HIV Prevention Strategy for Young People in Pakistan

June 2006

National AIDS Control Programme (NACP)
National Institute of Health

Ministry of Health
Islamabad, Pakistan

in collaboration with

UNICEF
Islamabad, Pakistan

Foreword

Over half of the new HIV infections globally are in young people of reproductive age. The need to ensure that young people have access to relevant information, skills and services they need to protect themselves is critical. In Pakistan over 50% of the population of over 150,000,000 is under 24 years of age. Although the prevalence rate of HIV in still low in the general population of Pakistan, the age of initiation into groups practicing high-risks behaviours such as drug use and sex work, begins in adolescence.

During July and August 2005, representatives of the National AIDS Control Programme and UNICEF travelled through six districts in four provinces of Pakistan meeting with a broad range of stakeholders from all sectors of society including the Provincial AIDS Control Programmes, other line ministries, local authorities, and representatives of a variety of ongoing youth oriented HIV prevention programs. These consultative meetings culminated in the *National HIV Prevention Strategy for Young People in Pakistan* presented here. It is targeted to both service providers and decision makers who can influence policies.

Taking young as persons with ages between 10 - 24 years, the situation analysis in Pakistan indicates all young people in all categories and ages are vulnerable to factors that may lead them to engage in risk behaviours, but out of all these youth, there are fewer youth who are most-at-risk for HIV infection. The *Prevention Strategy* prioritises interventions with adolescents and young people most-at-risk to HIV, primarily street-based living children in order to stem the epidemic where HIV exists or could potentially exist due to risk behaviours.

The Strategy includes a revision of Priority Area 3, Youth, from the *National HIV and AIDS Strategic Framework 2001-2006*. The *2001-2006 Framework* identifies youth as a national priority area for intervention; however, this *Framework* was conceived early in the epidemic in Pakistan, at a time when all youth were considered equally vulnerable, equally at risk. Through the provincial consultative process culminating in a national workshop in November 2005 partners from government, civil society, youth, and the UN contributed their experiences working with the general youth population, especially vulnerable, and most-at-risk young people. The result of this workshop was a revised version of the National Strategic Framework.

We would like to thank all individuals, institutions and government departments that participated in the provincial and national consultative meetings and contributed to the development of the *National HIV Prevention Strategy for Young People in Pakistan*.

Muhammad Nasir Khan
Federal Minister for Health
Government of Pakistan

Table of Content

Acronyms

AEM	Asia Epidemiological Model
AIDS	Acquired Immunodeficiency Syndrome
ANF	Anti-Narcotics Force
ARV	Antiretroviral (also HAART- Highly Active Antiretroviral Treatment)
BCC	Behaviour Change Communication
BTC	Blood Transfusion Centre
CBO	Community Based Organization
COC	Continuum of Care
CSO	Civil Society Organization
CSW	Commercial Sex Worker
EPE	Enabling and protective environment
FHI	Family Health International
FSW	Female Sex Worker
GOP	Government of Pakistan
HASP	HIV and AIDS Surveillance Programme
HCP	Health Care Provider
Hijra	Term of self identify of transgender person
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User (also Intravenous Drug User)
IEC	Information, Education, and Communication
IPC	Interpersonal Communication
ISS	Information, skills and services
KAP	Knowledge, Attitude, and Practice
LSBE	Life Skills Basic Education
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NACP	National AIDS Control Programme
NBTC	National Blood Transfusion Committee
NGO	Non-Governmental Organization
NIH	National Institute of Health
NWFP	Northwest Frontier Province
P2P	Person to Person Communication
PACP	Provincial AIDS Control Programme
PBTA	Provincial Blood Transfusion Authority
PC	Planning Commission Proforma
PHC	Primary Health Care
PLWHA	Persons Living with HIV and AIDS (also known as PLHA or PWA)
RTI	Reproductive Tract Infection
SPARC	Society for Protection of Rights of the Child
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
TACA	Technical Advisory Committee on AIDS
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing

Executive Summary

The National HIV Prevention Strategy for Young People in Pakistan lays out the situation of young people in Pakistan, an understanding of their vulnerabilities and risk to HIV and a Strategic Framework targeted to stem the current trend of the epidemic and to protect young people from potential risk behaviours. This strategy will help HIV programmes to reassess their current approach and revise their strategies, so that, in addition to ensuring the large population of young people have information to protect themselves from HIV, the especially vulnerable and most-at-risk young people have targeted interventions with relevant information, skills and services.

Although the prevalence rate in Pakistan's general population is still low, 0.1%[1] , there is growing evidence to show high levels of risk behaviours among sub-populations such as injecting drug users (IDUs), men who have sex with men (MSM) and female sex workers (FSWs). In 2005 Pakistan shifted from a low prevalence country to a concentrated epidemic as prevalence rates of over 5% were found in injecting drug users in Punjab and Sindh. In Karachi, the IDU prevalence rate was found to be as high as 26%[2] . While the data drawn from these sub-populations was primarily on adults, studies showed initiation ages into male commercial sex work as young as 8 years old, 15 for female sex workers, and 14 years for injecting drug users.[3]

While current resource allocation and programming is focused on the general youth population, most of whom are not-at-risk for HIV, the much smaller groups of especially vulnerable and most-at-risk young people need immediate targeted strategies because they are already in the high-risk behavioural networks between IDUs, FSWs and MSMs and already potentially infected with HIV. The challenge for Pakistan is to reassess HIV programming to ensure a rights based approach is applied and interventions which focus at where HIV infection is taking place are supported and promoted and reach the young people who are especially vulnerable and most-at-risk to HIV infection.

During July through August 2005, representatives of the National AIDS Control Programme and UNICEF met with the Provincial AIDS Control Programmes (PACPs), local authorities, and representatives of a variety of ongoing youth oriented HIV prevention programmes in six districts in all four provinces in Pakistan. These meetings made it possible to have direct exchanges also with youth themselves about these programmes, their benefits, and for them to participate in the formulation of this document.

1. WHO/UNAIDS forecast modeling estimated in 2005 that there were approximately 70,000-80,000 people infected in a population of over 150,000,000.
2. National Study of Reproductive Tract and Sexually Transmitted Infections, FHI, February 2005.
3. Ibid.

1. Background

1.1 Rationale and Objectives

Looking at young people between the ages of 10 – 24 years, the situation analysis in Pakistan indicates all categories and ages in this group are potentially vulnerable to factors that may lead them to engage in risk behaviours. However, not all are at-risk for HIV infection. Vulnerability of youth results from lack of literacy and knowledge, inadequate protection by adults at home, school, workplace and protection agencies, as well as peer, social and early marriage pressures. Especially vulnerable young people are those who make choices out of lack of parental support and ignorance of sexual and reproductive health. These factors are compounded for young people most-at-risk for HIV infection by abandonment, exploitation, or an inability to disengage from high risk behaviours including unprotected sex and sharing injecting equipment.

Current efforts for prevention of HIV among young people are focused on general awareness messages for those who are at relatively low risk of HIV infection, for example mass media prevention campaigns which can help to change social norms and contribute to behaviour change. Life Skills Based Education initiatives in secondary schools, while teaching skills for life and raising awareness of HIV and AIDS, have little impact on the epidemic at a high financial cost. Given the trend of the Pakistan epidemic and the involvement of young people in high risk networks, especially vulnerable and most-at-risk young people must be reached with targeted interventions, including access to services.

Most at risk children must be reached

Many other agencies responsible for especially vulnerable and most-at-risk young people also need to be brought into the portfolio of HIV prevention. These include the Ministries of Justice, Internal Affairs, Social Welfare, Labour, Population Welfare, and Youth. Similarly, NGOs will continue to be the close contact service providers, but more NGOs need to be encouraged to implement specific targeted interventions for especially vulnerable and most-at-risk young people, and donors need to provide essential funding if the numbers of especially vulnerable and most-at-risk are to be covered adequately to impact the trend of the epidemic. Finally, laws and regulations that protect young people's rights in schools and the workplace need to be implemented, and where laws and regulations on protecting youth rights are lacking, they need to be promulgated.

Goal of the National Prevention Strategy for Young People:

To reduce young people's risk and vulnerability to HIV and AIDS

Specific Objectives:

1. To increase understanding about young people's particular STI/HIV and AIDS vulnerabilities and risk behaviours
2. To increase access of especially-vulnerable and most-at-risk young people[4] to information and relevant skills and services to reduce their risk and vulnerability to HIV
3. To increase access of young people to appropriate BCC materials and peer education strategies
4. To strengthen the participation of formal and informal support structures and institutions in efforts to reduce the HIV and AIDS vulnerability and risk of young people
5. To strengthen support of gatekeepers for the implementation of effective vulnerability and risk reduction interventions for youth[5]

Goal and specific objectives will be monitored through the national monitoring and evaluation (M&E) framework, including second generation surveillance, service statistics, and special studies (see MDG and UNGASS indicators).

Guiding Principle

As this is a prevention strategy for young people in Pakistan, activities to support the strategy and the implementation of the Strategic Framework will not take place without the explicit involvement of young people themselves.

1.2 The National HIV and AIDS Strategic Framework 2001-2006

The National HIV and AIDS Strategic Framework 2001-2006 identifies youth as a national priority area for intervention. This Framework was conceived early in the epidemic in Pakistan, at a time when all youth were considered equally vulnerable, equally at risk. Through a consultative process initiated in the provinces and culminating in a national workshop in November 2005 partners from government, civil society, youth, and the UN contributed their experiences working with the general youth population, especially vulnerable, and most-at-risk young people. The result of this workshop was a revised version of the National Strategic Framework, included in this document.

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4. Some work has been done on the feasibility and necessary coverage of prevention interventions, according to the population prevalence of HIV infection (Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003, Policy Project, 2004), which suggests, for example, that 50% of out-of school youth and 75% of injection drug users and 60% of men who have sex with men would need to be reached by interventions in sub-populations with prevalence greater than 5%. Depending on HIV prevalence in the most-at-risk population, the denominator (total number of most-at-risk adolescents – as per their risk and vulnerability to infection) may actual be quite small, relative to all young people.
5. To create a supportive environment, we need to have support of religious leaders, opinion makers, the media, politicians, local councilors, and parents.

1.3 International Commitments

Millennium Development Goals (MDGs)

Pakistan is committed to HIV prevention work with young people in support of the global targets of the UN General Assembly Special Sessions (UNGASS) on HIV and AIDS and Children, as intermediate steps towards the achievement of the MDGs, and in particular MDG Six:

To halt and begin to reverse the spread of HIV and AIDS by 2015

In order to measure progress, 3 MDG indicators for monitoring Target 7 have been developed which are related to adolescents and young people:

i. **HIV prevalence data for pregnant women 15 to 24 years of age (MDG Indicator #18):** This is an impact indicator used as a proxy indicator for new infections.

ii. **Condom use at last high-risk sex (MDG Indicator #19a):** This indicator is a behavioural indicator that tracks increased condom use (sexual practice) among sexually active young people as a positive behavioural outcome.

iii. **Percentage of population aged 15–24 with comprehensive correct knowledge of HIV (MDG Indicator #19b):** This is a determinant indicator, as the level of knowledge about a risk will be a factor which will influence an individual's behaviour.[6]

In addition to the above-mentioned indicators to monitor target 7, the HIV and AIDS Task Force for the Millennium Project has recommended two overall outcome targets to strengthen the specificity of the MDG Target[7]. These are:

- Reduce prevalence among young people to 5% in the most affected countries and by 50% elsewhere by 2015
- Reduce prevalence within key vulnerable populations by 50% by 2015

United Nations General Assembly Special Session (UNGASS):

The Government of Pakistan is also a signatory to the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and the UNGASS Declaration on Children. There are two time bound targets which extend beyond 2005 which are mentioned in both declarations. They are:

6. This information can be found in the National Multiple Indicator Cluster Surveys (MICS) under HIV and AIDS.
7. Combating AIDS in the Developing World — Achieving the Millennium Development Goals. Millennium Project, Working Group on HIV, 2005, pg. 44

1. Reduce by HIV prevalence among young men and women aged 15 to 24 by **25 per cent globally by 2010**, and intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV and AIDS, encouraging the active involvement of men and boys.[8]

2. Ensure that **by 2010 at least 95 per cent of young men and women aged 15 to 24** have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young people, parents, families, educators and health-care providers.[9]

Specifically, Pakistan has committed itself to report on the following UNGASS indicators relevant to young people:

- % (most-at-risk populations) who received HIV testing in the last 12 months and who know the results
- % (most-at-risk populations) reached by prevention programmes
- % of (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- % of female and male sex workers reporting the use of a condom with their most recent client
- % of men reporting the use of a condom the last time they had anal sex with a male partner
- % of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid sharing equipment and use condoms, in the last 12 months (for countries where injecting drug use is an established mode of HIV transmission)
- % of (most-at-risk population(s)) who are HIV infected

Three Ones:

The Government of Pakistan has already begun implementing the "**Three Ones**" principle initiated by the Global Task Team, which requires all partners to work towards the establishment and operation of **one** agreed HIV and AIDS Action Framework; **one** National AIDS Coordinating Authority and **one** agreed country-level Monitoring and Evaluation System. The implementation of this principle should lead to more efficient use of resources and more rapid scale up of coordinated, aligned and harmonized actions and improved prevention results.

8. Paragraph 47 UNGASS on HIV and Paragraph 46(a) UNGASS for Children
9. (Para 53 UNGASS on HIV and Para 47.2 under "Strategy and Actions" in the UNGASS for Children). This target builds on a similar target first articulated in the International Conference on Population and Development (ICPD) +5.

2. Situation Assessment: Pakistan, HIV and AIDS and Young People

2.1 Age Definitions of Youth and Population

In Pakistan, the term 'youth' refers to the legal status of a person, from child, or minor (age 0-17), and into adulthood (age 18 and older). The term 'youth' also includes specific human development periods including childhood (age 0-9), pubescence (age 10-12), adolescence (age 13-19), and early adulthood (age 18-24). For our operational reference for youth prevention, we consider 'youth' and 'young people' interchangeable and defined as aged 10-24 years. In Pakistan, the population that is contained by these ages is large. Out of a projected population for 2005 of 154 million, young people aged 0-24, including infants, children, adolescents, and youth comprise 60% or 90 million. This is broken down further according to the different age group definitions as shown in Table 1.

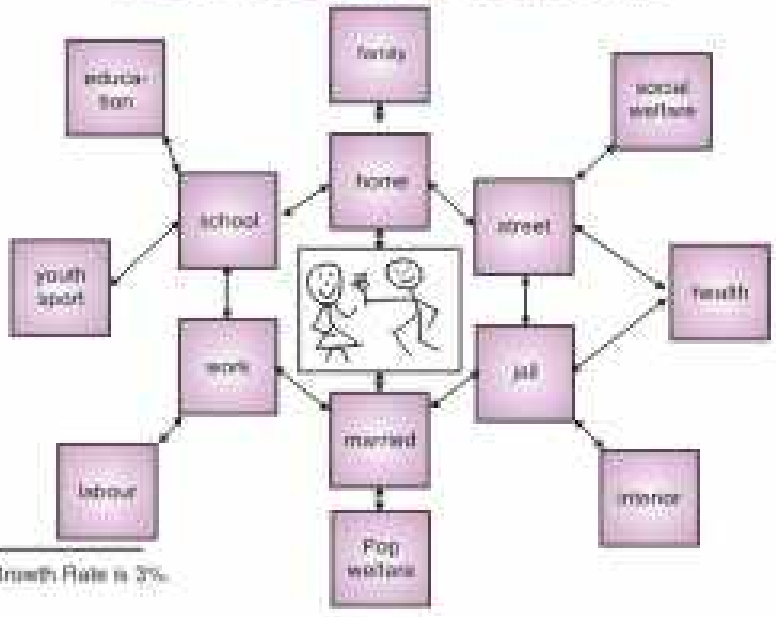
Table 1. Pakistan Population Tree[10]

Group	Absolute (estimated 2005)	Percentage
Total Population	154,000,000	100.0%
Senior age 60-80+	10,900,000	7.0%
Adult age 24-60	32,300,000	32%
Youth age 15-24	29,000,000	19%
Age 10-19	34,200,000	22%
Children age 0-14	64,300,000	42%

2.2 Child Rights and Protection

Children are borne into families which are responsible to protect and educate their child. As youth grow, they face a complex array of forces and influences on their life as shown in Figure 1 (P. Janssen, 2005).

Figure 1. Young People in the Centre of Life



10. Pakistan's Annual Growth Rate is 3%.

Young people enjoy human rights, including the right to education, protection, and security. The ten principles of Child Rights are summarized in the UN Convention on Child Rights. Pakistan ratified the Convention on the Rights of the Child on November 12, 1990.

Statistical and other reports on demography, labour, and education programs in Pakistan tend to show that as children approach puberty from age 10 they are generally considered to be of sufficient development age to acquire the necessary information related to their health and well being for HIV prevention. The right to receive this information is especially important as with the onset of adolescence or the teen years at about age 13, Pakistani boys and girls achieve puberty, subsequent to which boys generally enter the work force and girls are often promised in marriage or become married.

As children move from home into other social spheres such as school, labour, and onto the streets, government agencies take on responsibility for children until they become adults at age 18 as shown in Table 2 below. Civil society organizations, local government, and religious leaders also participate in the protection and education of children.

Table 2. Government Agencies with Social Responsibility for Youth by Age

Group	Age	Concerned Agency
Child	0-14	Local Government, Community Leaders
-Health Needs		Health
-In School		Education
-Out of school		Labour, Social Welfare, Local Government
Adolescent	13-19	Local Government, Community Leaders
-In School		Education
-At W ork		Labour
-Early Married		Health, Population Welfare
-Unprotected		Social Welfare, Justice, Internal
Youth	15-24	Culture Youth and Sport
		Health, Education, Labour

2.3 Epidemiology of HIV in Young People

HIV transmission is caused by unprotected sex with an HIV positive partner, through exposure to HIV infected blood, and from an HIV positive mother to her child. While all young people are vulnerable in principle and need to have their rights protected, their risk of exposure to HIV infection is related to specific risk behaviours, including unprotected sex and shared needles for injected drug use. To ensure effective HIV prevention programming the following baseline information must be understood:

- Age of sexual debut
- Number of sexual partners of young people
- Kind of sex young people have anal, vaginal, MSM, protected, unprotected, etc.

- Prevalence of drug use (all kinds)
- Evidence that glue sniffing leads to injecting drug use
- Blood transfusions among young people (note: most accidents happen to young people)
- Vaccinations, IM/IV medicines and utilisation of universal precautions

Currently in Pakistan, the number of young people infected with HIV is very small, though evidence exists of high rates of risk behaviour among some sub-populations of young people. Any sexually active or injecting drug young person may be at risk of HIV.

There are several factors of HIV epidemiology in young people which need to be recognized as contributing to their risk of acquiring HIV. These factors include but are not limited to, the level of sexual activity of young people, their knowledge of reproductive health, and the extent or quality of protection by responsible adults. The following cites some published reports on youth and HIV:

- Sexual activity. The Adolescent Reproductive Health in Pakistan (Policy Project, 2003) indicates that up to almost 70% of female youth were ever married. If any of their partners, for whatever reason are HIV positive or are involved in risky sexual behaviours, they place their married young wives at risk.
- Knowledge of Reproductive Health. The Adolescents and Youth in Pakistan Representative Study 2001-2002 (Population Council) reports that less than 50% of boys and girls receive information about puberty before it onset.
- Quality of Home Protection. The same Adolescent and Youth Study reports that 77% of boys and 49% of girls are living with their parents, that 25% of boys and 60% of girls have migrated, of which 60% did so for marriage, while 32% of boys did so for employment. While 80% of boys ever attended school, only about 50% of girls have. Among youth, up to 90% of boys and 49% of girls have worked, with as many as 35% of boys and 21% of girls working before age 15.

These and other reports suggest that the number of youth who are sexually active is high among girls in marriage, and less so among boys as a general population, but all young people share a low level of knowledge of reproductive and sexual health. The number of young people who are not under the protection of responsible adults is high, generally boys who dropped out of school (50%), are working (90%), and don't live at home (22%). Young people make up a substantial proportion of the sample of the population and these young people demonstrate very low preventive behaviour and low awareness of their risk.

According to a pilot survey conducted by the HIV and AIDS Surveillance Project (HASP)[11] using second generation surveillance on high risk populations in Karachi and Rawalpindi, where only 1 person was found HIV positive in Rawalpindi, young people can be as many as 60% of a risk group.

11. September 2005

Table 3. Risk Behaviours of Young People Sampled by HASP SGS in Rawalpindi

Behaviour	FSW	MSW	Hijras	IDU
Under age 24	21.7%	61.0%	43.6%	10.1%
Always use a condom	16.7%	3.1%	4.9%	5.0%
Consider self to be at risk of HIV	25.5%	17.6%	17.6%	n/a

Similarly, the Family Health International (FHI) study on RTIs and STIs in high risk groups[12] reports that there were 14 respondents under the age of 15, of which 12 were MSWs. In all five risk groups (FSW, trucker, MSW, Hijras, and IDU), there were a substantial number of youth respondents under the age of 24, with the youngest being age 13. Also it should be noted that up to 83% of the sample had no formal schooling.

2.4 Vulnerability and HIV Risk

Not all adolescent girls or boys are at risk of HIV infection in Pakistan. Their vulnerability depends on such factors as their age, and/or sex, gender power relations, being in or out of school, being married or not, as well as their social, economic and political context, all of which can affect their vulnerability. Their specific risk of infection depends on the levels of background prevalence in their peer groups[13] and sexual networks and communities. Especially vulnerable youth make choices that put them directly at-risk of HIV infection. The closer that young people are to their families and under responsible adult protection, and attending school and/or working, the less likely they are at-risk of those behaviours that can lead to HIV infection. At the same time, these same structures sometimes fail to provide adequate protection. Young people then are compelled to make choices about their own security, comfort, and meaning for their life. These choices can result in transitions from home to school to out of school making them especially vulnerable, and for some, to living unprotected lives on the streets, making them most-at-risk to HIV.

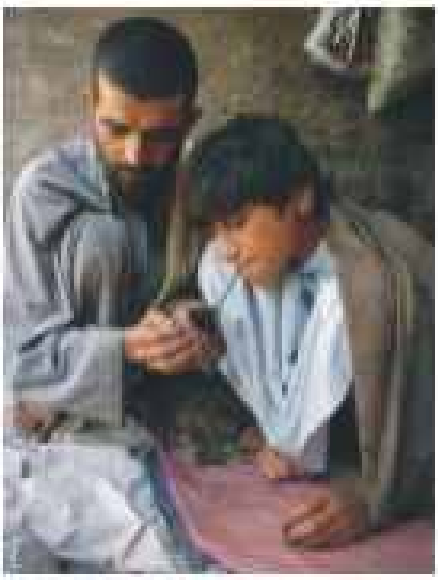
2.4.1 Most-at-Risk Young People

Young People Living on the Streets

When young people face hardships at home, at school, and at work, they have little choice but to survive on their own or in the company of gangs on the street. This choice places young people at a situation of extreme vulnerability, where they may face economic exploitation, sexual and physical abuse, and drug abuse. Young people living on the streets experience low or no access to nutrition, nurturing adults, and other personal support. They also have little access to social services such as health care, educational training, or police protection. Survival on the street

12. National Study of Reproductive Tract and Sexually Transmitted Infections. FHI. February 2005

13. If all adolescents when they became sexually active only had sexual intercourse with their peers then, in theory, they would not be at-risk of HIV infection from sex. It is when they have sex with older (and infected) partners that they risk HIV infection, and then HIV is brought into their age groups.



is extreme and can mean sex work, solvent and injecting drug use, violence, begging, and stealing. While there are institutions which are assigned responsibility to protect young people on the streets, in general these young people have not been well protected in Pakistan. The actual number of young people living on the street youth in Pakistan is not well known, but estimates suggest tens of thousands upwards, concentrated in most urban or populated peri-urban centres.

In some cases, young people on the streets may be under protection of a family or employers, but the nature of being on the street itself places the child at risk in violation of their rights. By living on the streets, young people are exposed to social sanctions and policing that can place them at risk of further abuse in the institutions which they are held for short or long periods. Living on the street affords little or no protection for young people, increasing the risk of sexual exploitation and exposure to injecting drug use practices.

Sex Workers

While sex workers, particularly female, may not be living on the streets, they are included as most-at-risk given the risk network that they are in and the low-level of condom use amongst sex workers: 16.7% amongst FSWs and 3.1% amongst MSWs in Rawalpindi (HASP) and the FHI STI/RTI reports that over two thirds of all commercial sex acts were not covered by a condom, and the real percentage of condom use is probably even less. Another factor which makes adolescent and children sex workers especially at-risk to HIV is that their bodies are immature and there is more potential for tearing of tissue and membranes.

2.4.2 Especially Vulnerable Young People

Adolescent Labourers and Out of School

Young people who are out of school (or never going to school) are likely to seek work, so as not to remain a burden on the family. Given the range of jobs that youth do from trucker assistants to shop or house work assistants, to newspaper selling, garbage picking and scavenging, the risk to HIV infection can increase from migration and exploitation including forced or consensual unprotected sexualtransactions. Income ranges from 500 rupees to 1000 rupees per month, most of which is added to the wealth pool of the family. Girls also work, or they may be married early. Being non-school-going or working can increase a young person's

vulnerability from lack of literacy and exposure to less responsible adults. The chief component of prevention provided to youth out of school is non-formal education for literacy, vocational education, and life skills. Overall, one considers that the risk of HIV infection for a child out of school is increased due mainly to the child's vulnerability and increased exposure to exploitation and abuse.

Garbage Picking Children

Early Married

One vulnerable subgroup of out of school youth are those young girls who are given in early marriage. When the young girl is not knowledge about sexual behaviours and reproductive health that are part of married life, she is vulnerable to infection, unwanted and early pregnancy, and abuse. While it is clear that parents and communities continue this practice, local government and health authorities can and should be brought in as key agents to ensure that these girls have the necessary reproductive and sexual information they need for marriage and to prevent HIV infection, which comes principally through unprotected sex with their exposed partners. As long as the number of adolescent marriages remain large, these authorities need to focus on this highly vulnerable subgroup to provide them basic information and condoms, so that they can make better choices about protecting their health. At the same time, as this subgroup are minors, they generally cannot access health care services without the consent of the protecting adult, so medical personnel need to be alerted specifically to the essential HIV prevention information which an early married girl must have.

2.4.3 General Population of Young People (Mostly Not-at-Risk)

Living at Home

Children obtain protection from their parents with the support of their social network, local government, religious leaders, and community services. The child's first line of HIV prevention is that their rights are met, that they are responsibly protected, and that they as young people have adequate knowledge and sexual and reproductive information.

When child rights are not being fulfilled, respected or protected by parents, young people make choices to protect themselves and to make their lives better. Young people make choices to avoid:

- Being afraid at home,
- Incest and child sexual abuse,

- Physical abuse
- Poor nutrition and lack of support
- Poor success at school
- Being exploited in and through labour

Unfortunately, young people in Pakistan routinely face restrictions on obtaining necessary information to protect their health and well being, as well as the social and parental pressure of early age marriage.

School-Going

Pakistan has a very low enrolment and a low retention rate of children in school at least half of all children have never enrolled or have dropped out by age 10. Children who successfully enter school and maintain their studies are generally not at risk for HIV infection. There are several factors which create barriers for child success at school, including poverty which means both lack of nutrition as well the lack of necessary means for uniforms, transport, books for school. Children often drop out of school simply as a means of self-protection from beatings, abuse, and other forms of humiliation. The chief component of prevention provided by schools is literacy and life skills to provide youth with knowledge they need to make good choices to protect their health and welfare obtained in a learning environment free from abuse. Overall, one does not consider the risk of HIV infection for a school child to be significant, except in those extreme cases in which a school child is sexually exploited by a teacher, as has been reported.

2.5 Responsibility for HIV Prevention in Young People

2.5.1 Responsibility for HIV Prevention for Young People Living on the Street

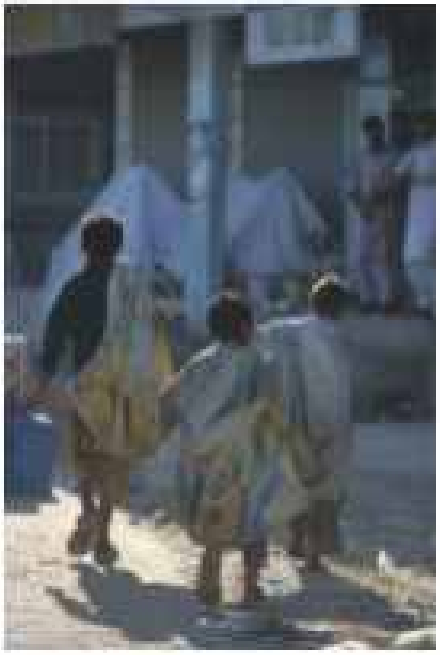
Young people living on the streets present the greatest challenge for HIV prevention, as they enjoy no protection and have moved far out of the reach of social agencies. They come to be on the streets as a survival response. When all of the family and social protection forces have failed them, they turn to the street for the place of last refuge. Once they find themselves on the street, they turn to other young people and other marginal groups on the streets to obtain what protection they can. Historically, these young people are viewed as a nuisance by local government authorities and are handled as criminals or ignored completely. At the same time, this population subgroup is critically important for the

prevention of HIV entering the general population. Young people living on the street have very few defences against exploitation by adults for sexual and drug related events directly concerned with HIV transmission.

While a great deal of study has been made about suitable responses to young people living on the streets, including the need for rehabilitation and reintegration, the challenge of HIV prevention has to be focused on the need to ensure that these young people have good knowledge about HIV and good access to services, including access to condoms, safe drug injection, STI treatment. Agencies which provide HIV treatment care and support should organize VCT referral services that link the potential clients and the support agencies.

2.5.2 Responsibility for HIV Prevention for Young People Out of School and Working

When youth remain out of school or drop out of school, the difficulty of reaching them with information for HIV prevention increases exponentially. Out of school youth are dispersed and the responsible child protectors are diffuse. The local government is an important partner in the overall community facets including families, employers, religious leaders, and community services. NGOs can also be mobilised to meet the life skills, literacy, and vocational needs of out of school youth through information outreach, skills and service provision. To the extent that local government offices are properly alerted and mobilised in the effort to prevent HIV infection among young people, they can be instrumental in supporting community initiatives to strengthen protection of these vulnerable youth.



2.5.3 School Responsibility for HIV Prevention

Schools provide an efficient conduit to teach young people both the life skills and essential information needed for HIV prevention. So long as a young person remains in school, he or she may obtain this information in a reliable manner through class room materials and teaching. The Life Skills Basic Education (LSBE) is a strong initiative which enables both teachers and students to obtain needed information about HIV prevention and remains the best and most effective action for schools to help prevent HIV infection in youth.

As children and youth report that they drop out of school for personal reasons, including lack of interest, and hardship, the challenge for schools is to increase retention. Basic education is improved by improving school infrastructure, teacher

competencies, student nutrition, learning and teaching materials, and student-teacher ratios.

2.5.4 Parent and Community Responsibility for HIV Prevention

Caring support, strong life skills, and solid health information are the best and most effective means to ensure that the vast numbers of children who are living at home, attending school, and working can be protected from the risk of HIV infection. This support and information is most effectively delivered to youth by those primarily responsible for their protection.

Generally parents depend on social traditions to guide how they protect their children. However, as HIV is a new phenomenon and new threat, it is essential that parents are given new information to protect their children. A key channel for this new information in Pakistan is the local government which is closely connected with the social fabric of the community and its religious and other leaders. Therefore, local government authorities can be advised of the importance of parents and communities to protect child rights as well as to be given necessary information by these authorities about how young people are vulnerable to HIV infection. Moreover, as many Pakistanis trust the information coming from the religious leaders, religious leaders must work hand in hand with local government bodies to ensure correct information on HIV is passed to their audiences. In addition to information passed through normal channels, the importance of parents and communities to protect the rights of youth and to prevent HIV infection should also be included in national media activities.

2.5.5 Ministries responsibility for HIV Prevention for Young People

The status of policies to reduce youth vulnerability is formal rather than implemented. As the Alternative Report on the State of Child Rights in Pakistan states, "In the past 12 years, despite repeatedly stressing the significance of the country's co-hosting the World Summit for Children and being one of the first signatories to the Convention, there has been little improvement in the state of children in the country." (SPARC, 2003).

Preventing HIV infection among young people on the streets is a multi-step process which involves a great number of social agencies, NGOs, and the local government which need to act in lieu of the parents. The National and Provincial AIDS Control Programs will provide technical leadership and support for the many public agencies and NGOs active with young people on the streets. The primary component of the process is that all agencies, including police, narcotics, and other justice agencies understand the risk behaviours of young people on the streets and are alerted to the critical role that they play in HIV transmission, as most public agencies have been oriented to removing young people from the streets. NGOs can be instrumental in communicating with public agencies as well as in contacting and supporting young people on the streets where they are found. Table 4 presents the Ministries and local agencies responsible for HIV prevention in young people.

Table 4. Responsible Ministries and Agencies for HIV Prevention Interventions for Vulnerable Young People

Responsible Ministry (for policy development)	Vulnerable Group	Agency at Local Level (for service delivery)	Prevention Intervention
Ministry of Social Welfare	• Youth at home • Youth out of school • Street youth injecting drugs	• Community groups-NGOs • Non-formal education	• Life skills, literacy, vocational, STI services • Walk in services, peer support, harm reduction, linked STI and VCT care, condom access
Ministry of Interior (police, ANF, FIA)	Street youth abusing solvent	• Local Interior and Justice officers • Local Police • NGOs	• Peer support services, • outreach services, • linked STI and VCT services, • condom access
Ministry of Justice	• Street youth involved in sex work, • Street youth involved in begging and other forced labour • Street youth incarcerated or detained, • Street youth in gangs	• Local Justice officers • Local authorities • NGOs	• Peer support services, • outreach services, • linked STI and VCT services, condom access • institutional STI and VCT services, • harm reduction; • condom access
Ministry of Labour	• Youth at work • Street youth involved in transport industry • Street youth who have migrated from their birth places and family home	• Unions • Trucker association	• Outreach services, information • Vocational training • Non-formal education
Ministry of Health	• Youth at home • Youth in school • Early married adolescents • Street youth involved in sex work	• Local health services • Private health care providers	• STI services, • Reproduction information • Walk in services, peer support, drug use information, linked care services
Ministry of Population Welfare	Early married adolescents	• Local health services • Private health care providers	• STI services, • Reproduction information
Ministry of Local Government	• Youth at home	• Local govt bodies	• Life skills, literacy, information
Ministry of Religious Affairs	• Youth at home	• Mosques, madrassas	• Life skills, literacy, information
Ministry of Education	• Youth in school	• Schools	• LSBE
Ministry of Culture Sports Youth	• Youth in school	• Schools	• LSBE

The danger in assigning responsibilities for large and not-exclusive cadres of youth to specific ministries is that young people whose situations cross line ministries may lose out on protective measures. It is crucial, therefore, to ensure that at a provincial level there is a forum for all responsible ministries and agencies to interact and collaborate.

3. Programming for Prevention of HIV in Young People in Pakistan

3.1 Key Programming Principles

Given the trend of the epidemic and the age of initiation into high-risk activities, Pakistan's prevention strategy for young people should focus primarily on especially vulnerable and most-at-risk populations through targeted interventions while ensuring that the general youth population has relevant information to protect themselves against HIV. Resources must prioritize and focus on those adolescents who are most at risk and vulnerable to HIV infection and to ensure that they have access to and can use prevention information, skills

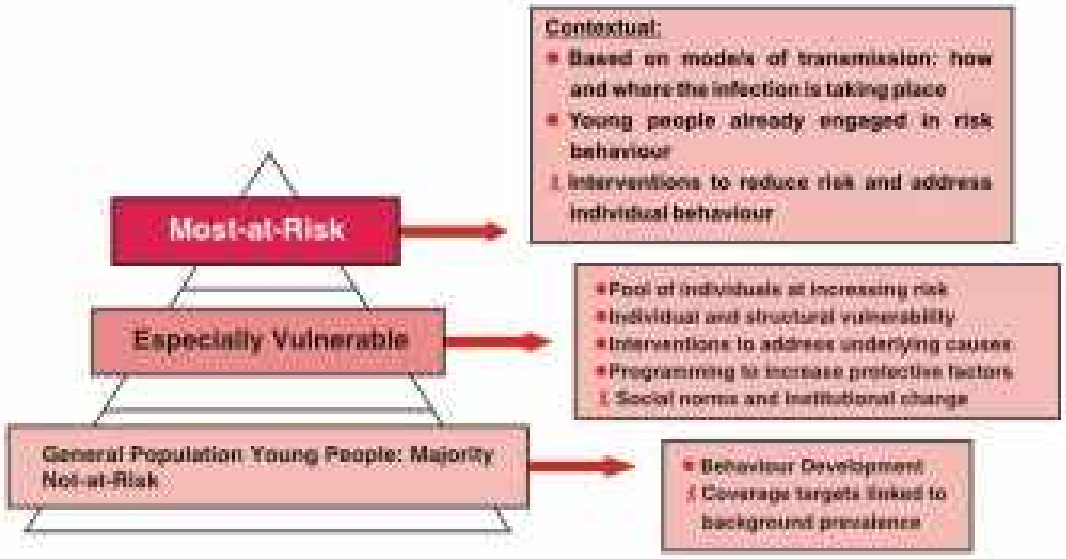


Figure 2. Most-at-Risk and Especially Vulnerable Focusing on Risk and Vulnerability

3.2 Key Programming Principles:

The following five key programming principles will guide the development and implementation of programme strategy and interventions for HIV prevention with and for young people:

1. Ensure that most-at-risk adolescents **are at the centre** of the prevention response
2. Ensure a **right-based** approach which focuses on **reaching especially vulnerable**

14. Figure 2. Most-at-Risk and Especially Vulnerable adapted from UNICEF HQ working draft Programming Note on HIV Prevention with and for Adolescents, September 2005

3. Ensure that all interventions have the dual aim of **reducing risk** factors and **increase protective** factors for young people
4. Ensure the **meaningful participation** of especially vulnerable and most-at-risk young people in the assessment, design, implementation and monitoring of the core interventions;
5. Ensure that content of the core interventions address the **age, sex and situational diversity** among young people.

Putting these principles into practice will ensure that HIV prevention information, skills and services interventions will be focused on averting new infections among the especially vulnerable and most-at-risk young people. Interventions to strengthen the enabling and protective environment will aim to increase protective factors and reduce young people's vulnerability to engage in risk behaviours. Most at-risk should be both implementers and beneficiaries and their capacity should be developed for assessing, analysing, identifying, designing and implementing the core information, skills development and service provision interventions. This will ensure that the content of information, skills and service interventions will also be age-relevant and gender-sensitive.

Young people participate in LSBE activities

To ensure an effective primary prevention response, programmes should promote abstinence, faithfulness, partner reduction, and consistent condom use through school- and community-based life-skills based interventions; peer education and outreach; adolescent-friendly health services, counselling, testing, outreach and referral; mass media and interpersonal communication interventions; all of which will aim to provide relevant information on sexuality, reproductive health; substance abuse issues; the prevention and treatment of sexually-transmitted infections; as well as the development of age relevant skills and services and other evidence informed measures to reduce adolescent risk and vulnerability to HIV infection.

In support of the risk reduction information, skills and services (ISS), the strategy supports the development of an enabling and protective environment (EPE) framework by promoting the strengthening enabling and protective factors like policy and legislations development and enforcement; supporting evidence informed advocacy; behaviour and social change campaigns to address social and gender norms and attitudes; and develop the capacities of parents, families, communities and service providers to support risk reduction practices; and address barriers to behaviour development and change and address social customs and economic practices which support or facilitate adolescents structural vulnerabilities.

3.3 Strategic Interventions

Preventing HIV among youth is a complex activity involving almost all governmental and social entities in a partnership of mutual support and collaboration. The chief partner is the individual youth who is the centre of what the society can provide through prenatal health care, adequate nutrition, competent parents, effective schooling, fair labour practices, and just authorities. In order for each youth to avoid HIV infection, he or she needs optimal safety and knowledge about life, including sexuality and reproduction. Youth are vulnerable and under the protection of their parents, community, and society until they become adults and take on responsibility for themselves. Table 4 presents different social environments and suggests specific prevention interventions for the young people found in those settings given the vulnerabilities they face. Duplication of services among settings indicates the potential for multiple risk behaviours amongst young people.

Table 5. Social Environments, Vulnerabilities and HIV Prevention Interventions

Social Environment	Vulnerability	Prevention Intervention
In school	• Peer pressure: sex, drugs, relationships • Lack of information on STIs • Early marriage pressure • Abuse and poverty	LSBE, Parental care, security, information
Out of school	• Lack of information • Stigma and taboo • Early marriage pressure • Abuse and poverty • Association with unconstructive values	Life skills, literacy, vocational, Parental care, security, information
Out of school and working	• Lack of information • Stigma and taboo • Early marriage pressure • Exploitation, abuse	Life skills, vocational training, non formal education, Parental care, security, information
Early married	• Lack of information • Stigma and taboo • Infected partners	Sexual and reproduction health information, STI care, HIV information
Transport industry	• Lack of info • Stigma and taboo • Exploitation, abuse • Lack of access to care and condoms • Authorities	Life skills, Outreach services, sexual health information
On streets[15] involved in sex work	• Lack of info • Stigma and taboo • Exploitation, abuse • Lack of access to care and condoms • Authorities	Peer support services, outreach services, linked STI and VCT services, condom access
On streets abusing solvents	• Lack of information • Stigma and taboo • Exploitation, abuse • Poverty • Lack of access to care • Authorities	Life skills, HIV information, condoms, VCT, Walk in service settings, peer support, drug use information, linked care services
On streets injecting drugs	• Lack of info • Stigma and taboo • Exploitation, abuse • Lack of access to care • Lack of safe injecting equipment • Authorities	Walk in services, peer support, harm reduction, linked STI and VCT care, condom access, life skills and HIV information
On streets involved in begging and other forced labour	• Lack of info • Stigma and taboo • Exploitation, abuse • Lack of access to care • Authorities	Life skills, Walk in services, sexual health information
Incarcerated or detained.	• Lack of info • Stigma and taboo • Exploitation, abuse • Lack of access to care • Authorities	Institutional STI and VCT services, harm reduction, condom access

15. These children on the streets may be in or out of gangs and may have migrated from their birth places and family home.

4. Pakistan National Strategic Framework Priority Area 3

Goal: To reduce vulnerability of young people to HIV and AIDS

Young people leading LSBE discussion.

The challenge to reach this goal is ensuring that HIV prevention programming is disaggregated amongst the different sub-populations of youth, namely general youth population, especially vulnerable and most-at-risk in order to effectively leverage resources and ensure that targeted interventions work to stem the epidemic and prevent it from spreading into the general population. This means applying an integrated approach to HIV prevention work, but with a much clearer focus on programming with and for especially vulnerable and most-at-risk adolescents, which requires reassessment, reprioritization and re-programming of current interventions, approaches and partnerships to ensure that they can effectively contribute to reducing new HIV infections among adolescents.

Objective 1: To increase understanding about young people's particular STI/HIV and AIDS vulnerabilities and risk behaviours

Strategies:

1.1 Ensure that the national research agenda (to be elaborated by the National Surveillance and Research Committee[16]) includes research related to young people. Support on-going age and sex disaggregated assessment and analysis of risks and vulnerabilities to HIV infection, including economic and social vulnerabilities, of young people between the ages of 10 and 24 years in Pakistan's concentrated epidemic, as well as in emergency settings where appropriate. Specifically, these research activities should include: a) a comprehensive literature review, b) focused regional situation analyses, and c) regional KABP surveys.[17]

16. In addition to the National Surveillance and Research Committee, any other relevant Government institutions contributing toward the national research agenda.

17. The challenge will be to identify and reach those who are most-at-risk and this will require innovative social mapping and rapid assessment research methodologies. Once the data is collected, it will need to be assessed and analysis. The findings will need to be reviewed collectively by national and development partners as well as the programme beneficiaries. Although this is a logical step, it is sometimes not effectively undertaken, because it is often under funded or not well organized and therefore the findings do not contribute to their intended result: substantial data and evidence based re/programming among partners which improves the content and targeting and impact of the interventions.

1.2 Identify the training needs of relevant research organizations and NGOs related to research on the HIV vulnerability of youth, and build their capacities through the provision of needs-based training opportunities.

1.3 Identify the training needs of relevant research organizations and NGOs related to research on the HIV vulnerability of youth, and build their capacities through the provision of needs-based training opportunities.

(Key partners for Objective 1: Ministry of Health through the National AIDS Control Programme, Provincial Departments of Health through the Provincial AIDS Programmes, National Surveillance and Research Committee, other relevant Government research institutions, Ministry of Youth, selected research organizations and NGOs.)

Objective 2: To increase access of especially-vulnerable and most-at-risk young people to information and relevant skills and services to reduce their risk and vulnerability to HIV

Strategies

2.1 Identify, map and assess in each of the four provinces the existing services, and access of especially-vulnerable and most-at-risk young people to these services including: Primary Health Care; Reproductive/sexual health services, including STI treatment; HIV testing, and counselling services; Care, support and treatment services for HIV; Social Services (access to shelter, food, clothing); Referral for services (Advanced medical treatment, legal, shelter, drug treatment/rehabilitation, reintegration into families, and vocational training).

2.2 Strengthen existing within the formal and informal service network (e.g. training, infra structural support, and reinforcement of referral systems and linkages) so that more effective, confidential, needs-based, and youth-friendly services are provided for especially vulnerable and most-at-risk young people including: Primary Health Care (sensitisation of health care providers, referral out to more specialised services); Reproductive/sexual health services, including STI treatment (referral to VCT, more specialised services); HIV testing, and counselling services (consent, confidentiality and counselling specifically for children and young people); Care, support and treatment services for HIV (sensitization of health professionals, lab strengthening, paediatric AIDS training, hospice care, PMTCT orientation for youth); Social Services (reaching out and scaling up with access to shelter, food, clothing); Referral for services (advocacy, networking with social institutions, MoUs with health institutions for referral and service provision, especially for young people under 18 years of age).

(Key partners for Objective 2: Ministry of Health through the National AIDS Control Programme, Provincial Departments of Health through the Provincial AIDS Programmes, Ministry of Social Welfare, Child Protection and Welfare Bureau, public and private sector service providers)

Objective 2: To increase access of young people to appropriate BCC materials and peer education strategies

a. Peer Education Strategies disaggregated by general youth population, especially-vulnerable and most-at-risk

i. Identify existing peer education programmes through base-line survey, RSAs and mapping and assess their needs with a view toward capacity building, expansion and reinforcement.

ii. Standardize peer education and peer outreach training, implementation and monitoring activities and materials.[18]

iii. Strengthen the existing awareness campaign for the general youth population and in-school and behavioural development communication for especially vulnerable and most-at-risk young people through a peer education approach that includes the development of communication and decision making skills. Awareness campaign and behavioural development communication should be implemented in consultation with provincial and districts counterparts, and use local language and cultural references, and for in-school be specific according to the type of school.

iv. Develop Youth resource centres at district and union council levels both by public and private sectors to support peer networks. Referral mechanisms should be established, and competent Master trainers taught to expand peer education programme, linking to service provision.

b. Strategies for Materials Development disaggregated by general youth population, especially-vulnerable and most-at-risk

i. Collect and review with young people existing materials and messages for youth on sexual health education and its link with HIV and AIDS.

18. By reducing duplication, this will ensure economies of scale and increased coverage, as well as expand the opportunities for multi-partner supported interventions. Partners jointly support a wide range of communication and education materials with messages which complement each other, linked together and mutually reinforce each other as parts of a national "peer education" programme.

ii. Conduct focus group discussions among youth to gain an understanding about their knowledge and information needs, and to define the concept of peer education.

iii. Conduct participatory materials development workshops with youth, based on information provided by them about the kinds of materials they need and communication mediums they would be most likely to respond to.

iv. In collaboration with young people themselves, support the production and wide dissemination of IEC materials and messages targeting youth in local language, easily understood, according to cultural norms, age and gender disaggregated where relevant. The disseminations mechanism should be identified with young people and the impact of the material assessed with them.

(Key partners for Objective 3: Ministry of Health through the National AIDS Control Programme and the Health Education Cell, Provincial Departments of Health through the Provincial AIDS Programmes, Ministry of Education, Ministry of Youth, Ministry of Information, Ministry of Religious Affairs, Ministry for Social Welfare, Ministry of Sports and Culture, UN agencies, Bilateral organisations, National College of Arts, NGOs/CBOs, youth networks such as Boy Scouts and Girl Guides), young people.)

Objective 4: To strengthen the participation of formal and informal support structures and institutions in efforts to reduce the HIV and AIDS vulnerability and risk of young people

a. Strategies for school-based initiatives

i. Adapt an age gender and culturally appropriate life skills curriculum for primary, secondary[19] and college levels designed to enhance young people's confidence, communication skills, and healthy decision-making.

ii. Develop a curriculum for teacher training institutes which corresponds with the life skills curriculum in order to enhance the capacity of new primary, secondary school and college teachers to provide effective life skills training for young people.[20]

iii. Provide in-service training on the new life skills curriculum to those primary, secondary, and college teachers who are already in service, in order to enhance their capacity to provide effective life skills training for young people.

19. For Secondary School Adolescents adapt the National Generic Life Skills Package (curricula + teacher training) to be ready March 2006.
20. For Secondary School teachers adapt the National Generic Life Skills Package (curricula + teacher training) to be ready March 2006.

iv. Provide training on the new life skills curriculum to Parent Teacher Associations as well as community support groups linked with local NGOs and CBOs.

v. Implement LSBE initiative at primary school level, as well as at secondary school and college levels, including sexual reproductive health through the MoE/DoE with partners where relevant.

vi. Promote STI/HIV and AIDS education in extra-curricular activities for school-based youth, including such activities as debate clubs, theatre groups, peer education initiatives, as well as providing fixed life skills information points such as designated teachers or information centres in school premises.

b. Strategies for community-based initiatives disaggregated by general youth population, especially-vulnerable and most-at-risk

i. Support the comprehensive mapping of key players, structures and institutions that could support general youth population, especially-vulnerable and most-at-risk young people in protecting themselves and their peers at the community level, including institutions such as families, communities, unions and employer groups, vocational training centres, NGOs/CBOs, political leadership with religious leaders, line ministries/departments, local government representatives, law enforcement, jails and *madrassas*.

ii. Identify sensitization and training needs of these above stated community groups, caretakers and service providers to implement targeted prevention initiatives and provide support for their training needs.

iii. Develop needs-based and specific messages for each support structure to reach the general youth population, especially-vulnerable and most-at-risk young people.

iv. Support multi-sectoral initiatives and private/public partnerships which build the capacity of and ensure the participation of formal and informal structures to reduce the general youth population, especially-vulnerable and most-at-risk young people's vulnerability to HIV and AIDS. Ensure that bridging advocates are included such as local leaders.

(Key partners for Objective 4: Ministry of Health through the National AIDS Control Programme, Provincial Departments of Health through the Provincial AIDS Programmes. *In-School*: Ministry of Education through the Curriculum Development Wing and teacher training institutes, private educational institutions, Parent Teacher Associations, line ministries/depadments, local government, community groups, unions and employer groups, NGOs/CBOs, National Vocational Training Board and vocational training centres, religious leaders and opinion leaders and *madrassas*.)

Objective 5: To strengthen the support of gatekeepers for the implementation of effective vulnerability and risk reduction interventions for youth[21]

Strategies:

5.1 Data-driven development of legislative measures, policy instruments and strategies for programmes on children, adolescents and HIV and AIDS, with special attention to the disproportionate and specific vulnerabilities of young women and girls[22]

5.2 Conduct advocacy workshops with policy makers, other decision makers, and youth at all levels and in multiple sectors for the purpose of reviewing the specific HIV and AIDS prevention needs of young people, for gaining their support for initiatives designed to meet those needs, and to promote a protective and enabling environment and strengthen measures to prevent or reduce: stigma and discrimination; vulnerabilities associated with high-risk behaviour; and gender inequalities, gender-based violence, and gender stereotyping. In addition, consolidate, develop and demonstrate practical and effective approaches to youth participation in these advocacy efforts for creating supporting environment.[23]

5.3 Develop and disseminate advocacy materials for decision makers, authorities, and service providers at all levels and in multiple sectors to promote the reproductive health needs and rights of youth.[24]

5.4 Develop and implement an advocacy agenda for educators at all levels within the Ministry of Education and non-governmental sectors to raise awareness about the need to provide HIV and AIDS prevention information and skills building opportunities to young people.

5.5 Support networking and inter-sectoral collaboration opportunities for organizations (both governmental and non-governmental) working with young people and HIV and AIDS and enhance the capacity of these organizations to advocate for young people's sexual health needs.

5.6 Implement targeted and specific communication strategies for the general public regarding the importance of enabling young people to protect themselves and their peers

(**Key partners for Objective 5**: Ministry of Health through the National AIDS Control Programme, Provincial Departments of Health through the Provincial AIDS Programmes, Ministry of Education, Ministry of Labour and Manpower, Ministry of Youth, Ministry of Women's Development, Ministry of Religious Affairs, Ministry of Social Welfare, NGOs)

21. To create a supportive environment, we need to have support of gatekeepers - religious leaders, opinion makers, the media, politicians, local councilors, and parents.

22. The findings under strategy 1.1 should also be utilized for assessing, revising, developing and/or monitoring the enforcement of legislation and policy which should be designed to address factors influencing the structural and social vulnerability of adolescents.

23. There is need to develop the capacity of the national responses (for example the media sector/ministry of information) to organize a programme approach with a national implementation mechanism which aims to harmonize and align partners activities, reduce duplication, and map economies of scale.

24. Reproductive health rights of youth include availability and accessibility of information and contraceptives.

Annexes

Annex 1. Documents Reviewed

1. 2004 Report on Global AIDS Epidemic: Focus on Youth, UNAIDS.
2. A Parrot on Your Shoulder, International HIV/AIDS Alliance, 2004
3. Adolescent and Youth Reproductive Health In Pakistan, POLICY Project, USAID, March 2003
4. Adolescent Reproductive Health in Pakistan (Qazi, undated), PAVHNA.
5. Adolescents and Youth in Pakistan 2001-2002, Population Council and UNICEF
6. Alternative Report on the State of Child Rights in Pakistan, SPARC, 2003.
7. At the CrossRoads: Accelerating Youth Access to HIV/AIDS Interventions, UNAIDS, 2004.
8. Baseline Study of the Relationship between Injecting Drug Use, HIV, and Hepatitis C Among Male Injecting Drug Users in Lahore, UNDCP and UNAIDS, Pakistan, December 1999.
9. Children's Consultation Toolkit for Participatory Research on Corporal Punishment. UNICEF and Save the Children, undated.
10. Children on the Brink, 2004. UNAIDS
11. Child Protection and Empowerment of Adolescent Programme Workshop, UNICEF, July 2005
12. Conducting a Situation Analysis of Orphans and Vulnerable children Affected by HIV/AIDS, USAID, 2004.
13. Creating a Protective Environment of Children in Pakistan. UNICEF, 2004.
14. Declaration of the Rights of the Child (Proclaimed by General Assembly resolution 1386(XIV) of 20 November 1959.
15. Girls, HIV/AIDS, Education, UNICEF, 2004.
16. HIV/AIDS Prevention among Vulnerable Groups in Nine Prisons of NWFP, Dost Welfare Foundation, 2005.
17. Outline of Draft Pakistan Youth Policy 2004, Minister of State for Culture, Sports, and Youth Affairs, October 2004
18. Pakistan, RHIYA, EU, 2000.
19. Pakistan Thematic Group Position Paper on Human Trafficking, CIDA/IOM, June 2005
20. Programming Note on HIV Prevention with and for Adolescents, UNICEF Working Draft. September 2005.
21. Protection for a Life Time: A Qualitative Assessment of Adolescent Health and Life Skills Need in Pakistan. World Population Foundation. Undated.

22. Situation Assessment of Adolescents in Selected Districts of Pakistan for Life Skills and HIV Prevention (final draft), NACP, 2005.

23. Skills for Health, UNICEF and WHO, 2002 (draft).

24. Solvent Abuse among Street Children in Pakistan, UNODC, 2004

25. State of the World Population 2004, UNFPA.

26. Swiss Development Review of UNICEF LSBE Activity

27. Trafficking of Women and Children in South Asia and within Pakistan, LHRLA, undated.

28. UNESCO's Strategy for HIV/AIDS Prevention Education, 2004.

29. UN Implementation Support Plan on HIV/AIDS Pakistan 2004, UN Agencies.

30. Wheel of Change: Children and Young People's Participation in South Asia, UNICEF, 2004.

31. Youth Helpline Report, Pakistan, 2004.

32. Youth Net Participation Guide, FHI, 2003.

Annex 2. Explanation of Interventions Related to HIV Prevention in Young People

- **Life skills based education**: An education program conducted in and out of school providing youth and adolescents with a developmental process of planned learning opportunities to acquire skills, knowledge, and attitudes enabling individuals to effectively deal with the demands and challenges of everyday life. In particular, life skills are a group of psychosocial competencies and interpersonal skills that help young people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathise with others, and cope with and manage their lives in a healthy and productive manner.
- **Literacy skills**: Formal and non-formal literacy education. An increasing school enrolment level, particularly among young girls, is one of the most effective 'social vaccines' against HIV recognizing that poverty, underdevelopment and illiteracy are among the principal contributing reasons to the spread of HIV.
- **Vocational skills**: Education and training on vocational skills. Recognizing that poverty, and underdevelopment are among the principal contributing reasons to the spread of HIV, giving out-of-school youth the chance to earn a living for themselves and their families keeps them out of potentially risky situations. However, keeping youth in school should always be the priority.
- **Information-media products related to HIV prevention**: Production of materials for both literate and pre-literate youth audiences is crucial.
- **Linked STI services-youth friendly services for identified group of clients**: STI treatment is a method of primary HIV prevention as studies have shown that STI treatment can reduce HIV transmission significantly. Services must be linked to VCT and primary care and reproductive health services and be youth-friendly, meaning that youth under 18 must be allowed to attend unaccompanied by an adult, and the approach to service provision should be supportive of needs of youth and not discriminatory.
- **Linked VCT services**: Youth friendly services for identified group of clients linked to family planning and reproductive health services, primary health care, TB care, and NGOs.
- **Condom Access**: Easy and unrestricted access to condoms, both free and for sale.
- **Walk in services**: Day time or 24 hour service centre providing counselling, social support, and the like on voluntary basis. This is particularly important when working with street-based youth who need the most protection at night. Also for other youth, their movements may be restricted and their access random, when they can sneak a visit.
- **Outreach services**-proactive counselling and contact services which are provided by trained outreach workers. Includes person to person counselling, education, training, and materials: This is particularly important when working with marginalized or poor populations that may not feel comfortable, or have the means, to attend centralized services.

- **Peer education**: Counselling and person to person services which are provided by trained peers.
- **Institutional STI and VCT services**: Specialized services that are provided within the institution where youth are detained.
- **Harm Reduction**: Counselling, detoxification, drug substitution, rehabilitation, and needle exchange services that are provided on a voluntary basis for injecting drug users.

Annex 3. Questionnaire Conducted in Provincial Consultative Meetings

This questionnaire was used informally in the 4 districts as a guide to ensure that we would raise the same issues and have potentially comparable responses.

Date_____

Who is being interviewed_____email_____

A. Description of your Agency

1. Name of Agency_____ Location of Intervention_____
2. Program running from year_____ to year_____ What Target Group_____
3. Overall budget_____ for how many years_____
4. Number of Staff of Your Agency_____ Size of Local Target Population_____
5. Number of Participants in Your Program_____
6. What government office do you coordinate your work with?_____
7. What are the other agencies working with children and youth do you know about?_____
   _____

B. What works

1. Describe the interventions you use_____
2. How can you tell what is working or what is effective_____
3. How do you increase understanding about young people's particular STI/HIV and AIDS vulnerabilities and risk behaviours?_____
4. How do you create a supportive environment?_____
5. How do you strengthen the participation of formal and informal support structures and institutions?
   _____
6. How do you ensure the provision of effective and needs-based STI/HIV and AIDS related services for young people, inc. referral?_____
7. How do you enable young people to protect themselves and their peers from HIV infection?
   _____

C. What doesn't work

1. With your kids (target group, or participants_____
2. In your environment_____
3. In your institutions_____
4. In your services_____

Annex 4. Schedule of Field Visits and Institutions Visited

Date	Field Site	Institutions Visited
7-8 Aug	Lahore, Punjab	• UNICEF Office PACP • VisionHope CSEC project • Nai Zindagi Project Smile • Vitae N' Hope/Cimtech CSW project • Open Reception Centre: CPWB • SWD – OCF Programme • PCYO • PACP Mtg including New Light AIDS Control Society, Savoire Faire, AIDS Awareness Society
9-10 Aug	Faisalabad, Punjab	• Hayat Foundation – DIC for boys, Office, Female Madrassa, Out-of-School Girls
11-12 Aug	Peshawar, NWFP	• UNICEF Office • DOST Foundation • Meeting at the Department of Health chaired by the Secretary of Health including Dr. Zaffar from the PACP, the Secretary of Health, and representatives from the Ministry of Education, Social Welfare, Youth, and Planning and Development • AWARD • Youth Meeting • NWFP AIDS Consortium including those NGOs working around youth (mostly the TAMEER project round 2): Health Society, SAHDAR, TB Association and Sharp
15-16 Aug	Larkana, Sindh	• Partners Meeting at the District Government in Larkana including representatives of Education, Health, the focal person for HIV and AIDS, Finance and Planning, the Director of Chandka Medical College, then NGOs Mehran Trust, Bright Education, Welfare Association, Girl Guides, Community Development Network Foundation, PAHVNA • Discussion with Girls in Larkana
16-18 Aug	Karachi, Sindh	• Partners Meeting at the District Government in Karachi including Participants included Infection Control Society, Welfare Society, PACP NGO Coordinator, WHO officer at PACP, Mary Adelaide, Sukkur Blood Bank, Pakistan Society, PAHVNA, AZAD Foundation, Madadgaar, AMAL and others • Meeting with Adolescents including AZAD Foundation and AMAL youth volunteers, members of the Madadgaar Child Rights Club, etc.
30-Aug – 2 Sep	Quetta, Baluchistan	• UNICEF Office • Boy Scouts @ school in Mureesbad • EA Working Group: FPAP, Voice, Boy Scouts, Girl Guides, PACP, DoE, WES, AMAL, Religious Leader/Madrassa, SEHER • Baluchistan AIDS Network: General Reproductive Health Organisation, Legions Society, DARES, Community Development Organisation • PACP Chaired Mtg including ANF, SWD, Chief of Planning, Director of Colleges • Girl Guides