each. The midwifes carry out all work concerning antenatal and child health, they also assist in some campaigns. They do immunisations and there have been no cases of the main 6 target diseases during the last 3 years. The health centre has carried out several campaigns for example on eradication of leprosy and TB. The staff seems to carry a very heavy workload. The rate of STD is unknown but cases are not that many. The HIV rate is unknown but 8 persons have died of AIDS. Because of PMTCT midwives have done a lot of testing but no women with HIV have been found yet. They have condoms available and sometimes the patient/the people from the village ask for them. Some village shops also have them. Mostly they are bought in tow in connection with CSW. In 1998 the health centre carried out HIV/Aids training for all the villages in this area.

5.3.3 The UNICEF SHAPE Curriculum and its implementation at The Basic Education Middle School Monywa Sagaing

The SHAPE Curriculum (School-based Healthy Living and HIV/AIDS Prevention Education)

Is a life skills school subject introduced once a week in the second grade when the children are 7 years old and then run throughout the school years? It has been run as an UNICEF program *but has recently been adopted by MoE for grade 2–9 as a national school subject to be implemented throughout the nation.* This means a total upscaling of the program. It has four components:

- Sound body, which covers topics as personal hygiene, nutrition, and contraceptives.
- Free from diseases, which covers such as malaria, HIV/AIDS, STD, drugs
- Life-skills, which covers such as communication skills, decision making, coping with emotions, refuse friends proposals.
- Healthy life, physically & mentally, which covers such as mental health, discipline, pleasure

Teachers as well as parents have been trained on the SHAPE-curriculum. The method used in SHAPE classes are built on participatory techniques, which allows the students to discuss. They play games, use cards, pictures and the desks are turned towards each other so that the students can see each other and there are no exams linked with SHAPE. The HIV/AIDS part of the curriculum is up for evaluation and possible improvement this year.

The consultants visited four classes, second grade, fifth grade, seventh grade and 10th in a school. Apparently the students were very interested and committed in

their work with the SHAPE program. They commented that they, when working with SHAPE, were given the opportunity to discuss and learn about important things. The headmaster was a firm believer in the curriculum and had given it a lot of attention.. The teachers seemed happy about the methodology but still felt a bit awkward about the more outspoken sexual matters and the condom promotion. In a grade 10 all boys had seen a condom but only 2 out of 14 girls.

5.3.4 World Vision International, Yangon and Drop in Centre, Mandalay

World Vision International is a Christian organisation. WV is running outreach work and drop in centres in Yangon and Mandalay since 1997 and also some hostels for long-term support. Over 1000 children, mostly boys have been sheltered in these centres over the years. An average of 70 to 80 children is sleeping in the shelters each night. They are provided: 3 meals per day, basic health care and emergency intervention, clothing, bathing, shelter, non formal education and skill training, school support, recreation, field trips and sports, counselling, family reconciliation and family support including income generating opportunities. The children have often experienced very traumatic events. The have often experienced physical and sexual abuse. Each child is assigned to a counsellor.. World Vision Myanmar also operates community-based preventive programs in slum areas targeting children in the risk of ending up as street children.

The team visited the centre in Mandalay that has between 2–4 mil. inhabitants. The outreach workers work mostly in railway stations where street children usually gather. Children come because they experience unbearable living conditions at home and have run away from home. They are often sent by their parents to be scavengers and to support the entire family on that income. The parents might then use the money for alcohol or gambling. Some are beaten or badly treated at home. Some are orphans with no other relatives to care for. Some are mentally retarded.

The centre has 10 staff including night staff. 44% of children leave the centre and go back to the streets. 14% go back to their families but there is no proper follow up of what happens because some live far away. They give children letters to send to them but few come. 1% of them join the army. 4% go to school. 10% come on irregular basis and 5% leave and get support to live independently through micro credits and help to find a hut to live in. The staff seems very knowledgeable and does not shun away from the problems of the children. They are open and can talk about reality in a way that apparently is helpful for the children.

M 15, girl, Myanmar

When M was 13 her mother died from diarrhoea. Earlier the father died from a train accident. M didn't have any relatives so she went to the railway station in Mandalay and spent her time almost one year there begging with her two younger brother Then she went to the drop in centre an has stayed there for a year now. I asked her to tell me about her life in the streets around the railway station. First she is silent and doesn't want to speak. Then I say that I am used to talk to children who experience scary things and have bad memories from that and that I know that it sometimes feel better to talk about those memories even if they are shameful and painful so she tells

met that once she was raped in a pagoda by five (shows five fingers) monks. She tried to scream but they had a knife and they covered her mouth. They touched her breasts and her body and took turns in inserting their penises in her vagina. She thinks of this every day and she feels angry every time she sees monks. She has told no one about this before. "And they didn't give me any money either", she says. I asked her if that was the only time she was raped and she shakes her head. I ask her how many times it happened and she says "I cannot count" When I ask her how she feels telling me this, she says that she feels shy and that she feels sad thinking of this. I'm telling her that I feel sad as well. She is happy now, she says, because she is going to school and no one is hurting her any more.

5.3.5 PSI (Population Service International), Mandalay and Headquarters in Yangoon

PSI is an INGO with the purpose of social marketing on condoms, on family planning, contraception, on user-friendly STD –services for private practitioners and on mosquito nets. On condoms PSI is active in all 16 states in B/M and has 7 offices. They are active in 268 townships, which are the possible ones since the others are areas of conflict. They work in 13 languages and have 150 employees; employing many from their target groups such as PLWHA, MSM.T hey are working with all possible commercial-marketing strategies. Information gathering (research) is the basis for all interventions. Condoms are sold to the retailer for 4 kyats and then sold to customers for 5–10 kyats. There is also a STD package with private clinics. They are trained in syndromatic management and family planning and counselling. They can then obtain contraceptives and drugs at a low cost and sell them cheap to customers. The idea is to flood the market with cheap medication of good quality to avoid the often-sold fakes. The concept could be adapted to a youth friendly profile. In all programs quality is controlled through among other things "mystery customers and clients".

PSI Mandalay does social marketing targeting high-risk groups such as sex workers (difficult), MSM, truck drivers, trig-shaw drivers, migrant workers and miners in teashops and at bus stops. PSI condom promotion in Mandalay has project co-ordinator and 8 outreach workers. PSI also operates a "Love-Boat". Three boats sail up and down the river and anchors at the villages. During the day they have a presentation during the evening they show a video on HIV which is a popular attraction in the countryside.

PSI aim is to have constant stocks and continual deliveries. In some places condoms are delivered by a 5-day horse ride along a small path. Because funding comes from 20 different sources these take up a lot of energy and impede development of f.i. the development of harm reduction programs for IDU and youth friendly services.

The results of PSI activities seem very good. In 1996, 60 000 condoms were sold/months in Burma/Myanmar. Today the figure will probably be above the 2.3 million/month sold 2001.

5.3.6 Save the Children UK

Save the Children UK operates mainly in two states along the borders of India and Thailand. Their main counterpart is Myanmar Nurses Association. They

have trained 1200 peer-educators. They operate a life-skills based program for youth. Through extensive information gathering SC, UK has got a good knowledge on the situation of youth. Some of their studies show that 20% of young men have their sexual debut with a sex worker 32% used condoms 18 is the mean age for a young mans sexual debut. SC, UK works a lot with trafficked children.

5.4 Conclusions

For obvious reasons the consultancy team had limited contacts with the policy-making parts of the government system. Likewise media interventions were not a part of our visit. We spent most time at the township level. This gave us some impression of how the public infrastructure functions at local level. The team would like to underscore the necessity for any government to have an operating infrastructure in order to combat HIV/AIDS. UNICEF seems to be instrumental in the development of the Health Care and the School system and these interventions thus has a potential for scaling up as well as sustainability. One of the obstacles of covering the country is that NGOs only get limited areas to work in their MoUs with the government. Several have the potential of taking their operations to scale.

Component 1 Prevention for youth

– SHAPE

  As in the health sector the team found the school and the teachers to be very well organised and knowledgeable. Although we understand the school visited to be especially active in the life-skills work we do think that the SHAPE-curriculum lays a good foundation for young people to understand HIV and its problems. Its basic working model is in line with the existing evidence base on how sexuality education should be carried out to have positive results. Indeed we wish every country to have a SHAPE-like subject included in its curriculum and congratulate UNICEF to the achievement in Burma/Myanmar.

  The team understands that UNICEF is doing an assessment of the HIV/AIDS part of the curriculum. We would advise Sida to actively support the developments that come out that assessment. From our observations we think there is room for some methodological development. An important area for such development might be gender-adapted approaches. The team would like to stress the necessity to be a bit more straightforward in the classroom. At our visit we asked the students in grade 10 who had seen a condom. All the boys had seen one but only 2 of the girls. We think teachers could have some more training and support to dare do just a little bit more in that direction.

– Youth work in general

  Sida support is aimed at youth and children. Although Sida does not require specific destinations UNICEF; B/M has supplied the team with their intentions for the Sida support as can be seen above under 5.2.2. (Religious community and youth friendly services) However the team had no opportunity to see any of the work with religious organisations. We were supplied with information by UNICEF that this was work with Christian organisations who

have youth groups and are fairly well organised. UNICEF now wants to embark on a collaboration with the Buddhist community through showing the examples from other countries. The other aim is to start youth friendly services. The team did not see or discuss any of these efforts safe the "user-friendly" clinic mentioned above. The youth representative of the team pointed out that in this clinic there was lack of anything that could attract female patients. Unfortunately the clinic was not an uplifting experience. Perhaps technical support on YFS could be of use for UNICEF in B/M.

The team met with some peer-educators approaching parts of the young working population. These peer-educators seem well trained and open. The consultants feel concern for the young girls who are moved into commercial sex and think perhaps there is need for more awareness raising on this topic in the peer-education. Especially since the population in B/M is so cut off from outside information.

The studies by SCUK among others show the need for more in-debt information gathering on the lives of young people before starting interventions like youth friendly services. Where do young people meet, what makes them tick, which are their thoughts about the future, what do they really know about sexuality and drugs, from where do they get their information and who do they trust are vital questions to be answered. As in the other countries there is a need for more gender-based responses which could develop from such investigations.

Component 2 and 3 Care and Support and PMTCT

– UNICEF support for the health sector – STI-management and PMTCT

The team found the existing infrastructure for health care (and for education) surprisingly good and well organised although it operates under big financial restraints and many difficulties. The staff is dedicated and well educated and performs it's utmost with resources available. UNICEF operations seem crucial for providing the existing infrastructure with resources for its operations. Equipment and materials for STI management and PTCMT would probably not exist otherwise. The team would like to underscore the importance of trust for the health sector in the fight against HIV/AIDS. In Uganda [27]this trust has been one of the critical success-factors. Fighting HIV/AIDS is largely a logistical challenge and a functioning infrastructure is a vital component of the answer.

The program for PMTCT that has started recently in 7 areas of which the team saw one seems very well organised. Besides being a valuable program in its own right it also provides the health centres with knowledge and counselling skills that we believe important for HIV/AIDS work in general-should VCT and treatment of opportunistic infections or other treatment become more readily available. The team would however like to state its concern for overburdening the midwives in the health centres. If the Area Focussed Activities expand this could well be the case and has to be considered for the future.

[27] Urwitz V and Andersson Å: Continuing support for HIV/AIDS work within the health sector in Uganda. A study. March 10, 2000. For Sida Department of Democracy and Social Development, Health Division.

– Counselling

The counselling currently given, f.i. In STD-treatment or PMTCT is given mostly from a medical and treatment perspective. The team feels it should be complemented by psychosocial counselling. Of course the medical staff needs this knowledge but as there is a potential of overburdening them with too much work the team would like to point to the possibility of linking them up with NGOs and self help groups for this purpose

CEDC /CNSP Street children and orphans

Sida is especially concerned for vulnerable children in the light of HIV/AIDS. Our visit to the drop-in centre demonstrates this concern to be very valid. From the UNICEF staff we have learned that orphanages are sprouting and there is certainly need for capacity building in many areas in light of the existing and increasing amount of orphans. The team has learned that UNICEF intends to do a study of the needs of AIDS-orphans and how the epidemic affects the community. More information is certainly needed on this topic an as well as collaboration with (I)NGOs. The team would advise Sida to support any such efforts.

6. Vietnam

6.1 Country presentation

6.1.1 Some facts and figures[28] [29]

Population (millions)	78.1 (2000)
Population under 18 (000)	31139 (2000)
Population under 5 (000)	7743 (2000)
% Urbanised	20 (2000)
Total fertility rate (per woman)	2,4 (2000)
Life expectancy (male/female)	66/70 (1999)
% Reaching grade 5 at prim level boy/girl	89/89 (2000)
% Females 15+ illiterate (%of total)	13 (2000)
% Access to safe water	52 (2000)
urban/rural	71/44
% Infant mortality rate IMR	31 (1999)
% Households under the poverty line urban /rural	18/44
% Households headed by a single woman	32

6.1.2 HIV prevalence

Experts maintain that the pattern in Vietnam is different from the rest of the Mekong area. There are two distinct epidemics in Vietnam. The first AID/HIV case was reported in 1990 but until a few years ago the infection seemed to be harboured within the established group of older drug addicts as well as sex-workers returning home from other countries. Since 1998 the pattern has changed and there is a new epidemic among a drug using population of youth These young people came into contact with IDU through the drug market emerging along the smuggling routes from the Golden Triangle. They often had had little contact with drugs before, shared needles and could get infected at their first shot. They are often ignorant and poor with no jobs. But not necessarily. The rate of heterosexual spread is still slow but increasing.

Thus the incidence HIV in Vietnam has increased during the last years. The MOH reported 23,631 cases in September 2001. According to the presenter, estimates indicate higher figures; between 135 and 160000, which constitutes 0,1% of the population. According to the World Bank there has been a fourfold

[28] country profile, UNICEF April 2002

[29] information given by UNICEF representative at the UNICEF office 27.06.02

increase between 1993 and 2000. 65% of the infections are reportedly associated with IDU[30]. Heterosexual transmissions seems to increase among the young with 9,3% of the new cases among the under under-twenty-year-olds and 50% in the age group under 50

6.1.3 Vulnerability and risk factors

Even though Vietnam's contribution to the opium growth in the Golden triangle is less than one percent, Vietnam is considered to be relatively major opium producing country Vietnam is also a drug transit country for several drugs. The growing availability has led to an increased consumption especially among urban youth[31] The sharing of needles is widespread and the condom use among IDUs are low. Studies have shown that only 50% of IDUs visiting CSW used condom and IDU do not use condoms when they have sex with girlfriends. Young IDUs from wealthy families seems to be infected to a less extent than IDUs from poor families.

Street children seem to have a high prevalence rate. The number of street-children in Vietnam are estimated to be 30 000. The cause of this is mainly IDU but could also have its roots in the fact that this group is offering sexual services as well as being victims of sexual abuse. According to the project proposal (2000) Increasing numbers of infants are being infected during pregnancy and birth. Vertical transmission from mother to child is now the second most common mode of transmission. Numbers of children orphaned by AIDS are steadily increasing

Although MSM is not seen as a "social evil" it is by no means an open issue. Furthermore there seems to be a close connection between HIV/AIDS, drugs and prostitution for both men and women. Many of the infected CSW are also using drugs. There are also large numbers of persons being trafficked to Cambodia and China. Some of the women return with AIDS. However experts maintain that the prevalence among CSW in Vietnam is declining. The amount of CSW in Vietnam is unclear to us. However a recent French study shows that over 60% of Vietnamese men have extramarital relationships and over 50% of men had their first sexual relationship with a CSW.

Data on HIV/AIDS are not reliable since VCT does not really exist in Vietnam. The big obstacle is lack of confidentiality. People who test positive and are IDU or CSW risk ending up in camps. There is still a big fear within the health care system. Few orphanages or persons seem to want to take care of infected orphans.

The so called "social evil" campaigns against "evil" behaviours and groups who are judged dangerous to Vietnamese morality might be difficult to discriminate from progressive HIV/AIDS programming. At the MHC mandatory testing of pregnant women is the closest you come to sentinel surveillance. There is a problem with confidentiality and a lack of counselling, which make test data unreliable.

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[30] Memorandum by Robert Bennoun UNICEF, May 2002

[31] Revisiting "The Hidden Epidemic" A Situation assessment of Drug Use in Asia in the context of HIV/AIDS Read & Costigan- The Centre for harm Reduction, The Burnett Institute, Australia. 2002

6.1.4 Protective factors

In relation to drug use and HIV Vietnam was quick to undertake prevention activities. Researchers claim that despite political complexity the government and the public sector have been open and have kept the public well informed about the HIV epidemic. HIV/AIDS programs have received the highest funding out of all Vietnams health programs. Also the concept of harm reduction is well understood in Vietnam and is advocated as a way to reduce the risk of HIV infection. Although drug use is illegal drug users are regarded as victims to be rehabilitated rather than criminals to be punished. STDs are decreasing in Vietnam. Syphilis and Gohnorrea are almost extinguished (under 0.3%). There has been a lot of treatment programs and people also eat a lot of antibiotics. This could account for the relatively low rate of heterosexual transmission. The most important and powerful protective factor in Vietnam is fact the relatively low prevalence. Though the number of infected people is increasing it still is a situation that is possible to control. Information given to the consultants underlined some aspects that might also be considered protective:

There is a CRC based National programme of Action for Children (2001 – 2010) it addresses child protection, HIV/AIDS and injury prevention. Literacy rate is around 90%.Contraceptive use is above 70%. The population is used to the notion of protection in sexual encounters.

6.2 UNICEF approach

6.2.1 Strategic approach

The consultancy team got the impression that UNICEF as well as the partners in Vietnam have operated along sectors in vertical programs. It has been the whish of the Vietnamese government. This has been fairly effective but now seems to have come to its limit. A multi-sectoral approach is now on the UNICEF agenda for many of its programs. It has however not been developed yet. It also seems other UN organisations have so far taken the lead in HIV/AIDS. However UNICEF now will start to support implementation of HIV/AIDS work more systematically along the MPB lines. In relationship to the increased amount of HIV+ pregnant women and their children UNICEF holds a specific responsibility. Also in relationship to CNSP, who are the most vulnerable UNICEF takes a specific responsibility and has a relatively strong section on CNSP. They are fully aware of how HIV/AIDS now are threatening the street children. For orphans and children, infected or affected the situation is very difficult. The social protection centres (public orphanages, etc) do not want to take them. Some of them have to live for years in hospitals. UNICEF supports three alternative orphanages. They are also initiating a need assessment for HIV-orphans and pilot models of care in institutions and in the communities. This is done in cooperation with the Women Union.

Some of the UNICEF country programs have integrated HIV/AIDS. The section for education is in progress of supporting a life skills curriculum for school. There are manuals and materials being printed at the moment (June 2002) The program will first target lower secondary school. This is a part of a 5-year project cycle. The life skills curriculum includes work in sexuality, drugs and

HIV/AIDS. There is collaboration in this with MoE (Ministry of Education) and other Un partners. Teachers are being trained through ToT. In this work there is also an embryo of multi-sectoral collaboration. Each school has a youth officer and the Vietnamese Youth Union can operate and run Healthy living clubs also for out of school youth with a community based approach (see field visit summary).

UNICEF also supports a self help group in HCMC, the Friend help Friends group. Through this group they have contact with PLWH/A who are willing to be more public and counteract the current discrimination. The stigmatisation of PLWH/A and the current epidemic drug use among young people have motivated the communication section in UNICEF to initiate a BDCC communication program targeting youth. Based on the survey mentioned above they will start this year (2002) together with their partners and the John Hopkins Hospital.

6.2.2 Objectives

In project proposal

- Prevent the spread of HIV (amongst the young)
- Provide care and support from those infected and affected by the disease (the young and their families)
- Reduce the vulnerability of individuals and communities to HIV/AIDS (such as disabled, street children and young unemployed etc, as well as school children and their families)
- Alleviate the socio-economic impact and human impact and human impact of the epidemic (as it pertains to children and their families)

In the memorandum for the mission team

- Increasing the knowledge of HIV-preventive behaviours amongst target groups, including adolescents and decrease discriminatory behaviour towards people living with HIV/AIDS
- Increasing and sustaining political awareness of and commitment to HIV/AIDS programming-Strengthening the capacity of communities, mass organisations and basic social services to provide supportive care to PLWHA and women and children affected by HIV/AIDS

Objectives presented at Consultancy team visit

No specific written objectives were presented to the consultancy team at the visit to Hanoi.

6.3 Field visits and meetings

6.3.1 Outreach program for street children in Hanoi

The team was invited to a gathering of street children. About 60 children were gathered in an open pavilion in a square. A peer educator – a street child herself, garbage collector, was holding a session on HIV. Social workers from the district were also there. Some people from counselling committees in other districts were also present. This project has inspired many other districts who also try to implement this type of work. The pilot is carried out in 3 districts. Voluntary social workers and police are trained. They get training on outreach and on issues around drugs, abuse of all kinds and child protection. Through the outreach children can come to educational sessions 3. Here they can find drop in centres where they can be offered counselling.

6.3.2 Community and family visit to Healthy Living Club in Hanoi, in association with the Youth Union

The team visited a family in a very poor district who had joined the Healthy Living Club.

The father of the family worked as a cycle driver between 5 o'clock in the morning until 6 o'clock in the evening. He is remarried since 6 years ago. His first wife had some small trading business by the border and one day she was missing no one knows what happened to her. For four years he worked to provide for his, at that time, 5 children, to feed them, dress them, cook for them. Then he met his new wife with whom he has one child. He joined the healthy living club because the love he feels towards his children made him want to be as good father as possible. Since he had so little to give them at least he wanted to give them a good fatherhood and hopefully prevent them from using drugs, stealing or being street children. The representatives of the Youth Union were very engaged in this work and willing to expand it.

6.3.3 Tu Du Hospital, Hanoi

In this hospital there are some 36 000 deliveries per year. The hospital seems well organised but overcrowded. 100 000 women come for antenatal care but not all deliver in the hospital. All women are HIV-tested at antenatal care and before delivery. If they are found to be positive abortion is recommended and most people accept that. Only single cases continue the pregnancy then they bring a grandmother to certify that there is someone to take care of the child. Some however are detected too late. The team visited the ward for mothers with HIV. There were 3 women. The hospital had developed proper counselling services for these women.

6.3.4 Binh Trieu Drug Rehabilitation Centre, Hanoi

This centre has no support from UNICEF but since the drugs are a part of the HIV problem in the country and this type of rehabilitation is the official solution at present. The visit provided some very valuable pieces of information.

The centre is 27 years old and has1000 inmates. It is a barbed and closed centre; however material living conditions are rather OK for Vietnamese standards. There is some access to education and HIV/ AIDS education and counselling.

80% of the inmates are currently HIV+. Most are below 30. 70% are in custody. The others are submitted by their families. The centre tries to care for the sick and let inmates with HIV stay in their hospital as long as possible. There is an almost total lack of organised support or resources for such support for the persons leaving the Centre

6.3.5 Condom Coffee shop No 2 Binh Thanh District, Ho Chi Minh City

In Ho Chi Minh City there are two Condom Coffee Shops where people can come, meet, have coffee, watch television, and provide themselves with condoms that are displayed on the tables and in the toilet, sometimes listen to music and anonymously talk to volunteer peer counsellors "at the table" about general or more specific, drug, sex and HIV- related issues.

6.3.6 Thao Dan Organization for Street Children, Ho Chi Minh City

Thao Dan is a grass root, non-profit organization that since 1992 is committed to helping street children find alternatives to street life. Thao Dan runs three houses and a drop in centre a well-established outreach program and a grocery shop.

The objectives of Thao Dan are to encourage and work towards re-integration of street children into the community and if possible reunite children with their families. They also want to "provide and support opportunities that allows street children to develop their self esteem and skills" and to "help street children to help themselves". Each of the Thao Dan's programs reaches over 200 children.

6.3.7 Case presentation

Interview with Minh, voluntary social worker and part of outreach program in Hanoi

In my district we have a counselling office. Every district has one. We also have a counselling committee. I am a part of that committee. The office has only 1or 2 employees and the committee has volunteers. We also have some 20 extra outreach volunteers. I am the co-ordinator for the outreach. Twice every week I go to my catchment area and try to talk to the street children. My catchment area is at the big lake. A lot of street children gather there. I try to build rapport with them through buying small stuff or through letting them shine my shoes and start talking. Once I built trust I ask them want hey would like to do, if they only want to work or if the want education. Almost all of them want education.

I try to make them come to our education for street children and if they need I tell them about the drop in centre and possibilities for shelter. Once in a while we also have to provide some food for them if they are very hungry but not for all. In the drop in centre they can have counselling and also study. We offer literacy, singing, sports and life skills. We try to work along three avenues – one is to help the young to a future by themselves, the second is reconciliation with families the third is sometimes care. The most frustrating thing are some of the communes they come from. They think that because they children left they are no longer their concern. They don't support their families so they can accommodate the children. The children have often left because the family is too poor to support them. The children themselves are also difficult to handle sometimes. Their behaviour is very complicated to understand. But we are trained and that helps.

We reach around 150 in our district. We< have a core group of around 20 who we have trained to become peer educators. The girl you just saw is one of them. She is a garbage collector. But now she will soon stand for examination for a secondary school exam. This alone makes my whole voluntary work worthwhile. I used to bee responsible for children issues in our ward. Then I was asked to do this. And I really wanted to do it. I work a lot but as long as I am healthy it is OK

Interview San 16, street boy, Hanoi

After having introduced myself I ask him to tell me something about his life. He says then that he loves his parent very much and that he misses them because they are dead. His mother died several years ago from a stomach disease and his father died three years ago from some injuries from the war, caused by chemical weapons. San is living in a guesthouse together with other street children. He has to pay for his food, for his bed and for the water he uses. In the daytime he is polishing shoes from 6 in the morning until 7–8 in the nights. He has been doing this for three years now. He tries to save some money for rainy days when he cannot work. If it rains a whole week he becomes hungry. He fears older boys in the streets, because they are beating and robbing the younger boys. He has to hide the money he earns otherwise he will be robbed.

His dream is to save some money and go back to the house in the village where his parents lived. That house is still there but it is empty. Sometimes he uses to go there and clean and take care of it "because there is still a little garden" He has a brother who is in the army. He is far away but once in a while they talk in the phone to each other. I ask him what he does when he feels sad because he has no parents. He says that then he just closes his eyes and try not to think about it and sometimes he cries. He has no one to talk to about how he feels and says he doesn't like to talk about himself.

I asked him about today's event and he is tells me that it is arranged so that the street children can meet friends and learn something about health and risks and how to protect themselves. I ask him what he learnt today and he tells me that he learnt not to use drugs and not to have many sex partners. When I ask him if he knows what a condom is he tells me that they talked about that also.

I ask him if he knows what sexual abuse is and he says he knows and explains to me what it is. I ask him if he met someone in the streets who sexually abused him or if he ever got some money for sex. He shakes his head to that and that means no. He has never taken drugs but his best friend uses drugs. He snorts, and he swallows and he injects. But now he is disappeared and no one knows where he is. Before we finish I tell him that I'm sure his parents will be proud of him, working so hard, saving money, not taking drugs and taking care of their house.

6.4 Conclusions

Overall impressions

The impression of the monitoring team is that the UNICEF office in Vietnam is in transition when it comes to work on HIV/AIDS. Some of the programs mentioned in earlier documentation have not been commented and have not been continued. The team got the impression that there will be a shift from pilot interventions on an ad hoc basis to policy development. The idea is to combine

these efforts with pilots on province and district level. If successful they can then be up-scaled and implemented on similar levels in other parts of the country. The outcome of this would hopefully be a more sustainable strategy. The school efforts of course already have potentials for sustainability.

As has been mentioned earlier there is seems to be little emphasis on multi-sectoral collaboration and capacity building at local level in Vietnam along the otherwise usual community development strategies. However the consultants encountered good multi-sectoral collaboration in some of the ongoing efforts. The collaboration between the PMTCT in the TU DU Hospital, the "social nurses" and the PLWHA in HCMC is one of many examples. The consultants would advice UNICEF to draw lessons from these when developing their community strategy.

UNICEF in Vietnam is involved with developing a social work curriculum at the university. Although we do not really understand how this involvement is organised, it seems Sweden is involved in this to some extent. The consultants would like to emphasise the need to analyse the inherent social work skills and counselling skills in such programs as the one for youth clubs and street children as well as programs for community support. It is vital to develop social work curricula so that ministries and NGOs get staff that can strengthen and sustain programs.

Component 1 Prevention for youth

The few and small scale examples that were presented to the team seemed interesting and well carried out and indicated that the projects supported by UNICEF (Healthy Living Clubs and Friend help Friend) are good enough. How these projects are going to be evaluated and up scaled remains to be seen. Peer education needs a good strategy and clear organisation, continuous sustenance efforts to be able to work in the long run. Peer education has a free standing and a potential to mobilise and empower youth. The youth representative would like to point out that the Vietnam youth surely have the spirit and capacity to undertake a lot of important voluntary work and should be used more. Also it is important that there are adults behind peer-educators, adults who can supervise them and to whom they can refer for counselling.

The planned survey on youth will hopefully give necessary information for good youth work. The team wants hope out that the survey will take such things as gender differences, youth sexuality and drug promoting / drug protecting behaviours into consideration. If so, it will give considerable input in the communications strategy planned with Johns Hopkins. This thorough approach to communications is excellent and surely one of the more strategic approaches seen in the region. An interesting aspect of the future is to se how the strategy on drugs works out and how it will be possible to communicate on both sex and drugs in a climate of "social evils".

Component 2 and 3 Care support and PTMCT (Prevention and Treatment of Mother to Child Transmission)

Sweden has a large bilateral support for the health sector. The team recommends UNICEF to cooperate with Sida to promote work with HIV/AIDS in the health sector. This could concern PMTCT, treatment for youth, youth friendly services and many other issues.

It seems there is a need to act against discrimination and for support in the local community. PMTCT initiatives could be a way to test the support of social networks. There seems also to be a need to identify and strengthen collaboration networks on the commune level. This is especially important for the orphans and for children whose parents are ill.

One big upcoming issue is Anti-retrovirals. There will be a need to address testing, counselling and support on large scale. It seems that UNICEF has to identify its role in this and develop appropriate strategies. One thing that is evident already is the need to develop skills and possibilities for counselling in consistency with the resources of the country.

CEDC/CNSP Street-children and Orphans

Vietnam shows a conscious and outspoken attitude in the work with street children and orphans. There seems to be need for more. Knowledge and experiences about the life of orphans and how they can be supported in the community has to develop.

It seems that there is a need for more balanced emphasis on drugs and sex as risk factors. Perhaps drugs nowadays are overemphasized as the source of transmission. In the Thao Dan Centre *all* of the infected boys that met with the team boys had been selling sex. It is not evident that they got HIV from drugs!

The emphasis on de-institutionalisation that UNICEF is promoting seems to be necessary. There is a need for advocacy to make decision makers shift from large camps and institutions to small homelike centres and to support orphans lives in the local community.

7. China, Yunnan, Province

7.1 Country presentation

7.1.1 Some fact and figures[32]

Population (millions)	1265.8 (2000)
Population under 18 (millions)	378,9 (2000)
% urbanized	36 (2000)
Total fertility per woman	1,8 (2000)
Life expectancy male/female	68/73 (1999)
Infant mortality rate (IMR)	32 (2000)
% Female 15+ illiterate of total	23 (2000)
% access to safe water urban/rural	94/66 (2000)
% reaching grade 5 at prim. level	91 (1995–99)

7.1.2 HIV prevalence

According to the project proposal[33] there are 500 000 people living with HIV/AIDS in China. Another report[34] indicates 1,5 million infected people, including 120 000 children. The relatively high rate of children affected by HIV is a result of unsafe plasma collection in rural central China.[35] In June 2001 the cumulative number of identified people with HIV/AIDS in China was 26058[36] Half of the total reported infections have been found in the Yunnan Province. Yunnan with its 43 million people shares borders with Myanmar, Lao PDR, Cambodia and Vietnam.

According to the Yunnan Centre for Disease Control 8000 cases are identified in Yunnan However all agree on the fact that the number of infected people are increasing and it is estimated that by year 2010 there will be three million people living with HIV/AIDS if no effective interventions are made. Initially infections among ethnic minorities were predominant. Now infections are equally distributed among minority and Han populations. Also significant is the shift of the spread from rural to urban areas, from border areas to interior populations. The estimated sero-prevalence is:

[32] Country profile, UNICEF April 2002.

[33] The Mekong Partnership & Beyond Project Proposal UNICEF 2002.

[34] HIV/AIDS Prevention and Care programs in Mekong Countries 2003 –2003, UNICEF 2002.

[35] Bennoun Memorandum, terms of reference for Sida

[36] Revisiting the "Hidden Epidemic" A situation Assessment of drug use in Asia in the context of HIV/AIDS,. The centre for harm and reduction, the burnet Institute, Australia, Reid & Costigan 2002.

- IDU's, around 50%
- CSW's 3%
- STD patients, 3%
- Pregnant women 0,2%
- Hospital patients 2%
- It is also estimated that about 1500 pregnancies and 500 babies were infected by HIV in 1999[37].

7.1.3 Vulnerability and risk factors

Yunnan is a great challenge for HIV/AIDS and care efforts. Over half of Yunnans 127 counties are recognized as impoverished. In addition there is a high illiteracy rate, 25 ethnic minorities with their own cultural traditions, values, habits and language, increased cross border trade with labour migration across the borders. The changing life style and sexual behaviour of young people also contribute to a considerable vulnerability of the population in this area

Presentations and written materials[38] that was given to the team pointed out several risk factors

- The sharing of needles and use of unclean needles because of lack of knowledge and access to harm reduction or the suitable hygienic conditions
- Low education level in general and specifically lack of HIV-knowledge of drug abusers. They make wrong judgement and have blind confidence in their odds of warding off HIV/AIDS infections
- Prevalence of sexual transmission because of the unwillingness to use condoms in sex among IDU's and in CSW.
- Tattoo in some special places such as reform-through-labour camps.
- Attitudes of exclusion on the part of the public masses toward drug abusers and little public acceptance of methadone maintenance, change of needles, public promotion of the use of condoms and other measures as ways of HIV/AIDS prevention. In addition, HIV sero-prevalence through sex transmission is increasing.

7.1.4 Protective factors

The Yunnan government has been commended for its proactive and quick response to the epidemic, especially compared with other provinces in China in equivalent circumstances. The response from the provincial government expresses a strong political will and openness to respond openly to the epidemic, promote multi-sectoral and multi-agency initiatives and facilitate INGOs to develop collaborative HIV/AIDS interventions.[39]

[37] Drug Abuse and HIV/AIDS in Yunnan Now, It's a Growing Trend and Our Prevention Li et al. Yunnan Institute for drug Abuse

[38] see 37

[39] Mekong Sub region STD/HIV/AIDS Project, Donor Report UNICEF Bangkok 2001

7.2 UNICEF approach

The Deputy Governor of Yunnan province is the leader of a coordinating committee for HIV/AIDS interventions. During last years great efforts have been spent on advocacy and training of leaders at different levels in all 34 sector in the province. This has resulted in coordinating committees at different levels. The presenter of this, Dr Hwang underscores the importance of UNICEF's contribution in this work. There is now a structure through which you can develop new efforts based upon lessons learnt from the pilot projects.

7.2.1 Strategic approach

As the team didn't meet with the UNICEF head office in Beijing, strategic approaches were not discussed, only picked up from general documents and information and impressions from the Yunnan province.

According to the project proposal "UNICEF will continue to support prevention and care initiatives in Yunnan and at the national level, pursuing a strategy of involving neighbouring Guangxi and counterparts from other provinces and the national level in initiatives implemented, technical assistance provided and training /workshops held at provincial level". The project proposal to Sida points out important areas for implementation such as behavioural development, change and surveillance, practical ways to reduce discrimination towards affected people to be carried out locally on large scale through strong relationship at the national level. The primary mechanism for UNICEF support is described as "capacity building of coordination and implementing counterparts.

Some examples of earlier implemented strategy in Yunnan province:

- Work with prevention and care started around 1996. Projects on prevention, VCCT, efforts of community awareness, care and support were carried out as pilots in some counties. The consultants understood that these are not yet fully up-scaled throughout the province.
- In Chen Jiong Province there is a prevention project that involves CSWs. By visiting entertainment places and educating entertainment girls as well as proprietors the condom use has increased to a level where now see no new infections are seen since 1997. This project is still ongoing.
- The YCDPC runs a VCCT. Although testing has been possible at the centennial sites there has been lack of counselling. Through new funding the experiences from the centre will be implemented in 40 places in the province.
- Peer education projects are run in Kunming through the Red Cross and the Women Union. Teachers have be n trained for life skills education although this is just (2002) starting.
- Monks have been mobilized in an area where they are of importance to the population and where men frequently become monks during a period of their lives.
- Syphilis screening and treatment has started just recently (2002)

– There are 45000 registered drug addicts in Yunnan but it is estimated that there might be 5 to 10 times more. Some initiatives of outreach and peer education have been tried but there are needs of massive awareness campaigns as well as more community-based treatment.

7.2.2 Objectives

In the project proposal

– Raise awareness of the Yunnan population on HIV/AIDS/STD and drugs and promote positive behaviours

– Develop life skills of youth and young people with high-risk behaviour and promote positive preventive behaviours.

– Contribute to development of replicable pilot community based approaches for care and support of people living with HIV/AIDS in selected pilot locations– Contribute to development of a MCT program in the future through experimental pilots in two project locations.

In the memorandum for the mission team

– Strengthen the role and the function of national HIV Working committee for leadership in HIV-control with inter sector cooperation

– Contribute to national policy development and implementation, leading to increased awareness, adoption of safe behaviours and tolerance (non discrimination)

– Promote a coordinated advocacy effort for intensified response for disease monitoring, prevention, care and support for those affected by HIV/AIDS

– Strengthen technical and planning capacity for HIV/AIDS prevention and surveillance at national and provincial levels.

– Improve the quality and efforts for HIV/AIDS prevention and care among highly affected areas to reduce further transmission to others (harm reduction), especially children

– Initiate campaigns promoting safe behaviour based on adequate design with special focus on young people.

Presented to the consultancy team at visit

Since we did not meet the country co-ordinator or the persons responsible for different components there were no such presentation.

At our visit we met the Yunnan Province partners and 1 representative of UNICEF

7.3 Field visits and meetings

7.3.1 Political Committee and school advisory Committee of Kunming

The Political Committee has an advisory policy role. Kunming schools have a basic education on HIV and basic sex education in all schools. All schools also have anti drug education. Life skills curricula are started in the high quality schools. It is the belief that a good result in these schools will be accepted as a

model for other schools. The attitude towards condom presentations in classrooms is mildly positive. One headmaster at the meeting said that they had good experiences in an exchange with Thailand. He referred to the Thai peer educators as very good educators.

7.3.2 Meeting at the office for Yunnan Provincial Government steering group on HIV/AIDS prevention and Control where NGO representatives were gathered

Family planning
There are two main principles of the work:

1. To integrate HIV/AIDS and STD counselling into all family planning and into the compulsory marriage school. This is education in group before marriage on relationships and family planning and parenthood.
2. Condom promotion together with Futures Group (former British rubber) for social marketing. They have also set up 300 vending machines that permit young people to get access condoms much easier than through the family planning.

They want to make their services more youth friendly. The FP has a network in 705 of the townships. The work is supported partly by DFID

The Red Cross
There is a long list of activities managed by the Yunnan Red Cross. It has 10 employees and 300 volunteers. The work is supported partly by UNICEF.

1. Cooperation with Australian RC on peer education skills
2. KAB-studies as a basis for intervention and training of peer educators 18–28 years old – mainly university students
3. Peer education in Kunming by 20 000 peer educators reaching for instance: travel companies, tour guides, hotel staff, CSW and their clients, nights club staff and owners, drug centres and PLWHA, migrants on train stations.
4. There is co-operation with other partners like Security and YRC who also have opened a half way house for former drug addicts.
5. Hotline

Save The Children UK
SCUK also has done some KAB surveys. They started off by working with trafficking at border crossings and with school based interventions. This pilot has now been taken over by the education board,

They have recently initiated community-based work in the Dehong prefecture. Main elements are youth participation, advocacy, capacity building. They also focus on child rights and gender issues.

They have trained youth who are very active. All schools participate in activities. They produce IEC material and based on students own drawing there is a competition going on. They are creating resource centres together with Health Link and has also set up a hotline for their county.

Education department of province
There are 7 million students in the province, 24 universities, 2000 high schools, 200 vocational schools and 10 000 primary schools. The logistics of putting new elements into the curriculum is an enormous task – especially when it is setting a new paradigm like "life-skills". According to the presenter, the results from pilots in 100 schools are good.

The Women Federation
The presenter underlined the fact that the Women Federation through a very well developed network from county level down to community level collaborated with other NGO: s. Their main focus is drop out schoolgirls in six poor counties, street girls, poor women to whom they provide information and training on HIV/AIDS issues. The training also includes a life skills curriculum, which aims at empowerment, assertiveness and strengthening of the girls. The presenter stressed that before starting the training the situation is thoroughly assessed and analysed by a public community–team that goes to the villages where the training is planned to take place.

The Public Security Bureau
The bureau is responsible for the investigation of drug-related crimes. It organises HIV/AIDS training of staff at the Governmental Drug Rehabilitation Centres where they also recruit peer-educators among ex addicts and provides IEC material. 50% of ex addicts are peer-educators? It also organises direct information campaigns for youth and runs training programs in 4 pilot villages. The bureau does education in schools having reached 110 000 students. According to the presenting policeman there are now only 26 drug addicts in school in Kunming.

Final discussion with NGOs
There was a discussion if young people engaged in the different programmes and activities are asked about their sexual behaviour. The consultants got the impression that such questions not were asked. Someone claimed that young people generally have little protection knowledge. There are no surveys about how frequent and at what age young men visit commercial sex workers.

How can young persons get hold of condoms? There are machines at places where young people go, for example around the universities. The group discussed the possibilities to train the skills of the retailers to be more youth friendly. Youth club or social marketing was seen as a solution to this. Such youth clubs will start as pilot projects.

How much sex-education is included in the training of vulnerable women? Everyone agreed on that this would be extremely important and would like to do it more than what is done so far.

To what extent is trafficking for sexual purposes going on in the Yunnan Province? According to the group this exists but it is not by force. Young girls migrate to for instance to Thailand to engage in sex work by their own free will to earn more money.

What does the group know about intra familiar sexual abuse of children, by fathers, stepfathers, uncles, and brothers? According to the group this is not discussed or disclosed publicly or professionally because what happens inside the family stays there and no one dare to report. Someone told a story where a 14 year old girl in a training course disclosed that she had been raped by an uncle for three years. Some one else pointed out that the most common cause of death for young women in China is suicide. The cause of this is often that they think they have shamed their family by having sex with someone who then leaves them or by getting pregnant before marriage.

7.3.3 Visit to Ying Jiang County, Dehong prefecture

Ying Jiang has 259 000 inhabitants divided into 19 townships and 2 cities. The townships are divided in 99 villages which consist of 996 house groups. Minorities are 595 of the population.

Since the first AIDS case was discovered in Ying Jiang the Dehong prefecture has taken the matter seriously. The county has had sentinel surveillance since 1992 in 2 places. In one the drug users are followed up and in the other pregnant women. In 1992, 6% of drug users were found to be HIV+. In 2000 it was 45% and pregnant women were 0.2%. The main transmission route is still drugs, which is an increasing problem in the region which borders to Myanmar. The region is on the drug route from the Golden Triangle and drugs are cheap and easy to come by. However as in the rest of the province other ways of HIV transmission are on the increase. Commercial sex work is on the increase as is the cross border migration as well as other mobility. 85% of the tested HIV+ is known to the Disease Control. They come for treatment and counselling. Treatment for opportunistic infections can be obtained but there is no PMTCT. The total number of infected people in the county is 846.

In cooperation with UNICEF a project started for development and systematic work on prevention and care. Some of the achievements:

- 30 TV spots and programs in 3 languages (cartoons and real programs)
- Activities on World AIDS Day:The public can have counselling and information. Stalls are set up in the street in cooperation with WU and YU
- Health education in schools, community, entertainment places and workplaces through videos, lectures and life-skill approaches
- 280 gov. Officers have been trained
- 500 village leaders have been trained
- Altogether 750 persons have been trained to form village health teams
- 40 staff from the family planning unit have been trained
- 129 PLWHA and families came together to discuss their needs and 16 were trained as peer educators
- The Red Cross and the epidemic centre do special outreach at the boarder crossings
- The coordination committee has had 8 big meeting of altogether 160 man hours.

– Some efforts for support and care have been made and there is an ambition to support relatives who take care of orphans

The results:

1. An existing structure for HIV/Aids work and all sectors can co-operate
2. There has been extensive information and awareness raising
3. There is a strong operating team

For the future there is a need to improve the care and support for orphans. The education for youth needs to be strengthened. It is hard to reach the out of school youth (and as can bee seen in the account from the school visit below) there is a need for technical skills improvement. Finally there is a need to upscale the efforts for intervention to high-risk groups.

At the prefecture level there has also been cooperation with UNICEF resulting in a structure of trained leaders including the students of the communist party school. There is a 5-year plan on the way. There is sentinel surveillance in the prefecture and also basic awareness rising in all townships. Lack of funds is said to be the obstacle for up scaling experiences from the project counties.

7.3.4 Case presentation

Visit to health education class in the vocational training school

By chance there was an evening health education class in the vocational school and we could join it on short notice. About 200 students in the age between 13 and 14 were assembled in a large hall. They had already got some assignments to discuss earlier in day and they were now presenting their conclusions. The exercise was on high risk, medium risk and low risk behaviour. The class was conducted via microphone. The teacher was lively and had good command of the audience. She invited participation and comments. Loud shrieks and shouts could be heard when sensitive issues or outspoken words on sex were uttered by the teacher or by students.

However the back rows had evident problems in following the class. They could not really hear all discussion or see what was on the board. And as participation goes, to say answers or ask questions in a microphone is not really a top method. However we had no opportunity to ask why it was organised this way.

7.3.5 Yunnan Institute for Drug Abuse

Yunnan Government provided funding support to set up Yunnan Institute for Drug Abuse (YIDA). YIDA is a scientific research institute under direct administration of Yunnan Provincial Health Bureau. Its work spans over fields of prevention, rehabilitation, training, research and international collaboration of drug use. There are more than 130 professionals working in this institute and they are psychiatrist, psychologists, biologist, medical doctors and nurses.

7.3.6 Daytop, Kunming, Treatment Program for Drug Abusers

The program at Daytop is voluntary. It is based on five steps from assessment to aftercare. They have also a program where ex addicts are trained to be peer-educators. They visit for instance the de-toxication clinics and give information about such things as Daytop, prevention, about how to leave drugs. Of course

only the most motivated constitute the group of 20% of the people entering that remains after one year. Nevertheless the Daytop has opened up a discussion on alternative treatment for drug rehabilitation.

7.3.7 Katong Village, a Community Based Program

Katong village is a farm village with 1470 inhabitants from the Dai people which is an ethnic minority in China. All 200 of the children in the village go to school up to 6th grade. The average income per capita in the village is 6 – 700 Yuan per year. The village has four orphans living with their grand parents

10 years ago, the village leader was worried because the use of drugs was so frequent in the village and he knew that that the prevalence of AIDS was related to drug use. He was afraid that the minority they represented wouldn't survive if nothing was done. He contacted the Health Department and asked for help. In 1992, 139 persons in the village were tested and 6 were found HIV-positive. With help from the Health Department they set up a program in the village with four components:

- Self help groups for the already infected
- Training and information of the people in the village about HIV/AIDS, drugs
- Prevention, condoms, transmission
- Adoption of a village concept: no drugs

Since then no one has been infected in the village and no one has started to use drugs.

7.3.8 Case presentation

Li ma san 12, orphan girl, Chinese farm village

Li ma san is an orphan, living with her younger sister and brother in her grandfather's house in the village since her parents are dead. She seems to be frightened and very shy and probably taken to interview against her will so I tell her that no one will hurt her, I present myself and why I want to talk with her. I want to know something of the life of a young girl in Chinese village that lost her parents so that we can know better how we can help children in China with difficult lives to live as happy and as healthy as possible She doesn't want to speak and when I ask her to tell me something about her life she starts to cry and so does the interpreter. We are not allowed to have any privacy, a lot of men are standing around us saying thing to her in the local language and other curious people are listening. She tells me when crying that she has sad memories that she doesn't want to talk about, that makes her sad to think of and that she never talks to any one about this. Her grandfather is deaf so she can't talk to him. She also tells the interpreter that she misses her parents. She tells me that she goes to school and after school she has to feed the animals and the cook for grandfather and her brothers and sisters. Sometimes she plays with the other children in the village. She doesn't dare to look at me once during the conversation and she whispers in a very low voice. I tell her after a while that of course she doesn't have to talk to me if she doesn't want to and if she wants to leave she can do that and then she leaves.

7.4 Conclusions

Overall impressions
The Yunnan Province has managed to build an exceptionally good structure for implementation of all important sectors. There seems to be real political commitment and leadership. In the pilot areas this has also resulted in a basic level of awareness and knowledge among different groups in the population. Considering the epidemiological situation this is a very positive result. The impression of the consultancy team is that phase one of the MP now has to finish and the Yunnan province operations really have to move beyond this to the phase of scaling up this program of "basic knowledge and awareness and organising for health promotion" The systems are there. It is unclear to us, however, how much UNCEF is engaged in this new process.

Component 1 Prevention for youth
- Presently drugs are the most important route of transmission. There is a need of more extensive programs for prevention and harm reduction for youth on drugs. Partly this might be difficult for political reasons. Through the use of regional advocacy and some goal oriented funding this might be possible. In the Yunnan province it seems there is a true understanding of the seriousness. The attitude towards alternative models for drug work seemed to be rather open.
- In general the methodology for health promotion and prevention for youth has to improve both in relationship to drugs and to sexuality. The session visited by the team was good in spirit but to some extent failing its purpose. Talking about sexuality in a megaphone to 200 students of whom at least a quarter were discussing something else seems a waste of pedagogical time. It seems that there were some fundamental core principles of life skills education that were missed. The consultants understand the enormous challenge of reaching the masses in China with this type of education. Perhaps some more attention should be given to these specific circumstances. The Youth Representatives thought that the youth themselves could be utilised much more for this effort and that the Friend tell Friend approach perhaps could be developed to a real peer-education program reaching more young people through regular sessions. The consultants would like to point to other UNICEF programs for inspiration, for instance My Life is My Choice in Namibia. At least in the Yunnan Province with its high prevalence figures the youth themselves could be mobilised for a wider approach. As in many of the other countries there is a need for more extensive quantitative as well as qualitative research and knowledge gathering on the lives and sexual practices of Chinese youth in the changing society. This could be of use for advocacy as well as the development of IEC and BCC.
- The consultants met with the media and got the impression that the staff seemed engaged in the IEC activities. However, due to language difficulties there were no possibilities of judging the quality of the efforts.

Component 2 Care and support

– The consultancy team met medical staff as well as PLWHA in the pilot areas. The medical part of these HIV/AIDS work seemed to be delivered with much professional skill and whatever resources were available. The groups of PLWHA that we met also had some support and a good rapport with the professionals. The infrastructure of the health care can theoretically carry the burden of VCT and at least treatment of opportunistic infections. It was unclear to us if there was going to be a PMTCT program. If so this could be a valuable approach in developing VCCT in the area and reaching out with knowledge and services to a broader population. A substantial number of young people test for HIV but never come back for the answer. Many who receive a positive answer do not go for counselling. Pre-test counselling specifically and counselling in general has to improve through increasing skills test sites and for the purpose of care and support. Youth friendly approaches could be developed.

CNSP

– Though based on very few observations, it seems that the situation of orphans has to be attended, addressed and investigated more thoroughly. The number of orphans will increase with the development of HIV/AIDS. They seem to be in need of better protection, care, support and counselling.

  People responsible for orphans, village leaders, foster-parents, caretakers, teachers, institution staff need supervision and training on such as child right issues, child counselling and child development.

8. LAO PDR

8.1 Country presentation

8.1.1.Some facts and figures[4041]

Population (millions):	5.3 million (2000)
Country: 18 provinces, 141 districts,	12000 villages,
Country: 18 provinces, 141 districts,	12000 villages,
Population (millions)	5,3 millions (2000)
Population under 18	2 601 000 (2000)[42]
% of population in rural areas:	76 (2000)
Total fertility rate (per women):	5.1 (2000)
Life expectancy (male/female):	57/61 (2000))
% Reaching grade 5 at prim level:	49.6 (2000)
% Female illiterate:	59.1 (2000)
% Access to safe water:	52 (2000)
% Households under the poverty line:	about 47 (1995)
Infant mortality rate:	82 (2000)

8.1.2 HIV prevalence

The prevalence of HIV/Aids is 0.05.[4344] Sentinel surveillance is poor and the NCCA (National Committee for the Control of AIDS Bureau) estimates this most likely to be an underestimate. Some regions have higher figures. Especially close to the Thai border, for instance Savannakhet. There is a slow but steady increase especially during the last 2 years. The first case was reported in 1992. In 2000 213 cases of HIV were reported and in 2001 207 were reported during the first 6 months. Most cases are found in the age groups 25–39. Men are still dominant but women constitute 39%. Other STDs are very prevalent. 17% of truck-drivers, 5% of factory workers and 31% of women in service occupation had had treatment for STD during the last year [45].

[40] Country Profile 2002. Planning M&E Section. UNICEF

[43] HIV7AIDS7STD policy. Ao PDR. Ministry of Health, National Committee for the Control of AIDS Bureau. Dec 2001.

[44] Lao PDR HIV Sentinel Surveillance and STI Periodic Prevalence Survey 2001. Dr Cahnsy Phimphachanh. NCCA.

[45]

8.1.3 Vulnerability and risk factors

High prevalence countries like Thailand, Myanmar and Cambodia surround Lao PDR. Laos is experiencing a rapid change with the construction of many new roads of which some are highways across the Mekong. Laos is also subject to a change in mind-set by the new openness in the PDR since a few years. Urbanisation and new media influence the young generation. The languages have many similarities with Thai and the Thai TV and radio station can bee seen over the country. The Thai labour market is a strong magnet for the poverty stricken young Laotians and in some villages 10% of youth has left for work mainly in Thailand. Many of these young people are at the risk of trafficking. Traffickers are often known by the villagers and are former village members. A remarkable fact is that many of the young people leaving villages for work are the best-educated youth. A study of CSW in Vientiane displayed the average years in schools to be 6.6. (Although at the same time 14% of the CSW were illiterate)[46]. It seems the best-educated youth will take initiatives for a better life but nevertheless are poorly prepared for the life outside the village. A strong factor pushing youth to Thailand is the fall of the Laotian currency in relationship to the Bath.

Although commercial sex is illegal many women sell sex. Most of these work in the service or entertainment sector and could be called "floating sex workers". The study reports around 60% of service women sell sex during a year and have a median number of 5 partners per year. The main group of customers are government officials and businessmen. Typically these groups were not targeted as vulnerable in the behavioural study. A factor which could increase vulnerability but also protect is the poor infrastructure in Lao PDR. This concerns roads as well as phones but also the schools and health posts. This limits mobility but at the same time it also limits the response in shape of condoms, safe blood and drugs and dissemination of knowledge.

8.1.4 Protective factors

There is a national leadership and a recent national policy and a committed leader of the NCCA:

Condoms are promoted and use has gone up in spite of the low prevalence figures. In the study mentioned above 59% of truck-drivers used condoms with CSW last time. However the fact that only 44% had used it every time with CSW can account for the relatively high incidents of STD. The comparatively low number of partners/year in comparison to neighbouring countries is probably one of the factors contributing to the relatively slow spread of HIV. Thus the efforts to keep more systematic CSW or regular brothels could be an important protective effort. Women have a stronger position in Laos than in other Mekong countries because household formation is matrilineal in the majority population. There is also no dowry system. Young people can marry from attraction. However ethnic minorities that do not hold the matrilineal system are almost 50% of the population.

There is also a relative openness on sexual matters and premarital relationships, which might make the environment more supportive for the necessary straightforwardness in the media and in education programs.

[46] Behavioural Surveillance Study. Lao PDR 2000–2001 Ministry of Health NCCA.

8.2 UNICEF approach

The Consultants visited Lao PDR for only 3 and 1/2 day. Furthermore the visit was over the weekend. This limited the possibilities to see ongoing operations outside Vientiane and also to meet the representatives of different UNICEF programs as well as national policymakers. UNICEF In Laos has a special team for HIV/Aids and specially targeted HIV/Aids approaches for IEC. The head of the unit is also has as her task to integrate HIV/AIDS into all programs through collaboration with the other departments. Integration into the education, safe motherhood and child protection programs are the most predominant integrative efforts. Until recently efforts have been mainly in the field of awareness raising and prevention. UNICEF is now moving more into counselling, care and support. UNICEF has a wide network of partners in the country.

Objectives in project proposal[47]

- To increase the effectiveness of the multi sectoral response to reduce HIV/AIDS and STD transmission among vulnerable youth groups, women and schoolchildren and to reduce associated co-factors such as the use of alcohol, amphetamines and other substances.
- To promote non-discrimination, compassion and support for PLWHA
- To build capacity of communities and partner organisations by:

Building on previous experiences and successes; Strengthening and expanding communication activities, decentralization and community participation; Skills building in care/counselling

Objectives for 2002–2003 According to me Memorandum for the mission team[48]

- Enhance institutional management capacity of partners at national, provincial, district and community levels to better co-ordinate response to HIV/AIDS prevention and care.
- Sustain HIV/AIDS awareness and behaviour development and change through mass media and IEC.
- Support development of safe behaviour in children, youth and women through life-skills, peer-education and workplace education.
- Support community based initiatives. Including Buddhist leadership, for care and support of PLWHA.

[47] The Mekong Partnership and Beyond. Project proposal. UNICEF East Asia Pacific Regional Office, Bangkok October 2000.

[48] Momrandeum, HIV/AIDS Prevention and Care Program in Mekong Countries (2002–2003). Robert Bennoun, EAPRO Regional Advisor HIV/AIDS 27 May 2002.

UNICEF response in support of government plan presented at Consultants visit to UNICEF, Laos[49]

- High level advocacy and capacity building as well as help to formulate clear policies and strategies for action
- Support for multi sectoral responses
- Expansion of BCC activities and approaches
- Support for capacity building in provincial and community levels
- Activities to advocate compassion for PLWHA
- Technical abilities for care and counselling
- Partnerships with other Un agencies (especially UNFPA) and INGOs and popular movements.

Sida support to UNICEF in Laos is 270 000 USD for 2002. It will go to:

Prevention

1.1 Community based peer education

1.2 Life skills in schools

1.3 Vulnerable mobile young populations

1.4 Institutional capacity building

Care and support for affected women and children

2.1 Hope and help (community based awareness and support)

2.2 Self help groups of PLWHA and their families

2.3 Involvement of Buddhist clergy

2.4 PMTCT

As of now UNICEF sees the biggest constraints in the care and support part. There is limited capacity to develop effective responses such as involvement of PLWHA and limited human resources for care activities (75% of population not reached by regular health service). UNICEF has just started on these activities these interventions. PMTCT is still on the planning stage and there are a few self-help groups, UNICEF is also promoting the Hope and Help video in all the programs run by Lao Youth Union and Labour Union to advocate compassion. UNICEF has yet to look into is the situation of orphans and vulnerable children. There are needs for exploration before anything else can be done.

Other constraints are that the government has a limited budget for HIV/AIDS and last but not least the deficient surveillance makes it hard to target the interventions.

[49] HIV/AIDS Prevention and Care INICEF_Vinetianne 2002 (mimeo)

8.3 Field visits and meetings

8.3.1 NCCA

The team met with the NCCA (National Committee for Control of AIDS Bureau) and was given some epidemiological information. These data can be found under 6.1.2 above.

8.3.2 Community based peer education

The team saw an example of peer education led awareness raising for youth in a local community in the outskirts of Vientiane. This was an example of the community based, multi-sector response. The activity was supported by the local decision makers and led by village volunteers. The partner in this work is Lao Youth Union. Activities like these are run by the LYU in 17 provinces in 2–5 districts/province. There are altogether 50 teams. They do 5–6 activities/year on an average. They assemble around 25 000 participants. Research shows that they in their turn talk to about 10 persons. It can be estimated the program reaches around 200 000/year for awareness raising. The programme has been running 3 years.

As awareness raising event the team found it good. It was positive, energetic and straightforward and participatory. It contained the basic facts and also a good condom demonstration. Messages on condoms and sex were positive and non-judgemental. The shortcomings (as in all the training events we saw) was that it did not really address youth sexuality.

8.3.3 Peer education for youth

UNICEF has supported a successful community-based peer education for behaviour development and HIV/AIDS awareness through the Lao Youth Union. So far 45 peer-educators have been trained. Some peer educators also conduct peer counselling on family problems, problems with girlfriends and friends in collaboration with existing youth centres. UNICEF plans to expand this initiative together with the Youth Union to target more difficult-to-reach populations of youth, such as street children, sex workers and youth working at large construction projects. Special consideration will also be given to reach ethnic minority youth, to build their capacity to communicate messages to their peer group and in their home communities.

The team visited a youth house where peer-educators during three hours were working with a group of 20 young people between 15 and 18 years of age. In this club-like environment there is also training of drama and dance as means of communicating messages. The purpose of the session this time was to raise awareness on HIV/AIDS related issues. They started after some warming up exercises with a brainstorming on risk behaviour. The group seemed to be quite aware of risk behaviours in relation to sex and drugs. The session was carried out in a very committed and playful way with a lot of jokes; laughter and good spirit, norms and values were addressed. However exercises more close to the participants than intellectual discussions and written tasks should maybe be elaborated for this purpose as a complement or a development, a “next step” in the process, another “leap in the understanding and behaviour change spiral”

8.3.4 Life-skills education school

As mentioned above schools were on holiday during the visit of the team. However large interventions are on the move.3 years ago it was discovered that UNFPA and UNICEF had parallel ventures with the MoE. UNFPA was trying to implement population education including HIV/AIDS education and UNICEF their Life Skills curriculum. In May 2001 a joint evaluation recommended that the 2 curricula should be merged. This was achieved through large workshops with all partners. *In Sept 2002 the implementation of the new curricula shall start throughout the whole school system.* Books are in print and teachers will be trained through ToT during the present vacations. A monitoring structure is also put in place. UNICEF is funding this in 9 provinces and is putting in money for the next 5 years. Whether this important but logistically very challenging project will succeed is doubted by some who would have preferred to implement it in steps during 2–3 years.

8.3.5 Mobile young populations

We saw a training session for female factory workers in the garment industry based on the Friends Tell Friends. The TRIMAX company employs 450 young women and 50 young men of whom most are mobile and live in dormitories. This was an awareness raising peer-education led event in co-operation with the Lao Workers Union. In the Vientiane Prefecture there are 15 events/month on an average. Around 75 persons/event are trained and they then talk to friends. Private companies who employ important target groups are the main venue for the interventions.

The event was good as an awareness raising intervention with the same good qualities as mentioned above in other events. However an interview with some of the participants disclosed that although they certainly learned something and their awareness was raised none of them thought they would be at risk because they would not have sex before marriage. This underlines the necessity for learning more about the lives of different youth groups to customize the approaches better to their specific situations. This intervention also contained the Hope and Help video with following discussion

Interview with Vangsy, Pon Povi and Keokhan factory workers 18, 19 and 26.

Vangsy, Pon, Povi and Keokhan are factory workers. They have worked between 3 years to 1 month at TRIMAX. Povi had never had any proper information on HIV/AIDS before this event. She had only heard something on the radio and heard her parents talk about it. The other knew something but had learned more. They thought the straightforward condom demonstration OK. They all knew of condoms because they had learned about from friends but two of them had never seen one.

They said that they talk about sex with their friends since they were around 18 not earlier. This is because around 18 people start to have boyfriends. One of them was married and lived in Vientiane. The others lived in the dormitories of TRIMAX and only went to their villages once a year for a week. They had no boyfriends but wanted one. They maintained that they would be able to discuss AIDS and condoms with a boyfriend. However they did not think they would have sex before marriage since this was not the custom.

Though they all wanted boyfriends they were unsure of how to get one. If you are a good person, someone will notice you, was the answer. All of them had learned about menstruation and sexual intercourse and possibilities of becoming pregnant from their mother or sister. The most fortunate one had a sister who is a teacher and had told her everything.

In their dormitories 34 girls sleep in 2 long rows on hard benches. They have around 1 meter wide space and a net. They also have a locker and possibilities to hang some of their clothes on hangers. There are 3 fans in the room. They must be in their dorm at 10 o'clock. This excludes possibilities of extra work in the entertainment sector. Some study at night.

8.3.6 Youth Friendly Clinic and Youth Centre

The team paid a brief visit to the FPA supported youth centre and clinic in Vientiane. Few staff were available. The centre was very nice with a lot of ongoing activities. The clinic had moved out of the centre for privacy.

Coming from a country with a lot of experience in this field the team felt some technical support might have helped the centre avoid some of the earliest constraints. The staff maintains counselling for youth needs improvement and upscaling in the country.

8.3.7 Involvement of Buddhist clergy

Lao is in many respects a devout Buddhist society. The team met the project leaders of the Mettha Tham project. This initiative to involve the Buddhist community started in the beginning of 2002. The senior abbots had come together on a workshop and decided to join the struggle against HIV/AIDS, (not without inner opposition). Now the project works on integration of HIV into Buddhist messages and to explain their new role to the public. The messages can be used in their mass-media activities that are run twice/month. The project leaders try to identify suitable monks to become educators and "counsellors" They also plan to use their herbal skills for opportunistic infections. Young people also come into the pagodas on their holidays. Finally the great counselling skills and the consultative approach that Buddhist monks possess and train as a part of their regular work should not be underestimated for the purpose of care and support.

8.3.8 Meeting with Lao PDR, Radio HIV/AIDS team on Lao & ethnic minority language radio programming

Half of the population in Laos has a radio. TV covers 30% of the population. 3 million people listen to the radio. One UNICEF sponsored 30 minutes program on HIV/AIDS related issues is broadcasted every week, on prime time. There is also some co-operation with PSI. Broadcasts started in 1998. Listeners are encouraged to write letters with questions that will be answered in the program. They receive 250 letters monthly. Different questions on ways of transmission are frequently asked. There are programs for the two largest ethnic minorities in Laos, the Monh people and the Komoh people. Among Monh people polygamy occurs and among Komoh people pre marital sex among young people is more accepted and frequent than in the rest of Laos

Related to these differences the message in the Radio programme was discussed. The staff seemed to be a little hesitant about which message would be an appropriate one. The team got the impression that the message to the listeners was both condom promoting combined with conventional abstinence and stay faithful messages difficult to adapt to ethnic groups that represent a more liberal life style. The staff at the radio was concerned about how they would improve their contact with the listeners and how they could be more precise and accurate on the message to different categories of listeners.

8.5 Conclusions

The Consultancy team visited Laos over the weekend. Thus the team has to base its conclusions on a segment of ongoing interventions and collaborations; mainly concerning the out- of school youth work. Other segments were totally excluded. Having said this the team is of the opinion that the activities presented were of good quality and seem to have a lot of potential.

Component 1 Prevention for youth
The impression is that the interventions are mostly built upon correct and qualified analysis, that there is a good co-ordination between players, a good working organisation for prevention for youth with a potential of reaching many. Media interventions seem to be coherent with approaches of both government and NGO: s. There is an open attitude and methods used are built on participation from the target groups and conveying a right on the spot message.

The intervention on awareness raising seem good, appropriate and also seem to have had some good results. EAPRO underscored the necessity to make the leap from awareness to behaviour change. To achieve this there is need for method development as well as research on young peoples lives. The more open attitude towards sexuality and the somewhat more equal standing of women might give Laos a comparatively good platform for the next leap in the behaviour change communication ladder. The consultants would advice Sida to discuss with UNICEF how this could be taken advantage of. Possibly other countries can benefit from this possibility to develop the work to the next step.

The method development in the life skill curriculum and in the peer-education must develop as far as personal values, attitudes and norms on sexuality, gender issues are concerned. Methods such as participatory drama and techniques for acquiring a personal language on sexuality might be introduced by technical support. Also the male specific perspective has to be strengthened. In Laos as in other countries the consultants came across sessions where there was no challenge of the wide-spread misconception was that men have a stronger sexual urge than women and that they have difficulties controlling this and this is "natural". Sexual habits and norms among minority people, especially if they differ from the rest of the society have to be considered

Component 2 and 3 Care support and PMTCT
The consultants have only been presented to projects on prevention rather than treatment, care and support. The Monks at WatPa Nakounoi was one exception

since they will be involved with support work. However that project is in an early development stage.

CEDC/CNSP Street –children and orphans

The team has not been presented to any approaches to "youth risk groups "such as drug users, street children, sex workers trafficked children, orphans, sexually abused children. There are plans to address these groups in peer educator projects together with the Youth Union. More research is needed to describe the needs and the situation for these groups.

Some suggestions in brief

- research on sexual habits of youth
- research of conditions and needs of youth high risk groups
- specific male related approaches
- method-development for behaviour change interventions.
- Training and development on counselling

9. Conclusions and Recommendations on the MPB

9.1. Overall impressions

The overall impression of the consultants is that the MPB is a project/programme with a lot of commitment and energy. Some of the important conclusions from the evaluation in 1999 have resulted in new initiatives and developments while others still have to be implemented further. Many of the points highlighted below are similar to the recommendations of the evaluation (Appendix IV).

There are some impressive initiatives within the MPB. The MPB –team has managed to mobilise most of the country offices to work with them and to take on the programs launched by the MPB. We are of the opinion that this has contributed to the quality as well as the speed of the HIV/AIDS work within UNICEF as well as among some of its partners.

It is also quite evident that the UNICEF structure is suitable for advancing HIV/AIDS work. Some of the reasons are:

- UNICEF works with important target groups for HIV/AIDS intervention: youth, children, families and other caregivers and their environment
- UNICEF works at different levels of society and is more operational than other parts of the UN-family. In the scientific literature on social change it is stated that implementation of new methods, issues or paradigms require a possibility for the change agent to go between different levels and different systems[5051] Through its structure UNICEF is in a position to take on such a role.
- UNICEF works with key sectors such as Education and Health and with multi-sector approaches as well as community participation. Both of these strategies have proven important success factors in HIV/AIDS work. Through their sector work UNICEF also has the potential to support interventions being tested and then taken to scale within sectors (for instance PMTCT and Life-skills).
- Many of the ongoing, long-term UNICEF programs can be combined with or can integrate HIV/AIDS components. Long-term maintenance is essential for necessary societal and personal change required to combat HIV/AIDS.

9.1.1 Scaling Up

Since Sida puts great emphasis on the possibilities of scaling up interventions the consultants would like to conclude that the MPB gives ample possibilities for this. Indeed the Life-skills curriculum is already going to scale up in three of the

[50] Lippit, Watson and Westerley: The Dynamics of Planned Change. Harcourt, Brace and World, Inc. New York. 1958

[51] Pincus A and Minahan A: Social Work Practice. Peacock Publishers Inc Illinois 1974

countries. (Burma, Laos and Vietnam) and is on its way in Cambodia. In China the Yunnan province is positive but grappling with the logistics. Furthermore the MPB has been instrumental in spreading the idea of the Buddhist initiatives from Thailand to the other countries. Other possible approaches to scale up are PMTCT Approaches could furthermore be developed on how to use the Hope and Help to move from awareness to action on community care and support activities. This could give any existing community work system a possibility to scale up the support component.

9.1.2 Dilemmas to discuss

The evaluation of the first phase, the MP, found it successful and the result of the project was a mobilisation of key players and systems for prevention work in the Mekong sub-region. As a result of the evaluationUNICEF then decided to start a new phase were they at the same time want to sustain and scale up the interventions of the first phase and start the phase 1 in some new countries. We think this puts EAPRO as well as the country officers for HIV/AIDS in a new situation where they have to find their path out of some dilemmas. Below we are trying to highlight some of these as a basis for dialogue between EAPRO and Sida.

9.1.2.1 Width and Depth

HIV/AIDS is a complex problem. It affects almost all parts of society. The MPB in parallel is trying to encompass as much of this as possible. The result is that the MPB is very complex and has under its wings many sub-programs and parts. There are also many countries involved at various stages in the development of then different components and sub-programs. Some are in phase 1 and some are entering phase 2. The result is a complex and sometimes not transparent web of goals, objectives and action plans that are to be realised and monitored. The consultants understand the urge to expand a successful program to other countries. We also understand the whish to keep the number of staff small at the regional office or at UNICEF in general and save funds for what is sometimes called " the real work" and the grants to NGOs etc.

A study done on what promotes long term HIV/AIDS work has pointed out the necessity for change-agents and co-ordinators at different levels of a society (this is probably also relevant for regions). The reason is that HIV/AIDS is an issue for a multitude of sectors into which it has to be mainstreamed. Each of these sectors might see HIV/AIDS as important but not as its main task but as a task on top of everything else or as a marginal issue. [52]Such tasks are easily dropped for reasons of funding or time-constraints. And even more so when the topic is sensitive. To be successful in multi-sector implementation the different sectors and their organisations must find the work rewarding and easy to do with a minimal extra effort. Readily available technical support, materials and encouragement must come from somewhere. In our minds this role has been fulfilled by the MPB-team at EAPRO in relationships to the country offices but also to others. With more countries joining the MPB and many countries progressing at different levels the team needs to develop a strategy together with country of-

[52] For example the school system certainly sees basic reading and writing skills or mathematics as more important than HIV/AIDS education. This phenomenon is highlighted in the literature on Community Development. for instance in Henderson P et al: The Boundaries of Change in Community Work. George and Allen Unwin. London 1980.

fices on how to solve the dilemma between the change agents role in expansion to new countries and the change agent role in long term sustenance. In the earlier mentioned evaluation of the first phase there are suggestions (see appendix IV) there are some suggestions on the need for increasing country office capacity for the phase of scaling up, as well as joint prioritising We would advice Sida to discuss these issues with UNICEF

One of the solutions might lie in having some more staff put in strategic positions. Another solution might lie in a clarification of the different responsibilities of EAPRO and staff at different stages of the phases as well as the role of the country office. One idea could be to develop a body of local consultants knowledgeable on the MPB for technical support on different items or systematise the exchange within the region.

9.1.2.2 Dilemmas in formulation of objectives and outcomes

Going through the documents we also often found a slight shift in the goals or rather a constant reformulation of goals and objectives which make the project seem less transparent than necessary. We think this phenomenon might arise because the MPB is so complex and is trying to encompass so much and beat time in the current rapid expansion of the HIV/AIDS problem in Asia. Another reason might be the need to formulate goals and outcomes together with every important partner in order to get them on board. There is ample evidence that such methods give stronger commitment and ownership. On the other hand goals, objectives and outcomes will vary with every partner. The dilemma then is how to achieve the long term objectives and outcomes and not loose yourself in the mobilisation process.

Far from advocating against dynamic projects we nevertheless think it would be helpful for the MPB to clarify, its *main* objective, tasks and desired outcomes and make them very clear to everybody in UNICEF. For instance the regional team mentions condom promotion for youth as one of its main approaches in Component 1. Although condom promotion for youth certainly is important we have not found any systematic initiatives on this approach. There is certainly social marketing of condoms in most countries but rarely with youth as a special target group (the consultants only saw this in Vietnam). Nor is there any systematic combination of peer-education and social marketing of condoms for youth. There might be many reasons for this but one could be that there are simply to many main objectives and strategies to keep track of.

Although not solving the M&E problems fewer main objectives, strategies and tasks within the MPB would certainly make it easier. This does not mean that there has to be an exclusion of activities, but simply a prioritisation of the necessary main elements that have to be there and that have to be promoted through UNICEF. This also highlights what others could (and should) do and what UNICEF can do if there is surplus energy and funding

9.2 The Components – areas of activities

9.2.1 Prevention for Youth

Life-skills in school

Recent research into health promotion for youth supports the idea that "life-skills curricula" addressing emotional education in the shape of cognitive structures, decision making skills, self-awareness, self esteem and empathy in combination with knowledge of health and health hazards can be an effective health promoting tool. Research on sexuality education/ HIV/AIDS education shows that sexuality education can be effective in increasing contraceptive (including condom) use and pushing the age of first intercourse forward. The sexuality education should among other things be based on the Social Learning Theory, be participatory and in groups, address ability to talk about sexuality, address norms and values in a non judgmental way and avoid simplistic abstinence messages, address gender issues and have a clear condom message[53]. The philosophy of life-skills education and sexuality education coincide and the methodology and content overlap. Therefore it seems very relevant to push the idea of a life-skills curriculum with a strong sexuality education/HIV/AIDS component as a long-term preventive intervention for children and youth. Especially so, since drugs and alcohol also are a part of risk behaviour in relationship to HIV/AIDS and especially in the Mekong Region. They are also addressed in the same curriculum. School interventions are also cheaper and easier to sustain in the long run.

We saw considerable and impressive efforts from educational departments and UNICEF in trying to implement the life-skills curricula on large scale in the different countries. We only wish the same efforts were made in our own country. Having said this we would however like to share some concerns and dilemmas to be discussed:

- The objective of implementing life-skills in general can overshadow the sexuality part of the curriculum. The sensitive issues can be given a low profile for the benefit of having the whole curriculum adopted. What are the MPB policies on this problem? What results have come out of the review on the HIV/AIDS part of the SHAPE curriculum in Burma?
- All over the world teachers will hesitate to take up sexuality issues unless they have been able to train this specifically. They have to cross a number of taboos. They must train to say words and they must train to be non judgemental. Such training generally takes a few days. In some countries we learned that the whole teacher training was 1 week only for the entire life-skills curriculum. This gives cause to be concerned for the success of the life skills curriculum as a tool to prevent HIV/AIDS. This is possibly also the reason why the teachers we met still felt hesitant to be straight forward or to discuss condoms in the classroom. Some even let the youth read the chapter on sexuality by themselves.

[53] See for instance UNAIDS Review on Sexuality Education in School.

– The possibility to prevent one self from becoming infected by HIV is closely linked to skills in talking about sexuality and negotiate safer sex. This is something every person has to be able to do. It is an individual skill that cannot be learned via mass education on megaphone. In countries with a large population this is a big problem. How can it be addressed?

Points for discussion on further developments in summary:
– The implementation of the life-skills curriculum in school and the sexuality part of this curriculum still needs a lot of attention and development
– Teachers (and their head masters) need more or better training.
– Mechanisms for reaching youth in a meaningful way in countries with large populations have to be developed

Life skills out of school and general issues around prevention for youth,
Some of the concerns for the life-skills education in school are equally relevant for the out of school approaches. These were often designed as peer education. The skills of the peer educators varied considerably along the lines discussed above. They were sometimes not straightforward, hesitant to address the real issues of youth, supplying normative information. On the other hand we also saw some very good and quite straightforward educational sessions. In general however the consultants think that the out of school programs and the peer led programs find it easier to be more open. It is also easier to test different methods and exercises within this context. The findings could then also be used in the more formal school settings.

We would also like to point to the necessity of taking the out of school approaches to scale and not permit them become pilot projects that are left after the first successful implementation. It is especially important to reach vulnerable youth groups. In countries with Youth Unions and the like there is already an existing infrastructure. The formal status of YU might however limit contacts with marginal groups if one is not careful. In other countries one has to explore the platform of community initiatives (CASD or AFA) with other possible initiatives and co-operations and NGOs.

Furthermore there is a need to research the lives and needs of young people to be able to adapt the programs more to the life in general, the sexual life and alcohol/drug life of young people in the various countries. This could benefit the work both in and outside of schools. One reason for this need to create more knowledge is that the curricula we have seen seem to focus a lot on the adult sexuality (intercourse) and on the existing norms of behaviour rather than what is really taking place. More knowledge would provide basis for meeting young people where they are in relation to sexual expression and general social behaviour.

In preventive work for youth a lot of concern is given to girls as victims of coercion and/or lack of knowledge. Less attention is given to the attitudes and behaviours of young men. The notion that men simply cannot control their sexual behaviour was often heard during the sessions we attended. This misconception has to be challenged. Sida emphasises the gender perspective in HIV/AIDS. The consultants want to underscore that the "male involvement" is the determining part of the gender-based response to HIV/AIDS.

Condom promotion is stated as a major goal. However this does not always display in the interventions at local level. We know UNICEF not to have the prime responsibility for condom distribution. However we do think that condom promotion efforts could be strengthened. The condom promotion possibilities within the ongoing systematic approaches could be reviewed. Condom demonstrations and social marketing can be a part of all peer-education efforts. Condom demonstrations should be done within the life-skills education etc.

Finally we wonder that there is no explicit initiative to promote Youth Friendly Services from the MPB. We have however found such initiatives in some country offices. Research shows that it is the combination of sexuality education and youth friend services that have an impact on the behaviour of youth. Perhaps we have missed information on other parts of the UN-system taking these initiatives.

Points for discussion on further developments in summary:
- Peer-education efforts could be used for methodological development
- Youth components have to be integrated in the community approaches
- There is a need for qualitative research on the attitudes, beliefs and behaviours and lives of young people as a basis for methodological development and program development
- The youth programs in and out of school should try to develop approaches for young men
- There seems to be a need to review the condom promotion perspective within the main ongoing programs and projects
- There is a need for clarification on the role of UNICEF in Youth Friendly Services

Media projects
In most countries there is collaboration with and support for mass-media interventions, mainly via Radio. We find this excellent for the purpose of awareness raising and knowledge dissemination. Training for the journalists as well as networking and exchange between countries would probably be useful and cost effective. There is also a need for following up how messages on drugs and safer sex are taken up and understood by the target audiences. The media initiative in Vietnam could yield some interesting experiences.

Points for discussion on further developments in summary::
- Regional training and exchange for media partners could be of use for improving the quality as well as for regional advocacy purposes

9.2.2.Care, Support and PMTCT
We have seen many interesting interventions for care and support. Most of them are at an earlier stage than the prevention efforts that constituted the main bulk of the earlier MP. Now the amount of PLWHA and the number of children and families infected and affected make programs for care and support urgent. The pilot programs for PMTCT that the team saw were well organised and the quality seemed good. It is a vertical program in co-operation with the MCH and UNICEF is in a good position to do this work. The notion of VCCT could be introduced and highlighted at policy level through this program. The

counselling within the PMTCT program seemed to focus on the medical aspects. This needs to be complemented by psychosocial counselling.

HIV/AIDS is a health problem where there is need for a good deal of counselling for various purposes. The counselling component was highlighted in the evaluation of the fist phase. In general the team found this component to be weak in most countries. In the places where it existed it was mostly in the shape of medical counselling.. In some VCT test sites the counselling was good but in others it was obviously lacking. For the purpose of prevention for youth, for drug rehabilitation and for the purpose of support for mothers with HIV infection there is also need for psychosocial counselling. The MPB could discuss how to include counselling skills in the different programs. In order to achieve this there might be a need for building connections between NGOs and the existing health systems.

Points for discussion on further developments in summary:
- UNICEF should continue its efforts in PMTCT
- Psycho-social counselling skills need to complement the present activities
- Psycho-social counselling and pretest/posttest counselling needs improvement in many places

The Community Approach

The consultants understand UNICEF to be starting their development of care and support approaches for families and children. Experiences from other parts of the world point to community solutions for care and support for families. Through the different community development efforts (AFA, CASD) UNICEF has a good platform for awareness raising on care and support as well as actual implementation of home-based care and support programs. UNICEF approaches the community development initiatives in different ways. In some countries they mainly seem to work on co-operation between the local representatives of sectors. In other countries this is complemented by the formation of "grass-roots counterparts" at village level. The hat trick is of course, to find the exact right level in each country where it is at all possible to sustain local care and support interventions. In countries with low prevalence there will a limited possibility for self help groups to organise outside the main cities. There is still a lot of development work to do on how the HIV/AIDS work in the villages and cities can be linked to care, home-based care and micro credits for needing families and carers. The consultants would advice Sida to discuss the future plans to address these issues.

The Hope and Help videos and the connected educational sessions seem to have the desired primary results. They create awareness and positive attitudes towards PLWHA. This is at least a starting point. We are uncertain of which mechanisms UNICEF wants to utilise to move from awareness raising to action on care and support.

Since we have not been able to see all the videos or the manuals accompanying them we hope that they all also include sessions on drugs awareness. In the Mekong region this seems to be extremely important knowledge.

There are already some good initiatives by NGOs in support of widows in the countries with higher HIV prevalence, for instance in Cambodia. There is a

need for exchange on good practices between countries. The need to make many NGOs learn from these initiatives and develop many small- scale interventions might in itself be a strategy to scale up.

Points for discussion on further developments in summary:
- Sida should discuss the EAPRO plans concerning the long term sustenance of community approaches
- Sida should enquire into how the Hope and Help video can be used to move from awareness to action
- Sida should enquire into future plans on how to scale up support for HIV/AIDS affected families

The Buddhist Initiative

The connections to the Buddhist community modelled on the Thai experience, is probably one of the most important developments for care, support and the important de-stigmatisation of PLWHA. The Buddhist community has an infrastructure all over the countries. Therefore these initiatives could be taken to scale and can also combine with community development efforts. The monks and nuns are highly esteemed. Their involvement could possibly be catalytic to discussion of many sensitive issues. The team think that if it would be possible, qualitative studies could help the Buddhist communities evaluate and develop its work.

There is a tradition for the monks to take orphans into the Pagodas. However this can never be enough for the orphan problems connected to HIV/AIDS. Instead it would be wise to help the Buddhist community develop structures and methods to help communities support their orphans.

In some countries there are also other large denominations that could be used. The religious communities sometimes have problems with the preventive side of HIV/AIDS work but never with the humanitarian aspects of care and support.

Points for discussion on further developments in summary:
- UNICEF should continue and expand its partnership with religious communities on care and support
- UNICEF should encourage the efforts for community support for orphans by Buddhist monks

9.2.3 Orphans and children in need of special protection

Even without the HIV/AIDS problem orphans and street children is a great problem in most of the countries. This problem will now increase. Orphans are furthermore one of the most vulnerable groups. Their rights are often violated. It is well known that HIV/AIDS orphans might suffer discrimination. It is of vital importance to get more knowledge on the situation of orphans for the purpose of good practices to be used in the respective countries. This must be a major task for UNICEF together with partners. Also the situation of orphans is an important issue for advocacy. Through strategic advocacy it could be possible to challenge the idea that orphanages are the only solution for these children.

Many orphans risk ending up in the street. Children in need of special protection are of special concern to Sida. The MPB is not primarily a CNSP pro-

gram/project. If Sida wants to support more comprehensive programs or projects for CNSP other mechanism have to be found. These children are nevertheless extremely vulnerable for HIV/AIDS. Therefore these programs and partnerships need to strengthen on the aspects of sexuality, drugs and HIV/AIDS as was already pointed out in the evaluation of the MP.. We found most of the children we met had been subject to sexual abuse and paedophiles. Psychologically this will make them even more vulnerable. To try to heal these children psychologically simple counselling techniques could be taught to orphanages and other organisations that meet the children.

Points for discussion on further developments in summary:
- Advocacy strategies on best practices for care of orphans seem necessary
- Sexuality and drug component in the care of street-children needs strengthening
- Staff meeting street children need counselling skills on abuse

9.2.3.High Level Advocacy

We understand UNICEF to be active in the UN theme groups and at various summits on regional level. There has been HIV/AIDS training for all resident representatives and other management staff. Many of the representatives take up HIV/AIDS in their diplomatic work.

As the MPB has developed from mobilisation of UNICEF offices and pilots to scaling up programs there is even more need for advocacy. Taking some of the programs to scale requires more commitment from the national leadership. UNICEF has been successful in obtaining such commitment in some instances. The consultants think it would be useful to summarise the lessons learned as a basis for more conscious work in this direction. When the consultants visited the EAPRO office the negative and judgemental attitudes of adults and policymakers towards young people were highlighted as one of the major obstacles for success. It seems to us that a proper strategy for advocacy on these matters could be of major importance.The regional approach might be especially useful for this purpose.

Points for discussion on further developments in summary:
- Summarise lessons learned on advocacy in the region
- Develop systematic and strategic advocacy to change policy makers attitudes to young people

Appendix I HIV/AIDS in the Mekong Region

Although established in Asia since the 1980s the spread of HIV/AIDS seemed relatively slow during the 1980s and 1990s, compared with other regions such as Africa and the Caribbean also in populations with high risk. Even in the late 1990s reports maintained only Thailand, Cambodia and Myanmar and some pockets in China and India had established epidemics[1]. In the last two years this picture has changed dramatically.[2] While sentinel surveillance seems weak in some countries, a number of directed behavioural surveillance studies[3] combined with existing surveillance data will explain some risk factors as well as of the current trends through which we can see a spread from high risk- groups into what is sometimes called " the general population". Analysing the data a complex pattern emerges whereby it is clear that there are no real boarders between these groups rather that the pattern of risk factors might be somewhat different from Sub- Saharan Africa but nevertheless fuelling the spread of the epidemic and that the epidemic could spread with the same speed. Below is an account for risk factors and the effects of HIV in the region. In short the situation can be summarised in the 4 bullet points below:

- There are more risk factors in Asia than in Africa
- There are more people in Asia than in Africa
- Risk populations /risk behaviours are interlinked and overlapping. This speeds the spread. HIV is moving from so called risk populations into the general population.
- There is little exact knowledge on prevalence in many of the countries in the Mekong region.

Immediate causes

The trade of sex for money

The most common risk behaviour for HIV across Asia is the trading of sex for money. Substantial proportions of men in many countries regularly buy sex and hundreds of thousands of young women make their living on supplying it. Among male work forces such as police, army, construction workers and drivers up to 70% regularly buy sex. If they are unprotected they spread HIV to other sexual partners, other CSW, girlfriends and wives. Many young men have their first sexual encounter with a sex worker. Prostitution can be said to fall in three categories. Women in pimp- or madam controlled brothel houses or large brothel complexes, free-lance or pimp-controlled street sex workers and women in "the entertainment industry", bar girls, girls working in massage parlours and girls promoting beer, [4]beer-girls, often young women and girls moving from the countryside into towns and cities. Karaoke bars and beer-gardens are emerging along the expand road network and with the expansion of towns and cities. This is the big drinking scene and one should not underestimate alcohol as a risk factor for unprotected sex. These young women often between 16-25 are often called indirect or floating sex workers, since not all women working in these places sell sex. And those who do might only do it occasionally. *A lot of the preventive efforts in the region have been directed towards increasing condom use in these groups and studies show that the work has been successful and more so the more "institutionalised" the sex work*

[1] *MAP – Monitoring the Aids Pandemic. Status and Trends in Asia and the Pacific*. 1999.

[2] *MAP- The Status and Trends of HIV/AIDS/STI epidemics in Asia and The Pacific.* Oct 4 2001. Melbourne. Australia,

[3] *What Drives HIV in Asia.* FHI. HIV/AIDS Prevention and Care Department. 2001

venue. The same trend can be found among the women as well as their clients. Condoms are available in all major towns and cities although not always in the countryside. They are also part of social marketing programs making them affordable. However the indirect sex workers as well as their clients are less consistent in condom use. Sex workers are often married or have boy-friends. They do not use condoms in these relationships. Nor do their clients use condoms in relationships with wives or girl friends. A special part of the commercial sex is the fact that there are old and new venues for paedophiles in many of the countries. They often target street children. Children are also trafficked for purpose of commercial sex. The knowledge on sexual abuse of children in Asia is scarce.

IDU

Injecting drug use is emerging as a main risk factor. The regions close connection to centres of illicit drugs production and transport seems to be a major direct cause of the current speed of the epidemic. There is a big lack of information on behaviours and trends in the IDU group.[5] Opium and Hashish have been traditional drugs and smoking them the traditional behaviour. In the mid 90-ties heroin began to flow along the expanding and often changing trafficking routes from the Golden Triangle. This attracted a new group of users, mainly low income or unemployed youth also mostly with poor education. The price of heroin along the trafficking routes is low. In general it seems the population was unaware of the dangers with the new drug or even unaware that it was narcotics. In the late 90s the drug taking practices changed from smoking to injecting the drugs. Needle sharing is common. At the same time Methamphetamines were also introduced (probably produced in China). These are also increasingly injected. This young population of IDU is also sexually active and also customers to CSW or CSW themselves. Estimates say that there are 7 million drug takers in China of which half are IDUs. This group now accounts for 70% of the cumulative cases. The rate of HIV infection is high and increasing. Reports also show that male dominance in IDU is changing. More women are using drugs and also become involved in commercial sex in China and Vietnam. Government responses to the drug problem is in general very weak and more concerned with the legal implications of drug taking rather than the public health implications. Treatment if any is coerced and recidivism is 70-90%. Alternative treatment or harm reduction programs are mainly run by NGOs or INGOs.

MSM

In several countries there is an active commercial sex market where men sell sex to men – and sometimes also to women. Studies show that MSM also have a lot of relationships with women. They are often married. In Cambodia 40% 0f MSM interviewed also had sex with women. Although there are active "Gay-groups" in some countries most MSM identify as heterosexuals. Homosexuality is not openly discussed and young homosexual men are at great risk of becoming infected because of ignorance. The MSM are in high risk because of ignorance and stigmatisation but also because anal sex is an important and high risk behaviour. Studies show that anal sex is practiced among MSM and also to a surprisingly high degree in heterosexual commercial sex. Few studies show if this is a practice in other relationships.

Mobile populations and workforces

Mixing between persons or population groups with different levels of risk behaviour seems the most important determinant of the spread of HIV in Asian countries. However physical movement is actively contributing to this mixing. Many people are highly mobile and many

[5] *Revisiting "The Hidden Epidemic", A situation Assessment of Drug use in Asia in the context of HIV/AIDS.* The Centre for Harm reduction, The Burnet Institute, Australia Jan 2002

persons with risk behaviour especially so. Young people move to commercial centres to seek jobs, even migrate across boarders. The stable population might add to its income through seasonal migrant labour. The brothel controlled sex workers are highly mobile. The trafficking of women and children in the region constitutes a special and horrible addition to this pattern.

Youth in general

The risk situations and behaviour of young people are the determinants of the future epidemic. Most of the risks mentioned above concern young people. However the studies of young people still living at home do not disclose such behaviour to a large degree. The conclusion would be that leaving home is a major determinant for more risky behaviour. However research shows that patterns of premarital sex are changing in general among the youth. As mentioned above vulnerable children and youth are at extreme risk of infection and
There is alack of proper research and in debt information of sexual knowledge, attitudes and practices of young people. There is also a need to research their knowledge attitude and behaviours in relationship to narcotics.

Underlying Causes

The same factors as in other countries are the underlying causes- poverty, extreme gender inequality, low education levels and a lack of human rights are the main ingredients. In some countries the lack of public infrastructure such as schools, health care contribute greatly to the lack of appropriate responses. In Asia some special underlying factors could also be mentioned. The opening up of the relatively closed peoples republics and the invitation to economic expansion has created a fast growing construction and infrastructure sector. It has furthermore eased the cross-boarder migration including the illegal one. The economic expansion seems to boost the economy in the region in general but at the same time create big income gaps that open up to exploitative situations because of lack of HR and appropriate legislative /control systems . Back-water spots suddenly find themselves becoming economic hubs or in contact with economic hubs, Young people will want to earn a "quick buck". At the same time parts of the old controlled and closed society prevails and there is fear of general attitude change that also fuels misconceptions and adequate responses.

Immediate Effects

Table 1. HIV in East Asia (Sub- Mekong Region) 2000[6]

	Prevalence 15-49	**Number**	**Proportion fem. 15-49**	**Proportion Fem. 15-24**	**Proportion Male 15-24**	**Est. number HIV+ children**
Cambodia	4.04%	210.000	34%	3.5%	2.4%	5.400
China	0.04%	500.000	12%	0.02%	0.01%	4.500
Laos	0.05%	1.300	50%	?	?	Under 100
Myanmar	1.99%	510.000	35%	2.30%	1.20%	14.000
Thailand	2.14%	740.000	41%	2.30%	1.20%	13.900
Vietnam	0.24%	99.000	20%	0.10%	0.3%	2.500

[6] *Every Last Child.* UNICEF EAPRO (Source: UNAIDS 2001)

The table above gives the official view of the HIV epidemic in the Sub-Mekong Region. Please note that the sentinel surveillance is deficient in many of the countries and that UNAIDS estimate the numbers could be much higher. The numbers are often based on a combination of MCH screening and surveillance of risk groups. However in countries where confidentiality is poor marginalized high risk groups such as IDU, CSW or MSM are very hard to identify and reach.

Immediate effects of the HIV epidemic in countries with this type of prevalence and infection pattern is a pressure on the Health Care Sector because of opportunistic infections. There is also an immediate effect on the treatment and care IDU which has to address the growing infection rate among its inmates as well as the fact they are becoming younger. The need of support for poor families and for an increasing number of widows is showing and the number of orphans and thus street children are increasing and needs a proper response.

Table 2: Cumulative number of Aids Orphans under age 15 [7]

	Cambodia	**Myanmar**	**Thailand**
Lost mother or both parents – all causes	167,900	537,900	222,700
Lost mother or both parents – HIV/AIDS	45.500 (13.000)	71.000 (43 000)	44.300 (75 000)
Paternal orphans – all causes	205 ,00	657,400	272,200

The figures in the parenthesis are the UNAIDS official estimates. However the number of AIDS-related deaths are often grossly underestimated in countries where there is a stigma or where prevalence is not yet high enough for the knowledge on symptoms to be widespread. Although some of the children included in the table are likely to have been HIV+ themselves and have died there is still a big need for more systematic care and support interventions.

Some take reassurance in the fact that only Thailand, Cambodia and Myanmar have prevalence rates over 1%. Unfortunately national averages are not very meaningful in countries where one province is like a big country in itself. The Yunan province in China has a prevalence rate of 4 % and the reported infected number of HIV+ IDU have risen by 67% during the first 6 months of 2001. HIV epidemics always begin with localized outbreaks and or outbreaks in certain groups. [8]

Long term effects

Based on the current speed of the epidemic UNAIDS maintains that there is now a three year window to act before the long term effects will greatly impede the development in the region and cause major trauma for all countries involved. Even at the current prevalence rate the huge populations in some of the countries will result in an AIDS tragedy and poverty will increase in the already poor.

[7] *Evey Last Child,* Unicef Source: Hunter and Williamsson (2000) .*Children on the brink.* Washington. USAID
[8] *AIDS epidemic update. December 2001.* UNAIDS

APPENDIX II Terms of Reference

Sida

DESO/Health Division
Gunilla Essner May 22, 2002

TERMS OF REFERENCE FOR THE FOLLOW UP OF THE SIDA SUPPORTED UNICEF PROJECT "THE MEKONG PARTNERSHIP AND BEYOND", HIV/AIDS/STD PREVENTION AND CARE IN CAMBODIA, CHINA, LAO PDR, MYANMAR, THAILAND AND VIET NAM, TWO SEPARATE MISSIONS IN JUNE AND OCTOBER-NOVEMBER 2002

Background

This regional programme started effectively in 1997 and was mainly funded by the Netherlands until 2000. A review of the first phase of the programme that was carried out during 1999-2000 showed that the Programme had clearly met its objectives and should continue to be funded.

The Mekong Parnership is a UNICEF HIV/AIDS programme in East Asia and Pacific Region building on the foundation laid by the Mekong project (1996-1999) in strengthening national and inter-country responses. The Mekong partnership proposal has been designed mainly by UNICEF but in consultation with a range of partners, including UNAIDS and the UNAIDS co-sponsors in the participating countries and the regional level.

The overall objective of the programme is to reduce HIV transmission on children, young people and families, through increasing the effectiveness of national and intercountry responses to the epidemic in the Mekong Subregion, and providing practical support at community level, encouraging full participation of people affected.

The design of the Programme is the same in all the participating countries focusing on:

(1) Behaviour Development and change;

(2) Development and Integration of Reproductive Health Services;

(3) Care and Support for People Affected by HIV/AIDS including counselling training;

(4) High Level Advocacy; and

(5) Capacity Building for National and Sub-national Government Officials and Local Implementing Partners as a cross cutting mechanism in all activities.

The target groups are:

(1) Children, Youth and Young People;

(2) Women;

(3) People Considered Vulnerable;

(4) Policy Makers and Government Officials; and

(5) Implementing Organisations/Groups.

The Mekong programme includes interventions directed to Children in Especially Difficult Circumstances (CEDC), an area which Sweden gives high priority to in its development cooperation. Sweden initiated the first international conference on combatting sexual abuse and sexual exploitation of children and youth.

The total project budget for three years including all project countries is US$24 million, out of which amount 17,8 US$ million is specifly for the Mekong Sub-Region.

Sida and Unicef have signed an agreement on Swedish support to the project at 30 Million SEK. Sida has also allocated 2 Million SEK for Consultancy for Sida-follow-up and preparation for annual review meetings, and technical assistance of the UNICEF Program.
The technical assistance will be upon request by UNICEF and within the financial frame of the Sida-funds to a total amount of 1,4 MSEK for the three-year-period.

Areas of particular interest for Sida's learning about the subject matters of the project are: Behavioural development and Change, Care and Support and Capacity Building within the identified areas below, Child/Adolescents Rights, Gender Equality, Sustainability and Country Ownership.

The following aspects are of particular interest for Sidas learning about the project:

- the following target groups: (a) children, youth and young people; (b) Policy makers and Government Officials; (c) Implementing Organisations/Groups.

- Sexual- and reproductive health and rights (SRHR) as the main area of focus including: (a) Lifeskills development for in and out-of-school children and integration of youth health concerns into formal and non-formal education (this falls under lifeskills development in UNICEF's project proposal); (b) Awareness raising of policy makers/Implementing Organisations/Groups and mainstreaming of health concerns for youth through training (this would fall under UNICEF's activities on advocacy/policy/capacity building in the project proposal); and (c) Development of SRHR services (this could fall under UNICEF's activities on small grant facility in the project proposal).

    - the six Greater Mekong Subregion countries, namely, Thailand, Myanmar, Viet Nam, Cambodia, Lao PDR and China.

It is a recent development at Sida to try and look for opportunities to involve young people in planning, implementation and follow up of programs related to adolescents. Therefore, Sida will include representatives of young people in this mission. The most important is of course to include young people involved in the program countries. However, Sida is also trying out possibilities to involve young people from Sweden to help Sida to better understand the youth perspective and to develop a resource base of young people as consultants. The youth representatives will participate in the mission on the same terms as the elder members as regards the tasks of the team.

Purpose of the mission

To review the ongoing activities in relation to the stated objectives.

The report from the mission, as well as the Project´s progress reports, will be an important input to Sida in the Annual Review meeting between Unicef/EAPRO and Sida planned to take place in November 2002.

To give recommendations on the plan of activities and the scope of strengthening the services.

To give recommendations on the scope and rate of expansion of the project, taking account of quality control.

Tasks of the Mission

Sida is interested in the implementation and management of the project, in order to be able to appreciate the value added that a regional approach might have in relation to a bilateral approach, as regards for example the management routines, flow of financial resources and the flow of knowledge in the project and between the countries. In order to be able to make a minor assessment of this the Team should be able to look into the following issues:

- the Project Document and the Plan of Action including the budget and any other relevant document,
- the progress of the programme and its expansion,
- the gender balance at various levels,
- the rights situation and the health/nutritional status of the children/adolescents in the programme,
- the involvement of the community,
- the recommendations of the Assessment,
- recommend areas and issues to follow up in the forthcoming Sida-Unicef/EAPRO Annual Review in November 2002.

<u>Management</u>

- the financial situation in relation to the project components,
- routine fund flow from central to district and below, information and transparency,
- the process of monitoring, reporting and indicator development,
- the organisational and administrative setup,
- staffing situation in the programme, vacancies and transfers,
- competence development/capacity building within the programme of staff, at all levels,
- intersectoral coordination with the health, the education and other departments and with concerned stakeholders as parents, children/adolescents, women´s organisations, youth groups, NGOs etc.

<u>Training</u>

- assess the training inputs regarding the child/adolescents rights perspective,
- describe changes occurred as a result of the training,

Method of work

The basic documents for the mission should be:

- Project Document covering the period 2001 – 2003,
- Progress Reports
- Report from the Assessment
- Swedens HIV/AIDS Strategy “Investing for future generations”

The follow-up will be carried out in two separate missions, one in June and one in October-November 2002 in connection with the review meeting.

The assignment will be planned together with UNICEF/EAPRO with feedback to UNICEF/EAPRO representatives both local as regional level, after each assignment.

Emphasis on this assignment, on the part of Sida, should be made on learning, partly on the regional approach, and partly on the areas of activities. The identified areas are interesting for Sida for future support to other similar projects. Best practices for adolescents sexual and reproductive health and rights and children in especially difficult circumstances are of particular interest to Sida.

Before making the field visits, the team shall be briefed by Sida/DESO/Health Division, Stockholm and UNICEF/EAPRO, Bangkok. In the GMS region the team shall meet and discuss with the project officers and make field visits to selected districts and interact with the projectstaff at all levels.

Participants

The team will be gender sensitive and gender balanced; include youth representatives; have experience from work in Asia; and be knowledgeable in monitoring and reporting techniques. The consultants will cover the issues of management (financial and delegation of project planning and implementation), adolescents sexual and reproductive health and rights and children in especially difficult circumstances.

Reporting

The report should cover a summary from each country and contain a brief assessment of the value added that a regionally based project might be providing. The report will provide an important input into Sida´s continued work with children/adolescents and HIV/AIDS in GMS.

Observations and recommendations made by the team shall be presented to UNICEF/EAPRO representatives in Bangkok by the mission before leaving and to the Health Division in a draft report by latest 3 weeks after arriving in Sweden.

The report will be written in English and should not exceed 30 pages, excluding annexes. A Summary shall be written in the introductory part of each Report. The draft report from each of the two visits shall be submitted to Sida electronically and in 5 hardcopies (air-/surface mailed or delivered) the first report no later than July 15,

2002, and the second report no later than November 30, 2002. Within 3 weeks after receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in 5 hardcopies. The reports must be presented in a way that enables publication without further editing.

Time Plan

June 2002 - 4 weeks

October-November – 3 weeks.

Appendix III Travel Plan

Thailand

Arrival Bangkok:	June 2, sun
Departure Bangkok:	June 3, mon

Cambodia

Arrival Phnom Phen:	June 3, mon
Departure Phnom Phen:	June 6, thur
Arrival Battambang:	June 6, thur
Departure Battambang:	June 8, sat
Arrival Phnom Phen:	June 8, sat
Departure Phom Phen:	June 9, sun

Mynamar

Arrival Yangon:	June 9, sun
Departure Yangon:	June 11, tues
Arrival Monywa:	June 11, tues
Departure Monywa:	June 13, thur
Arrival Mandalay:	June 13, thur
Departure Mandalay:	June 14, fri
Arrival Yangon:	June 14, fri
Departure Yangon:	June 16, sun

China

Arrival Kunming:	June 16, sun
Departure Kunming:	June 19, wed
Arrival Mangshi of Dehong:	June 19, wed
Departure Mangshi:	June 20, thur
Arrival Kunming:	June 20, thur
Departure Kunming:	June 21, fri

Laos

Arrival Vientiane, Laos:	June 21, fri
Departure Vientiane:	June 25, tues

Vietnam

Arrival Hanoi, Vietnam:	June 25, tues
Departure Hanoi:	June 27, thur
Arrival Ho Chi Minh City:	June 27, thur
Departure Ho Chi Minh City:	June 29, sat

Appendix IV Summary of Evaluation of MP and the Action Plan for 2002-2003

SUMMARY OF EVALUATION

These were the main recommendations for further development by the team evaluating the first phase-:
There should be a shift from providing solution to introduction of problem solving approaches and skills (including a normalisation of the discussion of risk behaviours.)
There should be better cultural and social/behavioural analysis in order to understand vulnerability and especially on youth and drugs and youth and homosexual behaviour
.There should be more involvement of PLWHA as well as bigger attention on the increased demand for care and support. and more sharing between countries.
In the next phase there should be an emphasis on scaling up successful projects into programs. When scaling up the life-skills program attention should be given to resource materials .Furthermore vulnerable groups such as CNSP and youth from cross border populations should be given more attention through peer- based work.

A need for better co-operation with reproductive health services and networks was identified. Better integration with safe-motherhood programs could be done through the work on PMTCT. Furthermore UNICEF should support development of care and support programs for women and children as well as identify its own role in these programs. Counselling was identified as an area for development.

UNICEF should continue to build and support capacity at different levels the education sector.

The regional office should build capacity in the country offices to cover all technical areas and involve them more in prioritising the tasks of the regional office and also be more active in co-operation with UNAIDS. Finally monitoring and evaluation should be given priority

THE ACTION PLAN FOR 2002-2003- SPECIFIC OBJECTIVES[1]

The five components (projects) of the HIV/AIDS programme for 2002-2003 will be:

- Advocacy and Programme Development
- Prevention of Mother-to-Child Transmission
- Youth vulnerability --- HIV/STI and Drug and Substance Abuse
- Care and Support
- Country Programme Support

Project (1): Advocacy and Programme Development
Specific Objectives:

Develop a specific strategy and support activities to strengthen regional and national advocacy and for seeking top level political commitment within regional forums and at all regional events involving top political and economic leadership, and with key private sector leaders.
Ensure that key regional priorities for HIV/AIDS prevention and care are effectively placed on the agenda of all key regional meetings and in all meetings in which UNICEF participates in other parts of the world

Project (2): Prevention of Mother-to-Child Transmission

[1] Info Note 3- EAPRO HIV-AIDS Workplan 2002.doc

Specific Objectives

By 2002/2003, comprehensive PMCT programmes are in place in most affected countries in the region, namely Myanmar, Cambodia, Papua New Guinea and specific provinces of China.
By 2002/2003, PMCT will be initiated as an entry point for broader HIV/AIDS prevention activities in most populous countries in the region - China, Vietnam and Indonesia
By 2002/2003, PMCT conducive programme/project policies, strategies and activity plans are well defined in countries affected by HIV/AIDS
Development of feasible infant feeding options for mothers who are HIV-positive in resource poor countries, worked closely with Health/Nutrition officers.

Project (3): Youth vulnerability - HIV/STI and Drug and Substance Abuse
Specific Objectives:

All countries with the exception of DPRK have a realistic and practical framework - a supportive and enabling environment - for HIV/STI prevention for young people, including access to necessary reproductive health services and necessary commodities.
Young people have knowledge, attitudes, and skills for HIV/AIDS prevention, care and support
Increased policy and programme attention to Drug and Substance Abuse and Men having sex with men.
VCT developed and promoted as a key prevention tool with young people.

Project (4): Care and Support
Specific Objectives:

Responding to the impact of HIV/AIDS on children -- infected and affected - becomes a high priority at country level.
Expansion and strengthening of Buddhist/Religious Leadership Initiative.
Increased acceptance of people with HIV/AIDS with support from the With Hope & Help video module. Initiate care and support activities in Myanmar.

Project (5): Country Programme Support
Specific Objectives:

Appropriate technical support to the preparation of country notes, CPRs, Annual Reviews and MTRs.
Strengthen the capacity of the Country Office and Country Programme in responding effectively to epidemics, and scaling up current support to national responses.

Financial and Human Resources

UNICEF will spend a projected US$50 million on HIV/AIDS prevention and care over the 2002-2005 period, responding to elevation of HIV/AIDS to one of UNICEF 5 global priorities within the UNICEF Medium Term Strategic Plan 2002-2005. This amount represents more than 10% of total Country and Regional Office expenditure, exceeding the global MTSP target in supporting inter-country initiatives, strengthening technical partnerships, and increasing Country and Regional Office capacities.

As part of the upscaling and strengthening of UNICEF support to national and intercountry responses to the epidemics, UNICEF is also establishing international and national HIV/AIDS posts in most countries in the region. To date 9 national officer posts and 10 international posts have been established.

Appendix V

Youth Representatives on Sida Missions
Experiences and ideas for further development

by

Ida Strasser and Jakob Strasser
September 15, 2002

For Sida,
Department for Democracy and Social development
Health Division

"The youth of today love luxury.
They behave badly and denounce authority.
They do not show respect to their elders
and love idle gossip instead of work."
Socrates 450 Bc

1. Background

Sexual and Reproductive Health as well as HIV/AIDS are two development issues of great concern to Sida. Sida also underscores the Convention on the Rights of the Child. The latter stresses participation of youth in issues concerning themselves. The possibility of bringing youth more closely into the Sida´s work came up during the planning of the monitoring consultancy on the Mekong Partnership and Beyond program. Sida is for this program goes mainly to work with children and youth.

2. Purpose of participation

The purpose of our participation was to give Sida input on the possibility of having youth represented in different mission concerning youth. Below we try to summarise our suggestions.

We would also like to take this opportunity to thank Sida and UNICEF for allowing us to participate in this interesting mission.

3, Benefits and Constraints with Youth Representatives

3.1 Benefits

The general discussion on youth participation is built on the belief that young peoples lives are influenced from many sources and that only young people themselves can vouch for how they think and act not any one of the "influences" (parents, school, religious leaders, etc). Young people are aware of the fact that their different "gate-keepers" might have different attitudes and norms and also have power over them in different ways. They therefore might hesitate to speak openly with any adult. As an YR we found the young people we met on different study visits liked to approach us. Since we were engaged in the same issues we could share experiences and talk openly and they told us very frankly about matters they themselves said would be difficult to discuss with their leaders or at home, for instance about the behaviour of friends (or perhaps themselves). Friends who regularly went to brothels or girlfriends that had had abortions in secret etc. Our conclusion is, that the more time a YR has to meet their peers on a mission the more qualitative information can be fed into the mission as a basis for discussion with project managers or policymakers. In a consultancy or other mission the YR could have a slightly different program allowing for maximum use of her/his position to get into contact with youth.

The notion young people should be the object of change rather than the partners in change guides

most work with youth all over the world. There are quotations on how badly young people behave since Socrates. Most people have this view as an integral part of their belief systems. This also includes normal consultants and officers of any UN or other organisation. The idea of an YR challenges this notion and will give the mission and the discussion a slightly different angle in regarding young people as resources. One idea that came up when our discussing youth representation with the other team members was to bring a YR from a similar project that Sida was supporting somewhere else. Sida supports many YSRHR projects in Africa. We have met some of the youth who are active in these projects. One of them could be a part of a mission. Of course the person has to be chosen carefully, as is discussed below.

3.2 Constraints

Any consultant or Sida officer that takes on an YR in the team must be willing to spend some time on supervision for the YR. The more skilled the consultants or officers are, the quicker they want to work. With an YR this is perhaps not possible. Time for such supervision has to be included in the planning. Perhaps not every officer or consultant is willing to take on such a task.

4, Issues of concern

We found three main issues of concern related to the YR project

1. Choice of person
2. Function of YR
3. Personal development of YR

4.1. Choice of person

The YR should have the following qualities:

Good English, both written and spoken

In many of the countries the persons interviewed speak poor English or with an accent that might be unusual for a Swede. On this particular mission the tempo was high and there were rapid changes between dialects and modes of expression. The ability to grasp what people say increases with the experience of different English-speaking environments.

Writing skills

The YR must have writing skills, being capable of taking her or his own notes and summarize their impressions and views in writing.

Previous experience of the issues dealt with in the mission in question

Every mission has its technical focus. It is necessary for the YR to have knowledge on the theme of the mission to be able to give any meaningful input. This could be either through participation in similar programs or issues in their own country, in other countries or perhaps through studies. You have to be able to see through the surface of every presentation and to compare it with other similar ventures.

Previous experience of developing countries

Daily life in developing countries differs a lot from West, at least on the surface. The first time you experience this difference you might suffer from the “culture shock” during the first days or

week and not be able to actually participate fully in the work.

The ability to function in what may be both physically and mentally stressing situations
On this particular mission we had a number of emotionally upsetting encounters. For instance we met families affected by HIV/AIDS living in extreme poverty and street children and orphans who had been subject to terrible abuse. Even if you have past experiences of poverty such situations are difficult to handle. The team leader therefore must be able to discuss it with the YR and the YR must be prepared that such instances might arise.

Outspoken and not afraid to talk about difficult issues
The YR must be able to ask sensitive questions and speak their mind in a polite but firm manner to be taken seriously as a part of the mission. This is another reason why the language skills must be good. You also need to have some personal confidence and social skills.

4.2. Function of YR
We felt that the outlines for the YR project were a bit blurred but understand that this was due to limited preparation time. However, both of us felt the need for some set guidelines.
SIDA should be specific about what the YR's work should result in and what is expected of him/her during the trip. It would be a good idea to think of a specific goal or mission for the YR. Should his/her observations be part of the general rapport or should it be something on the side? The schedule needs to be planned with the YR in mind. Special YR- related activities should be implemented. Time should be given for the YR to make deeper contacts among youths met on the trip, those involved in the project as well as the target groups.

4.3. Personal development of YR
The YR would most likely be someone who is already working with related issues and some thought should be given to how the knowledge from the mission could be implemented into the YR's studies or work afterwards. One idea would be to bring someone working on a thesis in the field or someone working in a project similar to those visited on the trip.

5. Conclusion
In this report we have tried to present a few points that we feel are of importance when considering implementing the youth representative project. First of all we would like to say that we think it is a very good idea to bring a YR on trips. It is of value both to the YR, the SIDA-team as well as the local teams. An YR sees things from another perspective than a trained team member and during the Mekong project this was received in a very positive way. However, we are not certain an extensive and full mission such as the follow up of the Mekong Partnership and Beyond is the ideal mission to bring an YR on. Since this trip covered 5 countries in 4 weeks the pace was quite hectic and we think it would be of more value for Sida as well as the YR to have more time in one place in order to both see how the team works and do some work on his/her own. On the present mission there was little time to make changes in the schedule to accommodate the YR ideas and needs. If, however, some more thought and time is given to the structure and form of the YR project we are certain that it would be very beneficial to everyone involved in the project.

Appendix VI Persons met

In the list below you can find most of the persons to whom we talked during our field visit.
We also participated in lager meetings and in educational events where it was difficult to get the names of the participants. Hence we have not been able to include them in the list. We apologise for misinterpretations of handwriting and our own disability to spell names correctly or any other mistakes that do occur.

Visit to Unicef East Asia and Pacific Regional Office, Bangkok

P.O. Box 2-154
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E-mail: eapro@unicef.org or initial and last name in one@unicef.org

Rodney Hatfield, Deputy Regional Director
Robert Bennoun, Regional Advisor
Greg Carl, Regional roject Officer, behaviour devlopment and change, lifr skills
Prue Borthwick, Regional Project Officer, care and support/inter country exchange
Thazin Oo, regional Project Officer, prevntion of mother to child transmission

Cambodia

'UNICEF Office

Louise-Gorges Arsenault Representative
Tomoo Hozumi, Programme Coordinator
Fabrice Laurentin, Consultant to the Interdepartemental Committe of the Ministry of education, Youth and Sport
Etienne Poirot, Project officer HIV/AIDS
Sedtha esponsible for PMTCT
Carolina Strandberg, Assistant Programme officer

The Working Group of the Inter-departementalCommitte on HIV/AIDS, Ministry of education, youth and sports (MoEYS)

Mr Pen Saroeun, Director of School Health Dept
Ms Hak Yanny Deputy Chief of Information and Dissemination Office
Ms Ham Sam Ath Department Primary
Ms Kim Sanh Dept of School Health
Mr Yung Kunthearith Dept. Of School Health
Mr Kem Sy Huoth Dept of Sports
Mr Ter Oeun Chief of Planning
Mr Som Savoeun Chief of planning, Youth Dept.
Mrs. Chhay Kim Sotheavy Deputy Director of School Health Dept.

Ministry of Cults and Religion (MoCR), Core group on Religious Response to Hiv/AIDS

H.E. Dok Narin, undersecretary of state
The venrable Seng Sonomy, Deputy director of national Buddhist Education

National Aids Authority

Nuth Sokhom, MD Permanent Vice Chairman
H.E. Ly Po, Prof. Secretary of State Vice Chairman

RHAC –The FPA of Cambodia

RDr Ouk Vong Vathing, Executive Director
Dr Chea Sovan, Program Officer

The Womens Media Centre of Cambodia

e-mail: wmc@forum.org.kh
Ms Som Khemra, Co-director, Director of TV Programs
Ms Channy Pkeakdey, producer
Ms Vuon Soviey

Seth Koma –Community Action for Child Rights, Kampong Speu province

Ms Kim Malis co-ordinating com, Health
Mr Ian Som Am Director of Seth Koma in Kampong Speu
Mr Seng Ly Vice chief of , agricultur officer
Mr Ung Sok Kan , Vice director of Planning
Mr Im Sophal , education
Mr. James Meiklejohn, Unicef
Villagers from Chamkar Sleng

Nyemo

Simone Herault, coordinator
Virak Hoeung, Coordinator Assistant
Ky Kanary Coordinator assistant
E-mail. nyemo@camnet.com.kh

Peer-educators of Cambodian Red Cross

We met with around 12 peer-educators as well as their co-ordinator.Unfortunately we did not obtain their names-

Visit to the Salvation Center in Cambodia (SCC)

Present:
Vorn Vong, Monk team leader
Yin Sam Art, HIV/AIDS Coordinator
Bill Storey, Technical assistant

Innathou association

MS Luon Monyl, Director
#127 #2 Street 109 Bloc Sleng Thay, Sangkat Mithapheap, Khan 7 Makara

Home Land (Meatho Phum Komar)

Mrs. Mao Lang, director
HP 012 881 784
41 Group VI, Phum Rumcheck IV, Khum Rattanak, Srok Battambang

Wat Norea Peaceful Children´s Home

The Venrable M Vansavet, Director
Sor Samnang, Deputy Director
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Burma/Myanmar

UNICEF office

Dr Pirkko Heinonen, Chief of Health and Nutrition
Mr Bertrand Mendis Res. Representative
Ms Pierette Vu Thi, Deputy representative
Mr Myo Zin Nyunt , teamleader HIV
Ms Aye Aye Mon, responsible for MTCT
Mr Ye Mon, working with out of school youth
Mr Robert Jenkins, planning officer
Mr Jorge Sequeira, Chief E/ECD
Dr Tin Mar Aung, responsible for the Shape project/programme
Ms Angelina Gui, child protection
Mr U Win Aung, Early childhood development section
Ms Susu Thatun, National Project Co-ordinator (trafficking)
Mr Win Tin, administrative officer

Visit to Monywa

The visit to Monywa was done together with
Dr Ye Myint Director of Disease Control, MoH
Dr Tin Swe Deputy Director Divisonal Health Director
Dr Than Tun STD Team Leader

Meeting with the Monywa AIDS/STD team and the co-ordination committee

HIV/AIDS&STD. Prevention and Control team, Monywa, Sagaing Division.

Kyemon Rural health Centre (Monywa)

Health assistant U Khong
DAW Aye, Head midwife

Visit to rban Health Centre, Monywa

Dr Nyunt Nyunt Sein

Visit Basic education Middle school Monywa Sagaing

U Win Kyi, Headmaster.
071-21253
Bems-3, Monywa

Vorld Vision, Drop in Centre,Mandalay

Ni Ni Hiwe, Project officer with staff
Street Children Centre
No 309/5 Bet 82nd-83rd St

Yadana BonmiEasy Quarter, Maha Aung Myay Township, Mandalay
Tel 02 24634
Karl Dorming, Special Program Manager, head office Yangon
wvm@mpt.mail.net.mm

PSI, Mandalay and Headquarters in Yangoon

Dr Tin Maung Win
Dr Oo And staff
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Guy Stallworthy Myanmar Country Director
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Save the Children UK 14 june

:Brian Heidel, Program Director
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Mayangone, Yangon
scukpd@mptmail.net.mm

China, Yunan Province

Yunan Centres for Disease Control and Prevention'

Me Zhao shi Wen
Mr Wang Web Xin
Mrs Jiu Mankong
Mrs Lun Mangbing
Mes tang Li

Visit to Dehong Prefecture

Meeting with the aids co-ordination comitte of the county
Mr Xi Baowen, Deputy director, Dehong Health Bureau
Mr Ming Yongji, Director, Yingliang County Health Bureau
The staff of the epidemic centre of Yingliang
Mr Lo, Labour union
The director of the Youth Union
Ms Yao, Deputy director of education
Ms Lee, deputy directoir of finanace
Mr Hoang, deputy director of the farmes hospital
Mr Lee, deputy director planning and development
Mr Dzou, deputy director trade and commerce
Ms Tung, deputy director Famliy Planning
The deputy director of Woemsn union
The deputy dir4ector of Tv and broadcast
Ms Zhao county communications
Kong Xiang Sheng , Epidemic Prevention Station.

Meeting with Political Com and School advisory Com of Kunming

Xwe met:

The Charirman and General secretary of the political Com
The Director of Educations in kunming
The Director of Health Education for schhols in Kunming
Headmasters from the 3rd and 12 th High School and from the Prep School
Teachers and other staff from the Political Com.

Meeting on peer education and prevention

X Hu Hong, deputy director, Office for Yunan provincial Gonernment leading Group on HIV/Aids prevention and Controle
Zhu Min, deputy director of Healyh education, Yunan province
Pan Xiao Yan Yunan Red Cross
Pan Xuyang Yunan Province Family Planning
Ren Chunhui, Deputy Director Anti- drug department, Yunan Bureau of Public Security
Huang Shan and Kelli Wilson, save the children, UK
Yang Li Ging

Yunnan Institute for Drug Abuse
Yuan Hiaobo, Director
Ma Kaijan Deputy Director
Xi-hua-yuan,Kunming 650228, Yunnan P.R. China
Yidazj@public.km.yn.cn

Daytop
Mr.Yang Maobin, Director
Mr.Xihua Rd 47, Kunming 650032, Yunnan P.r. China
Yang-daytop@hotmail.com

Visit to and Katong Village
Mr Yang Yong, village chief
Mr Li Chin Long, communist party
Mr Yang director of the bigger village
Dr Wu Youchang, director Yingjiang HIV/AIDS Office

Lao PDR

UNICEF Office
Ng Shui-Meng, Programme Co-ordinator
Thongdeng Silakoune, Assistant Project Officer
Southalack Assistant Project Officer

Metha Tam Project

The Venerable PhraChaikham Champaouthoum,
The Venerable Phra maha Boonthavy Vilaichakr
The Venerable Boune Thanh Khantisak
Wat Phra Thatluangneua, Vientianne LAO PDR, P O Box 775 tel /fax 856-21 412193

Youth Fight Aids, Vientianne
Mr Vampheng Singharad ,Team leader
Ms Yukiko Mouri, Consultant

TRIMAX
Mr Khama Phan Deputy president of Lao Trade Union in Vientianne
Mr Sourirong ,personell manager of Trimax
Ms Somebit, Trainer, Lao Trade Union, Vientianne
Vangsy, Pon, Povi; Keokhan, factory workers at TRIMAX

Lao National Radio
Sipha Nonglath, Deputy Director
Khamphone Sayoudom, HIV/AIDS prevention project , Lao Lum
Kona Ior Sotouky, HIV/AIDS Project, Hmong language
Ms Amphay, Khammon Radio

UNFPA
Bouphany Phayouphorn, National Programme Officer
P O Box 345, Vientianne Lao PDR
Bouphany.unfpa@undp.org

National Committee for the Controle of AIDS Bureau
Dr.Phouthone Southalack, Deputy Director
Dr. Phengphet Phetvixay. Surveillance
NCCA Co-ordination Bureau, Km 3 Thadeus Rd, Vientianne, LAO PDR
ncca@laotel.com

Vietnam

Unicef office and present at presentation

Damien Personnaz chief communications programme
Elle Girers-Barclay Chief health and Nutrition section
Le Hang Loon Chief Child protection section
Anne Attard Officer in charge/operations Officer
Eric Bentzen Chief education section
Le Thi Minh Chau project Officer Life skills education
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Chika Kitajima Assistant Programme Officer Child protection
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Phan Nguyen Ha National programme officer , Swedish embassy

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Svenska Rädda Barnen

Brita Öström

UNAIDS

Dr Laurent Zessler, country program advisor
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Community peer-education through Youth Union

Mr Nguyen Van Thing, participating father
Mr Nguyen Van Anh , peer-educator
Mr Tran Van Tuon, peer-educator

Life-skills peer-education for street children

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Co-ordinator, children and other social workers

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AIDS Standing Office, HoChi Minh City

Dr. Le Thuy Lan Thao, Program Manager
Dr. Duc, HIV/AIDS extert
Dr Too
Dr Tran Thinh, Project co-ordinator
Dr.Le Truong Giang, doctor at test site
59 Nguyen Thi Minh Khai St, District 1, HoChiMinh City
pachcmc@mail.saigonnet.vn

Tu Du Hospital

Dr Nguyen Thi Ngoc Phuomg, director,
Mr Truong Cong Ho, in charge of laboratory
Midwife Hue
Dr Hung Thu, head counsellor
Tu Du Obstetrical and Gynaecological Hospital,
284 Cong Quynh st, HCMC Fax 84-8-8396832

Binh Trieu Drug Rehabilitation Centre

Mr Nguyen Van Dung, director, Dep of Social evils
Mr Nguyen Thien Dai Director
Dr Lan director health division, DOLISA
Dr Ngai, deputy director of hospital
Mr Hiep, director of counselling
Binh Trieu Drug Rehabilitation Centre, DOLISA

Coffe Shop Nr 2

Mr Pham Truong Son counsellor,
Coffee Shop Nr 2
53 Vu Tung St, District Binh Thanh, HCMC

Thao Dan

Mr Mgyuen Van Hung
Mme Tam
Diep, Quang, Ngoc, Sang, Long, Dung, Han and Ly, children and counsellors
Thao Dan Street Children programme
451/1 ha Ba Trung, district 3, MCMC

Frineds Help Friends - self help group

Mr Nguyen Quong Trung, counsellor Friends Help Friends Project HCMC

Appendix VII List of Documents

List of Documents from EAPRO, Bangkok

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