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Children Living in a World with AIDS

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Children Living in a World with AIDS

World AIDS Campaign Media Briefing

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Facts and Figures

- The United Nations Convention on the Rights of the Child defines a child as every human being below the age of 18 years.
- There is still no cure or effective vaccine for HIV, the virus that causes AIDS.
- UNAIDS, the Joint United Nations Programme on HIV/AIDS, estimates that there are already over 23 million people worldwide living with HIV, over 40% of whom are women. In some of the worst affected countries, up to 40% of women attending antenatal clinics in urban areas are HIV-positive.
- In 1996 alone, 400,000 children under the age of 15 became infected with HIV, bringing the total number of children in this age group living with the virus to 830,000 at the end of 1996.
- By the end of 1997, a million children under the age of 15 are expected to be living with HIV, over 90% of them in developing countries.
- Since the beginning of the epidemic, according to UNAIDS and WHO estimates, well over 2 million HIV-positive children under the age of 15 have been born to HIV-positive mothers, and hundreds of thousands of children have acquired HIV from blood transfusions or through sex.
- Because HIV infection often progresses quickly to AIDS in children, most of the close to 3 million children under 15 who have been infected since the start of the epidemic have developed AIDS, and most of these have died.
- Of the 1.5 million people who died of AIDS in 1996, 350,000 were children under the age of 15.
- The US Bureau of the Census estimates that by the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75% and mortality in children under 5 by more than 100% in those regions most affected by the disease.
- UNAIDS estimates that, by mid-1996, 9 million children under 15 had lost their mothers to AIDS. More than 90% of these children live in sub-Saharan African countries.
- Most children orphaned by AIDS are concentrated in those countries most affected by the epidemic. For example, data provided by the US Bureau of the Census and the World Bank indicate that there are 1.2 million Ugandan children under the age of 18 who have lost at least one parent to AIDS. This figure is increasing by an estimated 50,000 children each year.

- According to UNICEF, children orphaned by AIDS are the largest and fastest growing group of children in “difficult circumstances” in Zimbabwe. It is estimated that by the end of 1996, approximately 8% of children under 15 years of age in the country had lost their mothers to AIDS.

- Even children who are neither infected with HIV nor orphaned by AIDS are affected by the socioeconomic fallout from the epidemic in hard-hit communities and countries. An AIDSCAP study estimated that, by the year 2005, Kenya’s Gross Domestic product (GDP) will be 14.5% smaller than it otherwise would have been had AIDS never occurred. Per capita income is projected to be reduced by 10%.

- The vulnerability of girls to HIV infection is exacerbated by denial or neglect of their recognized human rights - including gender discrimination - resulting in particular in low access to socioeconomic opportunities.

- In many developing countries, some 50% of the population is under the age of 18 years. Directing prevention efforts to children is crucial in minimizing the further spread of the epidemic.

- Adolescents are especially vulnerable to infection through sex or drug injecting.

- Commercial sexual exploitation and domestic sexual abuse of children are contributing risk factors for HIV infection among children.

- Figures reported to the 1996 World Congress Against Commercial Sexual Exploitation of Children indicated that worldwide more than 1 million children enter the sex trade every year.

- Countless numbers of children worldwide are at risk of sexual abuse by relatives, other members of the child’s community or strangers.

- Estimates suggest that there are as many as 100 million children and adolescents in the world who are working or living on the street, often in violent and dangerous situations.

- The physical and mental abuse of children may increase the likelihood of their engaging in risk-taking sexual behaviour and thus increase their vulnerability to HIV.

Children living in a world with AIDS

— From the sick and neglected infants dying of AIDS in the orphanages of Ceaucescu's Romania to the young people watching over their dying parents in East Africa, images of the children of the AIDS epidemic have been among the most compelling reminders of the reach of this global crisis.

Today's children - defined by the United Nations Convention on the Rights of the Child as people under the age of 18 years old - are growing up in a world with AIDS. They are having to cope not only with issues and problems that have long existed and are now being revealed by the HIV/AIDS epidemic, but also with those that result directly from the epidemic and which, until recently, people only had to face as adults.

More children are contracting HIV than ever before, and there is no sign that the infection rate is slowing.

Children below the age of 18 are vulnerable to infection through mother-to-child transmission, unsafe blood and injection practices, sex - including sexual abuse, coercion and commercial exploitation - and injecting drug use. Much of this vulnerability stems from failure to respect their rights, including those guaranteed under the United Nations Convention on the Rights of the Child.

Unfortunately, the magnitude of the problem remains to be documented with any precision. There is a glaring gap in data on the incidence of infection among children as they grow into adolescence. One of

the shortcomings of HIV epidemiological surveillance to date has been to use the cut-off point of 14 years for younger children for the collection and aggregation of data - the older 15-49 year age group being considered as adults. A first step therefore for governments in fulfilling their obligations to children in the context of HIV/AIDS is to collect comprehensive data on HIV transmission among older children and adolescents, so that they can design effective prevention and care programmes in the light of these data.

The number of children infected around birth is easier to estimate. Around 90% of children who become infected under the age of 15 years acquire the virus from their HIV-positive mothers, whether before or during birth or through breastfeeding. And as women of child-bearing age themselves become infected in ever greater numbers - a trend reflecting their own social vulnerability to HIV - the number of babies infected through mother-to-child transmission rises correspondingly.

Since the beginning of the HIV/AIDS epidemic in the late 1970s and early 1980s, UNAIDS and WHO estimate that close to 3 million children under the age of 15 years have been infected with HIV. In 1996 alone, around 1,000 children died daily of AIDS and even more became newly infected with each passing day. At the end of that year, it was estimated that 830,000 children under 15 were living with the virus, a number that UNAIDS

expects to rise to 1 million by the end of 1997. Well over 90% of these children live in developing countries.

In sub-Saharan Africa, the region most severely affected by AIDS so far, the US Bureau of the Census has predicted that AIDS will offset improvements in infant and child mortality achieved in the past decade. **By the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75% and under-five child mortality by more than 100% in those regions most affected by the disease.**

Children are not only infected by HIV, they are also affected. While the number of those infected by HIV continues to grow, the epidemic is also having a direct and devastating effect on millions of other children whose lives have been permanently altered by the intrusion of HIV/AIDS into their households or communities.

Children living in hard-hit communities feel the impact as they lose parents, teachers and caregivers to AIDS, as health systems are stretched beyond their limits, and as their families take in other children who have been orphaned by the epidemic.

Individual households struck by AIDS often suffer disproportionately from stigma, isolation and impoverishment, and the emotional toll on the children is heavier still. And as the number of children orphaned or otherwise affected by AIDS rises, social security systems, already underfunded and overburdened

where they exist, are at breaking point. The impact is most acute on girls and boys already facing hardship or neglect - children in institutional care, children in poor neighbourhoods or slum areas, refugee children - and even more so for young girls who have unequal opportunities for schooling and employment.

In countries such as Uganda, where the epidemic already took hold over a decade ago, the impact of AIDS on the socioeconomic fabric of communities is becoming increasingly visible. As one UNICEF/WHO report puts it, "the effects of the epidemic are starkly obvious from the banana plantations going fallow, the houses closed or abandoned, the funeral processions on the roads and the recent graves near homes where grandparents care for children whose parents have died." AIDS sets back development and changes patterns of life. To a child, this translates into a world turned upside down.

But the shadow of the epidemic extends far beyond even these millions of infected and affected children. **In the final analysis, all children of the world henceforth face a lifetime of risk from HIV. They are exposed to the risk of HIV infection at different life stages as they grow into adulthood, because of circumstances such as sexual exploitation and abuse, or simply due to violation of their rights to information, to education and services.** There is a need for greater recognition of the specific needs of

girls and especially vulnerable children, both boys and girls, such as refugees, street kids, and children exposed to drug use.

In short, children and young people in all countries, and those who care for and are responsible for them, are having to adjust and adapt to this new world. The global epidemic is continuing to accelerate. There is, as yet, no vaccine against the virus. Neither is there a cure. For all the welcome recent advances in scientific treatments, there also remains great uncertainty as to whether and how such treatments could ever be made accessible to the vast majority of people living with HIV who are in the developing world.

AIDS has changed the world for children. The United Nations Convention on the Rights of the Child provides a framework for promoting and protecting the rights of children which can minimize the impact of the HIV/AIDS epidemic on them. Yet, despite its almost universal ratification, the response to infected, affected and vulnerable children has remained inconsistent. Internationally, AIDS programmes for children have been ad hoc and fragmented and have lagged behind those for adults. In many developing countries, this situation is worsened by poverty and other factors, such as wars and the resulting social breakdown of many communities.

The industrialized world has unmet needs as well. In a survey conducted in 1992 in the United

States, government lobbyists on children's issues admitted that while they were generally successful in promoting other causes such as education and anti-poverty programmes, they were much less so with childhood AIDS issues such as prevention, orphan care and education around sexual health.

In a world with AIDS, children must become everybody's responsibility.

On World AIDS Day 1994, heads of government from 42 countries attending the Paris AIDS Summit called for a global partnership to reduce the impact of the HIV/AIDS epidemic on children and young people.

Through the 1997 World AIDS Campaign, UNAIDS and its partners aim to bring to the attention of the international community the many facets of the epidemic's impact on the lives of children. The campaign will offer a platform for children and their communities to voice their concerns and aspirations in relation to the epidemic and to support the development of appropriate responses.

This briefing summarizes how the epidemic is having an impact on children who are infected by HIV, those who are directly affected by HIV/AIDS in their families or communities, and the children who are at risk of HIV infection. It outlines the global and national action needed to support children and their families as they face life in a world with AIDS.

The Rights of the Child in the context of HIV/AIDS

All children under the age of 18 living in today's world - whether they are themselves infected with HIV, affected by AIDS in their households or communities, or living in the shadow of HIV risk - are recognized by the United Nations Convention on the Rights of the Child.

The United Nations Convention on the Rights of the Child in the context of HIV/AIDS has spelled out principles for reducing children's vulnerability to infection and for protecting children from discrimination because of their real or perceived HIV/AIDS status. This human rights framework can be used by governments to ensure that the best interests of children with regard to HIV/AIDS are promoted and addressed:

- Children's right to life, survival and development should be guaranteed.
- The civil rights and freedoms of children should be respected, with emphasis on removing policies which may result in children being separated from their parents or families.
- Children should have access to HIV/AIDS prevention education, information, and to the means of prevention. Measures should be taken to remove social, cultural, political or religious barriers that block children's access to these.
- Children's right to confidentiality and privacy in regard to their HIV status should be recognized. This includes the recognition that HIV testing should be voluntary and done with the informed consent of the person involved which should be obtained in the context of pre-test counselling. If children's legal guardians are involved, they should pay due regard to the child's view, if the child is of an age or maturity to have such views.
- All children should receive adequate treatment and care for HIV/AIDS, including those children for whom this may require additional costs because of their circumstances, such as orphans.
- States should include HIV/AIDS as a disability, if disability laws exist to strengthen the protection of people living with HIV/AIDS against discrimination.
- Children should have access to health care services and programmes, and barriers to access encountered by especially vulnerable groups should be removed.
- Children should have access to social benefits, including social security and social insurance.
- Children should enjoy adequate standards of living.
- Children should have access to HIV/AIDS prevention education and information both in school and out of school, irrespective of their HIV/AIDS status.
- No discrimination should be suffered by children in leisure, recreational, sport, and cultural activities because of their HIV/AIDS status.
- Special measures should be taken by governments to prevent and minimize the impact of HIV/AIDS caused by trafficking, forced prostitution, sexual exploitation, inability to negotiate safe sex, sexual abuse, use of injecting drugs, and harmful traditional practices.

Source: The Role of the Committee on the Rights of the Child and its Impact on HIV/AIDS: Problems and Prospects, presentation by the World Health Organization Global Programme on AIDS at "AIDS and Child Rights: The Impact on the Asia-Pacific Region", Bangkok, Thailand, 21-26 November 1995.

Children with HIV: A future compromised

HIV/AIDS is a disease of the young. Last year altogether 400,000 children under the age of 15 years became infected with HIV worldwide, bringing the total number of children living with the virus at the end of 1996 to 830,000. Hundreds of thousands of HIV-positive babies are born every year to HIV-positive mothers.

By the end of 1997, UNAIDS estimates that 1 million children worldwide will be living with HIV.

In 1996 alone, of the 1.5 million people who died of AIDS, 350,000 were children under 15. Analyses indicate that, by the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75% and under-five child mortality by more than 100% in regions most affected by the disease. Health services, already under strain in many developing countries and in poorer areas of the industrialized world, are likely to have to care for increasing numbers of children with severe HIV-associated illnesses.

Children with HIV/AIDS in developing countries

HIV infection in children typically runs a faster course to AIDS and then death than in adults. And paediatric AIDS kills especially fast in developing countries. Sick children in developing countries are gener-

ally at greater risk of death than children in industrialized countries and this is no less true of children with HIV. In Europe, 80% of HIV-positive children survive at least until their third birthday, and more than 20% reach the age of 10. In Zambia, however, nearly half of HIV-positive children in one study had died by the age of two. In another study in Uganda, 66% were dead by the age of three.

In Africa, in general, the situation for sick HIV-positive children is very grave. **Many of the common, inexpensive antibiotics and other medications used to treat sick children without HIV also work for children with HIV - but often, even these drugs are unavailable.** Poor families are less able to afford health care and basic drugs to tackle opportunistic infections, a problem which is even more acute in countries with low health budgets and where health services are difficult to access. In addition, drugs for rarer HIV-associated illnesses have not been part of essential drug programmes that supply the world's poorest hospitals and clinics and clinical practice guidelines for paediatric AIDS are often less clear than those for adults. Increasing the availability of basic antibiotics for acute respiratory infections, anti-fungal drugs for thrush, and of drugs that can cure tuberculosis, is an urgent priority for developing countries with children and adults affected by AIDS. UNAIDS has made greater access to these drugs one of its primary concerns.

However, the more rapid course of paediatric AIDS in Africa is explained not only by less developed health care systems, but also by poor nutrition and widespread infectious diseases to which children are particularly vulnerable.

Poverty is a key reason why children die more quickly of AIDS in developing countries. If children are sleeping three or four to a room, for example, which is more common in poorer households, they are far more likely to transmit and contract tuberculosis or other respiratory diseases if one of them has any of these infections. If children are poorly nourished, their immune systems will weaken. If families do not have access to clean water, they are more vulnerable to waterborne diseases including diarrhoea.

Children with HIV commonly experience wasting and delayed development and are often killed by typical childhood diseases like diarrhoea, measles, tuberculosis and other respiratory infections. Because these diseases are often the same as those that kill other children, it is sometimes difficult for health workers in poor countries, without access to expensive HIV testing equipment, to distinguish HIV-positive children from others. This may have at least two important consequences. First, children with HIV may not receive the special care they need. Secondly, a general apathy about child health may arise, with consequences for all children.

In communities around the world, increases in infant and child deaths due to AIDS may lead to a mistaken belief that immunization and nutrition programmes for children do not work. Disenchantment with these programmes could increase mortality in uninfected children.

Women and children - a dual vulnerability

The dominant mode of transmission of HIV in newborn babies is so-called vertical transmission from their mothers. While in poorer countries some babies are still being infected through contaminated blood or medical equipment, virtually all HIV-positive infants have acquired the virus from their HIV-positive mothers during pregnancy or delivery, or through breastfeeding.

And women of child-bearing age make up an ever-increasing proportion of people with HIV worldwide - a trend that reflects their own biological and social vulnerability to infection. **Last year, 2.7 million adults became infected with HIV, nearly half of them women, and AIDS now kills more women annually than men in sub-Saharan Africa.**

Long-standing legal, economic and societal manifestations of gender discrimination and inattention to their sexual health influence considerably women's vulnerability to HIV/AIDS.

In Kenya, for example, an AIDSCAP report found that the vulnerability of women is exacerbated by historical trends which have removed men from their families for lengthy peri-

ods of time, increased the acceptability of male sexual activity outside of marital relations, and sanctioned the behaviour of older men to use their wealth and prestige to seek sex with girls and young women.

In the longer term, therefore, reducing the vulnerability of infants to vertical transmission calls for the same kind of action as reducing the magnitude of sexual transmission to women. The human rights of women must be fully promoted and protected, an approach that was reinforced by both the International Conference on Population and Development held in Cairo in 1994 and the United Nations Fourth World Conference on Women, held in Beijing in 1995, which called for a strengthening of preventive programmes and for gender-sensitive initiatives to address HIV/AIDS and to end the social subordination of women and girls. This encompasses the ability of all women, whether or not infected with HIV, to make and effectuate decisions about their reproductive and sexual health, including the avoidance of unplanned and/or unwanted pregnancies. In the immediate term, it is also vital to increase women's access to information about the prevention of HIV transmission in general and, within this, about existing ways of diminishing the risk of mother-to-child transmission both before and during pregnancy, and after birth.

But for prevention strategies to be equitable and effective, AIDS programmes must avoid falling into the ancient trap of seeing women only as mothers. And it would be tragic if, once again, as for contraception, women alone were left

with the responsibility for HIV prevention within sexual relationships, and men were absolved of this responsibility. HIV prevention must also move beyond measures that primarily focus on reducing the transmission of HIV between sexual partners. As stressed by UNFPA and other leading agencies, the respective status and roles of men and women in society must be considered in order to understand and act on the constraints imposed by the gender gap on behaviours relevant to HIV.

Why babies born in poor countries are at greater risk

While not all children born to HIV-positive mothers become infected, **this risk is, again, significantly greater in poorer countries.** Most studies suggest that the probability that an HIV-positive woman's baby will have the virus is between 25% and 44% in a developing country, and between 13% and 25% in an industrialized country.

There are a number of factors that increase a woman's risk of having an infected baby. They include a depressed immune status, poor nutrition, complications in pregnancy, and protracted labour after the waters break.

A further risk factor for the baby is breastfeeding - a practice that by and large is the norm in developing countries. It is estimated that, on average, approximately 1 in 5 babies born to HIV-positive mothers become infected around delivery and 1 in 7 during the breastfeeding period. A recent study of transmission through breast-

feeding to infants over six months of age in Côte d'Ivoire found a rate of 12%. Another South African study found that the mother-to-child transmission of HIV infection was 17% for bottle-fed infants and 38% for breastfed babies. Variations in rates are thought to be dependent on such factors as the level of viral load in the mother and in the breast-milk, the nutrition status of mother and infant, infected and bleeding nipples, and teething problems of the baby.

But while breastfeeding can kill by transmitting HIV, bottle-feeding can also be dangerous and increases risks to child health. In recent years, breastfeeding has been heavily promoted and encouraged for good reason. It affords vital protection against deadly childhood diseases, particularly diarrhoea and respiratory infections. And breastfeeding is a natural, cost-free method, whereas the cost of infant formula and even the clean water and fuel needed to prepare it, are often beyond the means of poor families in developing countries.

The HIV-positive mothers of newborns thus face a difficult dilemma in choosing between breastfeeding and bottle-feeding. The context will differ depending on the country and the woman's own socioeconomic status. For example, in Thailand where there is relatively wide access to safe water, HIV-positive mothers are given free infant formula by the government, provided with information on the risk factors, and the mother is encouraged to decide not to breastfeed. In countries in sub-Saharan Africa, however, providing infant formula would not be appropriate in many settings

because clean water for making up the formula is not available.

The policy of UNAIDS and its cosponsors is to encourage HIV-positive mothers to be given as much information as possible on the relative risks of breast-feeding and bottle-feeding so that they can decide whether to breastfeed or not. Women must decide for themselves how to handle the delicate balance between the risks and advantages of the two approaches - there can be no universally valid recommendation. But only women in possession of all the information are in a position to make fully informed choices.

To increase women's control over the situation, it is also important for countries to make voluntary HIV testing and counselling more widely available. This is important now - for example, women who know they are HIV-positive may choose to shorten the breast-feeding period or use artificial feeding - and will become increasingly important as new drug regimens are developed to reduce the risk of vertical transmission.

Anti-HIV drugs to keep babies from getting infected

In 1994, French and American researchers found that the antiviral drug AZT (zidovudine) administered to HIV-positive women in pregnancy and to their newborns reduced the rate of vertical transmission by 68%. Without AZT there was a mother-to-child transmission rate of 25.5%. With AZT, it was only 8.3%.

While clearly an important breakthrough, it soon became clear that this discovery would create an enormous ethical dilemma because a preventive regimen like this is difficult if not impossible to apply in many developing country settings. To begin with, AZT is a very expensive drug. **A full course of preventive treatment for a pregnant woman and her newborn costs about US\$1,000 - 1,500 in the United States.** An equally important problem is that the AZT regimen as initially developed, calls for the drug to be given for months before delivery, and to be administered as an intravenous infusion during delivery - neither of these being suited to prenatal and delivery care in many developing countries.

As a result, in many industrialized countries including the United Kingdom and the United States, and in countries such as Brazil, the initial AZT regimen is now routinely offered to HIV-positive pregnant women and their newborns. In other countries, such as Thailand, promotion of its use in this context is under consideration by the government. **But in many developing countries, where the annual per capita health expenditure may be as little as US\$10, and where women often attend clinics for prenatal care only late in pregnancy if at all, AZT is only available to the very wealthy or to women participating in clinical trials sponsored by agencies from industrialized countries.**

UNAIDS has made improved access to all drugs needed for the treatment of HIV disease in the developing world one of its highest priorities. For this purpose, it is conducting a trial

in five sites in South Africa, Tanzania and Uganda to evaluate the efficacy and tolerance of three simpler, shorter regimens for the prevention of mother-to-child transmission of HIV in a population where breastfeeding is the norm.

The UNAIDS trial has been designed to ensure that it is comparable to the real situation in which the local standard of care applies. The 1,900 HIV-positive participating pregnant women are fully informed about the way the trial is being conducted.

Every year 350,000 children get infected with HIV in developing countries from mother-to-child transmission. Finding shorter and more effective regimens which are adapted to the standards of care of most developing countries increases the chances that women will have access to drugs to protect their newborns.

At the same time, every effort must be made to ensure that women are counselled and supported in refusing unsafe sex during pregnancy - for their own sake, to maximize their chances of staying uninfected, and for the sake of protecting their infants. Equally important is to recognize and promote male responsibility in this respect.

It is not just mother-to-child

About 10% of HIV-positive children under age 15 become infected through routes other than mother-to-child transmission.

Some children acquire HIV from blood products containing HIV or from contact with unsterile skin-piercing instruments.

In Western Europe and the United States, a large number of

children with haemophilia, a blood-clotting disorder that affects mainly males, were infected through blood products in the early 1980s. Although medical practices and blood supplies have since been revamped in these and many other countries, elsewhere the dangers of transmission through unsafe blood and contaminated injection equipment in hospitals and other medical settings persist. The risk of contracting HIV infection through a blood transfusion is particularly great for children living in countries where the blood supply is not properly screened for HIV.

Adolescents are particularly vulnerable to HIV infection through injecting drug use and, above all, through sex. Issues regarding these children at risk are described in a later section of this report.

Children orphaned by AIDS

No one knows exactly how many children have been orphaned by AIDS worldwide but UNAIDS estimates that **by mid-1996, 9 million children under 15 years of age had lost their mothers to AIDS, more than 90% of whom were living in sub-Saharan African countries.**

While the global figure of 9 million is appalling, it reflects only a tiny part of a far larger social tragedy. Children whose mothers, or both mothers and fathers, have HIV begin to experience loss and suffering long before their parents' death.

In Brazil, for example, the Global Orphan Project (Boston & Brasilia) has estimated that there are some 183,000 children with living or deceased HIV-positive mothers. Of these, only 6% have already been orphaned. The overwhelming majority - 94% - still have their mothers. But many of these women are already suffering from HIV-related illnesses and lack the physical strength or family and financial support to take care of their children. All these children face deprivation and orphanhood in the years ahead.

Extrapolating these findings from Brazil to other countries is difficult because fertility rates and HIV infection rates among women differ from one country to the next. However, the results make it clear that, in any given country, the number of children with an HIV-positive parent is far greater than the number of children who have already lost a parent to AIDS.

Children orphaned by AIDS are just the more visible part, the tip of the iceberg, of the larger looming problem of children with parents living with HIV/AIDS.

Most children orphaned by AIDS are concentrated in those countries most severely affected by the epidemic. Data provided by the US Bureau of the Census and the World Bank indicate that there are 1.2 million Ugandan children under the age of 18 who have lost at least one parent to AIDS and that this figure is increasing by an estimated 50,000 each year.

According to UNICEF, children orphaned by AIDS in Zimbabwe are the largest and fastest growing category of children "in difficult circumstances". AIDS experts in the country estimate that by 1996, approximately 8% of children under 15 had lost their mothers to AIDS.

A uniquely painful experience

Children who lose a parent to AIDS suffer grief and confusion, like any other children who experience the death of a parent. But there are special differences.

For one thing, the psychological impact can be even more intense than for children whose parents die from more sudden causes, such as in armed conflict or as a result of an accident. HIV ultimately

makes people ill but it runs an unpredictable course. There are typically months or years of stress, suffering or depression before a parent dies. And in developing countries, where the epidemic is concentrated, effective pain or symptom relief is often unavailable to alleviate a parent's suffering.

The children's distress is often compounded by the prejudice and social exclusion directed at individuals with HIV and their families. This stigma may translate into denial of access to schooling, health care and of the inheritance rights of orphaned children. In this respect, girls may be at a further disadvantage.

A final cruel difference from other parental diseases is that HIV is likely to have spread sexually between the father and mother. Thus the child's chances of losing a second parent relatively quickly are far higher than, say, those of a child who has lost a parent to a disease that is not communicable to the partner.

These uniquely painful features of parental HIV/AIDS are of course of deep concern to the adults themselves. For HIV-positive mothers and fathers, making provision for their families is a main priority when they learn that they are infected. "My biggest fear was what was going to happen to the children", says Major Ruranga Rubamira, a major in the Ugandan army and the founder of the Ugandan National Association of People Living with HIV/AIDS. "I didn't know how long I was going to

live and I still felt that within the time left I must try to do something. I tried to start some kind of business for my wife and I tried also to put up a house."

Extended families soak up the pressure - but for how long?

The extended family is the traditional social security system in many countries. In many developing countries, deep-rooted kinship systems have accordingly provided support to children and families affected by AIDS. It is common, for example, for children orphaned by AIDS to be taken in by aunts and uncles or even grandparents, who may have little income and may have been counting themselves on being supported by the very son or daughter who died of AIDS.

The remarkable generosity of many people in countries most affected by AIDS is also shown by the high incidence of fostering of orphans by unrelated families, often by neighbours. A study in Kagera, Tanzania, indicated that families who had themselves experienced an AIDS death were more likely to take in children orphaned by AIDS from other households. Those households with the most dependents were also the most willing to take on additional orphans.

Financial pressures on those least able to afford them have inevitably increased. "I have 11 orphans living with me", says Leone from Uganda. "My elder sister died and left me with her six children. And the other five belong to my daughter who also passed away.

Taking care of these children is difficult", she says.

Even before the AIDS epidemic, many of these communities were already being pushed to breaking point as a result of labour migration, demographic change and other factors. With the advent of AIDS, the constraints have become even greater. One of the symptoms of this is the increasing numbers of households now headed by children - some of which may previously have been headed by grandparents at the death of the parents. "The death of a grandparent may leave the situation where there is nobody else in the extended family willing to care for the children, giving rise to orphan households headed by older siblings", says Geoff Foster of the Family AIDS Caring Trust in Zimbabwe.

It is not only in developing countries that the extended family system is under strain. "Many European countries, particularly in Central and Eastern Europe, are experiencing problems as family systems come under pressure because of changing social structures and demography", argues Naomi Honigsbaum of the European Forum on HIV/AIDS, Children and Families. The same is increasingly true, for example, in metropolitan areas of the United States, such as New Haven and New York.

A vicious circle of poverty and discrimination

The relation between HIV/AIDS, impoverishment and denial of human rights is apparent

in the impact of the epidemic on children who have been orphaned by AIDS.

When an HIV diagnosis in the family becomes known, friends may come to visit less often, and children may be taunted or harassed by school-mates. In Zimbabwe, focus group discussions with members of AIDS-affected communities indicated that the **social isolation of children orphaned by AIDS was common**. And in the north of Thailand, a 1994 study of 116 households affected by HIV found that stigmatization, due largely to incorrect beliefs about HIV transmission, was widespread in everyday life. It was acknowledged by 20% of HIV-affected families that other children in the area were forbidden to play with their own.

Family poverty can follow in the footsteps of stigmatization. The Thai study found that many parents had lost jobs as a result of AIDS and family enterprises had lost customers.

Many extended families that have accepted orphans cannot afford to send all their children to school, and **orphans are often the first to be denied education**. "My foster mother wants to stop me from going to school. She wants me to work as a maid so I can earn money to buy food", says Beatrice, a 16-year-old from Kenya. A study in Zambia indicated that in urban areas, 32% of orphans were not enrolled in school, compared with 25% of non-orphans. In rural areas, 68% of orphans were not enrolled compared with 48% of non-orphans.

For many families, sending their children to school simply becomes an impossible option. "When my father died I was 14 years old", says Maurice Kibuuka, a 14-year-old Ugandan. "There were eight of us and my mother was left in care of us. I became the head of the family and I was responsible for looking for money, food, clothing, and even shelter... I had no choice but to drop out of school."

Discrimination in accessing health care is a major form of social exclusion faced by orphans. About two-thirds of children born to HIV-positive mothers do not contract the infection and grow up to be as healthy as any other child in the community. However, this fact is often unknown or ignored. Evidence suggests that children orphaned by AIDS may be at greater risk of dying of preventable diseases and infections because of the mistaken belief that when they become ill it must be due to AIDS and therefore there is no point in seeking medical help.

Children orphaned by AIDS are also at risk of losing their property rights, and rights to inheritance. Moreover, as shown before, the realization of children's rights is inextricably linked with their mothers' human rights - hence laws which disenfranchise widows have a devastating effect on the lives of their children.

The resulting poverty and isolation can create a vicious circle, placing children orphaned by AIDS, and particularly orphaned girls, at greater risk of contracting HIV themselves.

"This lady likes mistreating me because my mother is dead", says one Ugandan girl

interviewed by Panos. "She wants me to sleep with men because I stay at her house. She brings these men into her house and introduces me to them. She often tells me to be good to them and says this is the only way I can continue to live in her house", she says.

What is being done to help?

The problems faced by AIDS-affected families have become a major priority for many national aid programmes, as well as for international organizations such as UNICEF, and the Save the Children Fund. There are thousands of small community-based schemes around the world that aim to provide care and support to children orphaned by AIDS. In Uganda, for example, an organization called Uwesio provides emergency material support and vocational training for these orphans. In Côte d'Ivoire, the International Catholic Child Bureau is helping to place orphans in foster homes and provides training and assistance. In Kenya and Tanzania, the African Development Foundation has funded farm projects, secondary education and housing for AIDS-affected families.

But such projects are not being carried out on the scale that is required. Most orphan programmes can only help fewer than a hundred children at one time. In countries like Thailand, Uganda and Zambia where tens or hundreds of thousands of children are affected, the response desperately needs to be geared up to provide even

basic support to those who most need it.

Finance is an important consideration. Many orphan programmes rely on funding from non-governmental organizations based in economically affluent countries and UN agencies, and are seldom self-sustaining. Investment in these orphaned children is necessary for a stable future, both for the children themselves and for their communities. **But in the world's poorest countries, children orphaned by AIDS may be seen as only one of many competing urgent priorities.**

Despite a widespread belief that orphans are well-served by AIDS care organizations, there is a growing realization that such care is inadequate and that children orphaned by AIDS are in reality often a neglected group.

Reaching children before their parents die

Problems for children affected by AIDS are most acute from the time that HIV is diagnosed in a parent. If organizations wait until children become orphans, it is almost too late. Before the massacres in Rwanda in 1994, Caritas Rwanda, a Christian NGO, tried to help parents plan for the future of their children. They worked with parents to identify solutions and arranged for children to move in with relatives or foster parents. Caritas also advised parents on legal and property matters.

In 1994, representatives from NGOs throughout southern

and east Africa drew up the "Lusaka Declaration on Support to Children and Families affected by AIDS". It urged that wherever possible, **efforts should be made to keep children in AIDS-affected families in their communities.** These efforts, it argued, should begin before the death of the parent. Home-based care schemes, in which visiting health or community support teams attend AIDS patients at home, should also be involved in helping parents plan ahead for their children.

The declaration also recognized that families affected by HIV are vulnerable to exploitation and recommended that NGOs inform people affected by HIV of their legal rights, and that governments revise existing laws to further protect these individuals.

Orphanages - a last resort

Orphanages should only be considered as a last resort in providing care to those orphaned by AIDS, according to experts. Dr Eric Chevallier of AIDES Médicale Internationale argues: "Orphanages are far more expensive than community-based approaches and they can be culturally inappropriate if they cut children off from their social origins. The link between generations is very important", he emphasizes.

Orphanages may be more successful in countries where they have been more commonly used in the past, such as in Thailand and India. **But even in countries where orphanages are the norm, they can act as a magnet for stigmatization.**

In 1995 in Romania, a group of citizens led by a town mayor stormed an orphanage because it housed children who were known to be HIV-positive. "The local population argued that these children can infect the other children in the town, as well as those in the orphanage", reported Romanian journalist Dan Stoica for Panos.

Institutional care has many limitations, as it usually cannot provide children with an ongoing, trusting relationship with a specific adult primary caregiver. Furthermore, institutionalization has proved to have adverse effects on people once they try to reintegrate into their communities, as they tend to lack support networks and the skills to develop them. Institutionalized care has also been found to nurture dependency and to work against self-reliance.

Children in the shadow of HIV risk

In a world with AIDS, there are children who are infected with HIV and those who are affected by the epidemic's intrusion into their families or communities. But the epidemic casts its biggest shadow by far on the hundreds of millions of children who live in risk of HIV infection because their fundamental rights, including to medical care and to HIV information and education are ignored, or because their personal circumstances make them especially vulnerable.

HIV and child sexual abuse

Sexual abuse during childhood and adolescence, while not a new phenomenon, has recently emerged as a pervasive problem affecting all societies.

Sexual abuse of children takes two main forms - commercial sexual exploitation, which is now known to be a multi-billion dollar world industry; and sexual abuse in the home or community, whether by relatives, "friends" or associates of the child's family, or others with easy access to the child such as schoolteachers or employers.

Children in the sex trade

No one knows how many child sex workers there are in the world. Because of the clan-

destine nature of the trade, precise figures are not known, and there is a chronic lack of accurate research in this area. Figures reported to the first World Congress Against Commercial Sexual Exploitation of Children, which took place in Stockholm in August 1996, suggested that:

- worldwide, more than a million children enter the sex trade every year;
- children are working as prostitutes in the Netherlands;
- there are between 400,000 and 500,000 child prostitutes in India, according to a survey by *India Today* magazine;
- around 25,400 minors are engaged in prostitution in the Dominican Republic, according to a survey there.

What research has been done suggests that such exploitation is growing, and the age of the children involved is falling. Most children in the sex industry are girls aged between 13 and 18, although there are instances of much younger children being sold. Many such children spend most of their lives on the street, often because they are escaping violence or sexual abuse at home. Other children live in brothels, having been drawn into prostitution by procurers. For example, female children are often purchased from their parents or lured to the city with promises of jobs, education or money, only to be sold to a pimp.

Girls are at greater risk than boys because of systematic

gender discrimination resulting in lack of access to educational and employment opportunities. Those who have been abused or forced into prostitution are often stigmatized and marginalized, which further undermines their status, and reduces their opportunities for accessing education, formal employment and, in many societies, marriage.

The HIV/AIDS epidemic has made child sexual abuse and child prostitution more dangerous than ever before. **Studies everywhere indicate that rates of HIV infection among child sex workers and street children are often very high.** Surveys of Kenyan girls living on the street indicated that as many as 30% were HIV-positive.

The belief that children are less likely to be infected has raised the demand for younger sex workers in recent years. The vulnerability of children to sexual exploitation, either through sex work or abuse, may well result in their becoming infected with other sexually transmitted diseases such as gonorrhea, syphilis and chancroid. By damaging the surfaces of the reproductive tract, physical trauma and sexually transmitted disease each increase the child's susceptibility to HIV as well as the HIV/STD risk to their clients. The problem is compounded by the lack of health care services meeting the sexual and reproductive health needs of children.

Only recently has a strong activist movement, driven primarily by non-governmental child action groups, brought the commercial sexual exploitation of children to international attention. The 1996 Stockholm World Congress Against Commercial Sexual Exploitation of Children marked the first concerted international attempt to tackle the problem.

Steps are being taken at national levels to target not only commercial sexual exploitation at home but also abroad. New extraterritorial laws in some countries, including Australia, Germany, Japan, the Netherlands, Sweden, the United States and the United Kingdom, now permit countries to prosecute nationals guilty of sex offences against children overseas. The World Trade Organization recently established a new Task Force to target tour operators and hotels that knowingly cater to sex tourists. Enforcing these new sanctions and laws will require international cooperation from a variety of actors including government entities such as the police and judicial systems, as well as NGOs.

However, several experts at the Stockholm conference also stressed that, while sex tourism is a major problem and was well documented, "commercial sexual exploitation of children is predominantly a local issue, with both clients and agents coming from the local community."

Abuse closer to home

Awareness all over the world is growing of the scale of child abuse which takes place

in or near the home. **Countless numbers of children in developing and industrialized countries alike - above all, girls - are at risk of sexual abuse by relatives, other members of the child's community or strangers.** Sexual abuse in the home is also a significant factor in pushing children to leave home, thereby perpetuating a cycle of vulnerability.

A study in Zimbabwe found that most cases of child sexual abuse probably go unreported. Some are detected when the child develops a sexually transmitted disease - proof that abuse took the form of actual sexual intercourse. In 1990, 907 children under 12 were treated for a sexually transmitted disease at the Genito-Urinary Centre in Harare. Most of the offenders responsible for passing these infections to the child were either neighbours or close relatives.

While in some cases sex takes the form of actual rape, in many instances it ranges from enticement to coercion. The growing phenomenon of "sugar daddies" illustrates the grey area surrounding the exchange of sex for goods and cash. These are older men who seek out young girls (often, because they believe they are at less HIV risk from children) and entice them into sex with offers of meals, clothes, luxuries and cash, including money for school fees. The age disparity between the girls and their sugar daddies, who are older and sexually experienced men, creates a particularly great HIV risk for the children.

Girls employed as domestics are vulnerable to another type of sexual abuser - the male head of household, or his sons. Occupational exposure to sexual

coercion is, of course, not restricted to household employees, but live-in domestics run a particularly great risk because they are accessible around the clock.

Sanctions and laws are only a first step in stopping child sexual abuse. In the shorter term they may raise awareness of this terrible affliction. Increased attention will in turn help change the culture of silence surrounding abuse and make societies more sensitive to abused and exploited children. **But while laws forbidding sexual exploitation of children exist in nearly every nation on earth, they are notoriously hard to enforce.** Even when cases are brought to court, abused children often make reluctant witnesses.

HIV and consensual sex with peers

Children are not only at risk of HIV infection when they are sexually exploited or abused, but also when they engage in consenting sex. In many countries, many children have their first sexual relationships when they are under the age of 18. Adolescents also engage in unprotected sex with sex workers.

A major source of vulnerability as far as children is concerned is their lack of knowledge about HIV transmission and their lack of skills in recognizing situations that may turn risky, such as alcohol consumption, standing up to pressure for sex (and drugs), and negotiating condom use and other forms of safer sex.

Love and trust also make children vulnerable. The rate of partner turnover is often greater

during adolescence and the early twenties than in later years. This applies not only to casual partners but to regular relationships which occur one after the other. Although these relationships may not last long, in the minds of young people they are often considered to be "safe" in terms of HIV transmission because they are regular and monogamous. Thus unprotected sex (intercourse without a condom) occurs with a series of partners, but the risk is masked by the apparent monogamy and trust involved in each such relationship. Yet the unwanted pregnancies and high rates of STD infection among young people show that the unintended consequences can be severe and - in a world with AIDS - lethal.

HIV and drug use

In a world with AIDS, the injection of illicit drugs, always a risky behaviour, carries an additional danger - HIV infection. When people of whatever age share needles and syringes to inject drugs, microtransfusions of blood occur - and these are relatively efficient for transmitting HIV and other microbes. Drug injecting is thus a phenomenon that policy-makers, educators and HIV prevention workers concerned with child protection cannot afford to neglect.

Drugs do not have to be injected to carry an HIV risk. Alcohol, smoking drugs or glue-sniffing are apt to make people forgetful or careless about safe sex, and reduce the likelihood of condom use. While some adolescents inject drugs, many more engage in non-injecting use of substances that can increase their vulnerability to HIV infection.

Many factors, both individual and social, influence drug use. However, the association between drug use and HIV infection appears to be particularly dangerous for females involved in commercial sex and for both girls and boys on the street. The environmental factors involved include poverty, discrimination and lack of access to education and health services. "When surveyed, young people in developed or developing countries often indicate that boredom, curiosity and wanting to feel good are perceived as the main reasons for use. Other functions served by substance abuse are to relieve hunger, to adopt a rebellious stance, to acquire courage to beg or be involved in commercial sex, to keep awake or get to sleep, and to dream", says a WHO report.

Children in difficult circumstances are more likely to maintain and escalate substance abuse. For girls living or working on the street, the risks are particularly great as they often have to cope with violence, HIV and other STDs, unplanned pregnancies and unsafe abortions. If they carry their pregnancies to term, they are often left to their own devices to support themselves and provide for their children.

Refugee and displaced children

As civil conflict, political persecution, and natural disasters continue to plague many countries, millions of people are forced to live outside of their countries of origin. The majority of the world's refugees are children and women. In conditions ranging from large

rural encampments with very limited infrastructure to intensely crowded urban shanty towns, young refugees are particularly vulnerable to nonconsensual sex. Even if there is consent the availability of condoms is often quite limited.

The same is also true for many displaced children who remain within the borders of their country, but not in their homes. They survive in very unstable, often threatening environments where risks are high and rights are rarely protected. To make matters worse, refugee and displaced children are known to be targeted for rape and sexual abuse by adult tormentors from within their own communities, and from external exploiters taking advantage of these environments in which children's rights are often violated.

Children in detention and HIV

Similar to the saga of their adult counterparts in prisons, children who are in detention or remand centres are often exposed to violence, abuse, and unwanted sex. Drug abuse is also a compounding factor for HIV transmission, along with the prohibition of condoms, and body piercing and unsanitary/unsafe tattooing. Young people in reformatories and other such facilities often have few, if any, options for preventing HIV and other sexually transmitted diseases. Without radical reform in juvenile justice and social welfare institutions, these children will remain with their rights violated - and their risks increased.

The window of hope

Strengthening development to strengthen coping

The socioeconomic costs of AIDS are affecting the ability of developing economies to sustain their development gains - and this has enormous repercussions on children.

Other diseases have profound effects on the survival and well-being of children. But a distinctive feature of AIDS is that it affects a tremendous number of young people who are also parents - adults in their most sexually active and most productive years. In the worst-hit areas, resources become increasingly stretched as AIDS mortality increases the burden of income-generation and child care and places it on the shoulders of fewer and less able-bodied adults. AIDS stigma can affect the willingness of communities and extended families to care and support those who are most affected. Society's coping capacity is further adversely affected by the fact that the effects of HIV manifest themselves over periods of years and that AIDS deaths tend to be clustered within families, with very often more than one parent and more than one child in a particular household becoming infected.

However, it is still difficult to make reliable estimates of the impact of AIDS on economies, because AIDS impacts differently on different socioeconomic systems and even on different sectors within the same economy.

For example, the loss of a single income earner in a family may have a different impact in rural and urban areas due to the types of family structures. In urban areas, the loss of a single wage earner can affect a large group of extended family members. Labour-intensive farming systems are also more vulnerable to the loss of able-bodied adults than others.

Improving understanding of these issues is not just of theoretical interest. It is a practical necessity. Unless knowledge of the socioeconomic effects of AIDS improves and is reflected in planning and policy development, strained economies around the world will tend to consider HIV/AIDS as just one more competing need to respond to, and may find it increasingly difficult to allocate resources for prevention programmes.

Just as important, a deeper understanding of these issues strengthens the argument for building up development as a way of helping families and communities withstand the impact of AIDS.

A shift of emphasis is needed away from relief towards longer-term intersectoral approaches to meeting the needs of AIDS-affected children. A relief approach of providing directly for children's needs is generally not sustainable where the number of affected children is large. Wherever possible, resources should be directed to enabling families and communities to

establish and maintain a sufficient economic base to provide for children's needs. And children themselves need to have their educational and employment opportunities bolstered if they are to break out of the pernicious cycle of poverty and AIDS.

While children are an increasing part of the AIDS problem, they are also a critical part of the solution. "We have a window of hope between the ages of 5 and 18 years", says Dr Sam Okware, Uganda's Commissioner for Health. "If that group can be educated, if their behaviour change can be modulated to ensure they do not have risk behaviour, I think we have a future".

Education and empowerment combined with the promotion of children's rights are believed to be key to HIV/AIDS prevention by leading agencies such as UNICEF and UNESCO. However, much of this needs to be directed not only to the youngsters themselves but to their families - the most important social support for children. Reducing children's vulnerability to HIV means improving the economic situation of their families. Development agencies such as UNDP have repeatedly emphasized the need to create micro-funds, micro-credit schemes, rural employment schemes and other instruments that can raise living standards and ensure sustainable livelihoods for children and their families. Reducing children's vulnerability also means keeping the various communities' HIV risks constantly in

mind when, for example, targeting development assistance. In northern Thailand, for example, the Daughters of Education project provides funding for girls who might otherwise be sold into the sex trade to remain in school and develop better employment prospects.

In other words, development not only strengthens society's ability to cope with the impact of HIV/AIDS. Development strengthens society's ability to withstand HIV transmission.

School education on HIV/AIDS

Provision of AIDS education and education concerning sexual health is an issue fraught with controversy the world over. The objection to providing education on sexual health is most commonly stated as a fear that such education will encourage early sex. UNAIDS recently commissioned an update of an earlier WHO review of studies - mostly in the USA and Europe - on the effect of sexual health education. The aim was to assess the impact of sexual health education on the behaviour of students in terms of rates of teenage pregnancy, abortion, birth, sexually transmitted diseases, and self-reported sexual activity.

The review showed that responsible and safe behaviour can be learned. Education on sexuality and/or HIV does not encourage increased sexual activity. Quality programmes in fact help delay first intercourse, and protect sexually active young people from sexually transmitted disease, including

HIV, and from pregnancy. Among other things, quality programmes feature a clear explanation of the risks of unprotected sex and methods - including abstinence - for avoiding them, and help young people practise communication and negotiation skills.

There are also questions as to how early the provision of AIDS and sexual health education should begin. Issues such as the increasing evidence of sexual abuse in particular has persuaded some teachers and AIDS workers that some form of "life-skills" education at primary school is necessary. The UNAIDS-commissioned review also found that sexual health education is best started before the onset of sexual activity. Such early education is believed to be particularly important by AIDS workers in developing countries, where secondary school enrollment is much lower than primary, especially for girls. In many countries, the majority of children have left school by the age of 15. Reaching these children quickly enough, many of whom are poor, unable to read and write and are among the most vulnerable to HIV infection, is arguably the highest AIDS prevention priority.

According to one AIDS worker in Zimbabwe, "we start in schools from about 8 years or 9 years old. It sounds too early but in our country there is a lot of child sex abuse, even rape, which makes it very important for us to introduce the subject during that period or even earlier. We want to have this child know that this is my body, nobody has a right to my body, if anybody fidgets around with my body I should report it to my

mum and dad so that I am protected. We start talking about the information that helps this child to know who they are and how they can best protect themselves", she says.

In recognizing the important role children can play in protecting themselves and their communities from HIV, it is equally important to recognize the power that many people and institutional structures may exercise in preventing children from accessing education, information and life-skills training. These "gate-keepers" may be parents, teachers, educators, community and religious leaders, media professionals, policy makers, and government officials. Experience shows, however, that when parents are given the facts, they generally agree on the need for AIDS education. There is an urgent need to bring these gate-keepers on board and gain their cooperation in promoting early life-skills education and prevention for children. This implies the need to provide AIDS and sexual health education also to adults.

Reaching children outside the school setting

Although some of the most intense arguments around AIDS education have centred on sexual health education in the school setting, UNAIDS and its cosponsors have insisted that education also needs to be targeted as a high priority at those children who are not in school.

In some countries, up to 80% of children do not continue beyond primary level. And it is these groups who are often at much higher risk of HIV infection than those who stay in school. Among these children are those living in rural areas, in urban slums, those employed in factories, refugees, migrants and those engaged in sex work.

Among those at greatest risk are street children. Some estimates suggest that there are as many as 100 million children and adolescents in the world who are working or living on the street, often in violent and dangerous situations. In Brazil alone, there are an estimated 7 million children and adolescents from very poor families living and working on the streets. These groups are some of the most vulnerable to HIV infection and to other dangers. For many, sex may be a means of securing money, food, shelter, protection, comfort or affection.

Injecting drug use and HIV prevention

As with the prevention of sexual transmission, HIV prevention related to drug use must encompass far more than the simple provision of information. There must be an emphasis on the acquisition of skills for negotiation, building self-confi-

dence, making the right decisions and resisting peer pressure. And the disempowering context within which these children live must be recognized and remedied - for example, the interface between drug use, with its stigma especially for females, and the commercial sexual exploitation of girls.

A key need is to integrate sexual health education and drug education, not conduct them separately, because they are both inextricably intertwined in HIV transmission.

Measures must be designed and carried out in a way that helps build a supportive environment for these children. Information per se is not enough. HIV prevention means tackling their vulnerability at its roots. It means helping the children acquire the skills they need to negotiate safer sex, resist peer pressure for sex and drug use, and establish personal support networks. Counselling is important because it helps children mature and make sound decisions. In short, preventing the HIV risk associated with drug use calls for programmes targeted at the drug users themselves, their sex partners and family members, health care workers and the general community. It also requires advocacy to raise the consciousness of adults not to lure children into drug use.

Involving children

If children really do offer a "window of hope" for influencing the future course of the AIDS epidemic, understanding their needs and perceptions will be critical.

At an international conference on AIDS in Kampala in 1995, a "delegation" of young Africans from 11 countries ranging in age from 14 to 24 issued a declaration of their needs and priorities. "We strongly believe that our energy, idealism and commitment can be used to stop the further spread of the AIDS epidemic that is devastating the social and economic fabric of our countries", they declared.

At the same time, it must be recognized that children are not in this world alone. Parents, school teachers, religious and community leaders must also be involved in developing programmes for children if they are to be accepted by the community and help build a safe and supportive environment. Securing their involvement requires ensuring that they hear the concerns and aspirations of children. Creative ways can be found of "amplifying" the voice of children.

In Thailand, for example, a Children's Forum has been created in parliament, while a "media page" in newspapers and magazines captures children's voice and channels their experience to the adult world.

AIDS is the most publicized disease in the world, but its impact on children has received an inadequate response. Adults can and must do their part to ease the suffering of children infected with HIV, help children in AIDS-affected homes and communities, and enable all children living in the shadow of HIV risk to grow up uninfected. But it may be that the epidemic's future course will be shaped by the actions of those it is increasingly affecting: the children who live in a world with AIDS.



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Youth Health and Development

**Discussion paper
for the review and appraisal of action taken to implement the
World Programme of Action for Youth to the Year 2000
and Beyond**

Prepared by: WHO UNICEF UNFPA UNAIDS

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This discussion paper has been prepared for the World Conference of Ministers Responsible for Youth. It has been produced by WHO in collaboration with UNICEF, UNFPA and UNAIDS, and incorporates the consensus from on-going collaboration with UNESCO, UNDCP and UNHCR. The views expressed represent the current programming consensus, not necessarily the policies of the individual organizations. The involvement of the different UN organizations in this area of programming is based on their mandates, mission statements and strategic advantages, and young people's health and development will be a growing focus for health sector and UN reform.

1. Introduction

This report is a synthesis of the current understanding within the four UN agencies on the main challenges in promoting youth health and development ^a. We now know the complex nature of young people's health and development as well as what can be done effectively to promote healthy development. The time has come for countries, with support from the international community, to make a concerted effort to plan, monitor and strengthen their activities for youth health in a way that allows the interventions to go to scale in a efficient and sustainable way.

A multiplicity of interconnected health problems and behaviours challenge the health and development of youth. These include the consequences of unprotected sexual behaviour which increases the risks of too-early and unwanted pregnancy and childbirth, induced abortion in hazardous circumstances, and sexually transmitted diseases including HIV/AIDS; problems associated with the use of tobacco, alcohol and other drugs, impairing judgement, and increasing the long-term risks of cancers, cardiovascular diseases, and respiratory ailments; accidental and intentional injury; mental health and problems of malnutrition and oral hygiene, as well as some endemic diseases such as tuberculosis, malaria and schistosomiasis.

At the same time as there is an increasing awareness that young people face many problems, there is fortunately also a growing appreciation that they themselves are not the problem. On the contrary, in general they will be a key element of the solution to the problems that confront them. Young people are a force for positive change, but if they are to make their unique contributions to their families and communities and societies in which they live, it is essential that their health and capacities be given adequate attention. Furthermore, it is only if their rights to health and development are met that they will be in a position to benefit from the positive aspects of the rapid changes that surround them, rather than having their growth and potential undermined.

The "Framework for country programming" (see Annex 1), developed by the Study Group, highlights the essential elements and strategies needed to establish, implement and sustain programmes for youth health. The Study Group on Programming for Adolescent Health that WHO, UNFPA and UNICEF held in 1995 recommended a Common Agenda¹, which was adopted by UNFPA, UNICEF and WHO to accelerate and strengthen programming for health, including the global and regional support needed for country-level programming. A steadily rising number of countries are devoting resources to young people's health and development through a variety of sectors.

No single institution alone, whether private or public, can take the action needed for the health and development of young people. Alliances at the national and global level in a cooperative spirit are needed to create environments that will maximize the potential of all young people. This cooperative spirit is vital to the achievement of this goal and within the UN family was exemplified by the joint Study Group.

^a. "Youth" is defined by the United Nations as 15-24 years. WHO considers "adolescence" as the period between 10-19 years and the term "young people" is used to refer to the composite age-group 10-24 years. It is recognized that the notion of youth varies across countries, in accordance to the socio-economic-cultural context.

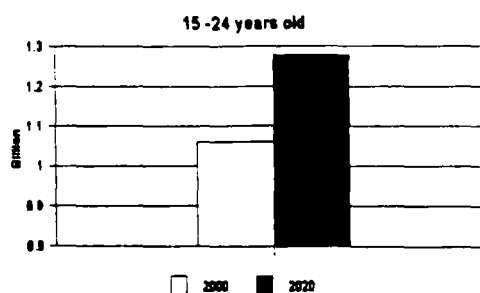
2. Youth: a healthy start of the new millennium?

2.1 The world in which they live

The more than one billion youth (aged 15-24) make up 17 % of the worlds population. The great majority of youth, 85%, live in developing countries and this proportion will grow to 89% by 2020 ².

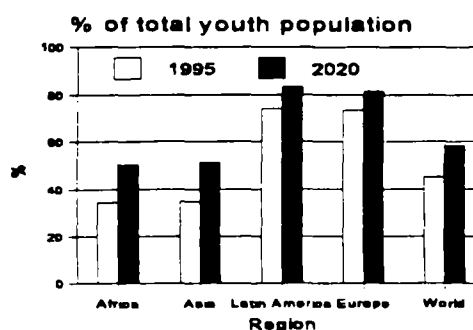
Rapid urbanization results in an ever growing group of urban young people. In Latin America most young people live in cities whereas in Africa and Asia the majority still live in rural areas³. Through urbanization social conditions and support networks are changing rapidly. The features of the contemporary world offer immense opportunities coupled with hazards of unprecedented proportions due to the rapidity with which people, ideas and images move across cultures, including the rural to urban transition ^b.

Global population of youth



This can be threatening to adults who believe that their value systems are being eroded, their authority diminished, and their knowledge seen as irrelevant. For young people, the increase in communication is an opportunity for exposure to information and ideas that can be of value, although they are sometimes coupled with negative models of human behaviour. Meanwhile, the shift of economic control from the public to private sector accentuates a competitive rather than cooperative model of society, and this may also threaten traditional values. Global communication also changes aspirations, and the increasing gaps between the "haves" and "have nots" are putting many young people at increasing disadvantage. On top of these changes is the continuing rapid increase in population in countries with fewest resources to meet the new challenges, reducing young people's education and employment opportunities and threatening the environment in which they live.

Youth in cities



2.2 The challenges

These rapid changes in societies are being accompanied by changing trends in young peoples behaviours - and consequently in health status. While new technologies and improved standards of living in many societies potentially offer good opportunities for the development of young people, other changes are increasing the risks to their health, often by influencing behaviour. Decreasing family influence, and generally earlier puberty and later marriage are extending the risks of unprotected sexual activity in unmarried youths in some parts of the

^b Between 1970 and 2025 the urban adolescent population in developing countries will have grown by 600%².

world. In others, a large proportion of first marriages and first births continue to occur among adolescent women. Rapid urbanization, expanded telecommunications, greater access to (and pressure to use) alcohol, tobacco and other psychoactive substances, and increased travel, tourism, migration, refugee populations and homelessness are changing societies with unpredictable effects on the behaviour of young people. Adolescent girls are especially vulnerable to problems arising from these changing conditions, above all when there is inequity between the sexes.

The best justification for paying special attention to young people is that their needs and vulnerabilities differ from children and adults. The vulnerability to health risks as well as the developmental needs are different in adolescents and older youth. Adolescence is the period of most rapid changes which makes them also most vulnerable and it is exactly this group that are being defined as children by the Convention of the Rights of the Child. Young age is associated with certain increased health risks e.g. pregnancy related mortality and morbidity and STD. So whereas young people share many characteristics that justify a common approach, it is important to be aware of the programmatic implications of the differences between the age groups with regard to some of the health and development needs.

In the past, because of considerations concerning mortality rates alone, adolescents and youth were viewed as one of the healthiest periods in a person's life span. As a consequence, epidemiological and statistical attention to adolescents and youth as age groups is still underdeveloped. This 'measurement trap' (we are not aware of the problem because we do not have data --> as there is no problem, we do not measure) has and still does seriously hamper attention to the health of young people. However, there is growing recognition that because of a combination of biological, psychological and societal reasons, young people today face a range of choices, challenges and health problems that frequently combine to limit or curtail the likelihood of positive and healthy development.

The challenges to their health and development some of which are elaborated upon below will not only impact on the current generation of young people, but also on their health later in adult life as well as on their children's health when they become parents.

In most societies **sexual and reproductive life** starts with sexual relationships during adolescence. Because many of these relations are unplanned and unprotected, the incidence of sexually transmitted diseases (STD) is often highest among youth.

- Of the estimated 333 million new STD's that occur in the world every year, at least 111 million occur in young people under 25 ⁴.

Not only do untreated STDs increase the risk of infertility, they also make young people more vulnerable to infection with HIV.

- Globally, in 1997 more than half of all new HIV infections, some 7000 each day or 2.6 million were among youth⁵.

Unprotected sexual relations can also lead to early pregnancy. One third of all births taking place each year are among young women, many of which are unplanned or unwanted. Pregnancy, especially among young adolescents, has an increased risk of obstructed labour and other complications which can result in maternal morbidity and mortality.

- In developing countries, maternal mortality in young women under 18 is 2 to 5 times higher than in women from 18 to 25 ⁶.
- Adolescent abortions are estimated as between 1 and 4.4 million per year, most of which are unsafe because performed illegally and under hazardous circumstances by unskilled practitioners⁷.

Though malnutrition is mostly associated with infants, **poor nutrition** (under - and over-nutrition) in adolescents, female and male, is a big problem in some countries. Micro nutrient deficiency can lead to iron deficiency anaemia and also affect babies born to malnourished mothers.

- Iron needs of adolescents, increased by growth, development and menstruation, are being hampered by malaria, hookworm and schistosomiasis which affect young people disproportionately⁸.

Adolescence is a time of experimentation, exploration, curiosity and search for identity. Such quests can involve risk taking. At times, this is manifested in risks to personal health, such as the use of alcohol, tobacco, pharmaceuticals, volatile solvents, illicit drugs and other psychoactive substances. **Substance use** patterns are often established during adolescence: most regular smokers for instance started before age 20. For example, the health risks of smoking only become clear many years later in life.

- Half of regular smokers who start in adolescence and smoke all their lives, will eventually be killed by tobacco⁹ This means that of the 300 million youth that currently smoke 150 million will eventually die of tobacco related causes.

Accidents, often associated with substance use are a major cause of mortality and disability among young people. Risky sexual behaviour while intoxicated can increase the possibility of unplanned pregnancy and STDs, including HIV/AIDS. The sharing of drug injecting equipment and drug preparations can also spread HIV, hepatitis and other infections.

- In the USA, the most common substance related to the deaths of young people is alcohol¹⁰
- Unintentional injury is the leading cause of death among young people, especially road traffic accidents among boys¹¹

The scope of **mental health** problems in youth has not been fully recognised. A rather visible form of poor mental health are suicide attempts and deaths. It is estimated that for each

successful suicide at least 40 attempts had been made.

- Suicide in young people is increasing in many countries and is responsible for at least 100.000 annual deaths in youth worldwide¹²

An alternative methodology to express the burden of disease has been the Disability Adjusted Life Years (DALY). This methodology intends to take into account both mortality, morbidity and disability resulting from disease combining them in one measure. The following table shows the five leading causes of DALYs lost among youth. Mental ill-health clearly comes up as an important element in the burden of disease as it shows that depression is the leading cause for DALY loss in both male and female youth as well as suicide in females and schizophrenia in males.

Five leading causes of DALYs lost

Male	15-24 year old	Female
Unipolar major depression		Unipolar major depression
Road Traffic Accidents		Obstructed labour
Alcohol use		Suicide
War		Chlamydia
Schizophrenia		Iron-deficiency anaemia

1990 estimates¹³

Although this methodology tries to capture the impact of morbidity hence complementing mortality data, it does not capture the way unhealthy behaviours adopted by young people will lead to premature deaths or disease only many years later, during adult life. Therefore, it has been difficult to convince policy makers that it is worth investing in the health and development of youth. One clear challenge is to provide compelling economic evidence that it is good practice and cost-efficient to invest in the health of young people, every's country's present and future workforce.

3. Action for Youth Health and Development

There has been growing acceptance of the arguments for the need to promote youth health. For many years NGOs have implemented activities geared towards promoting the health and development of young people. Increasingly, national authorities consider healthy youth a priority. Much has been learned from all the initiatives and enabled the identification of guiding principles for action. The WHO/UNFPA/UNICEF Study Group confirmed these guiding principles and identified the major interventions that will effectively promote youth health. One of the most important findings was the intrinsic linkage between the health and development of young people.

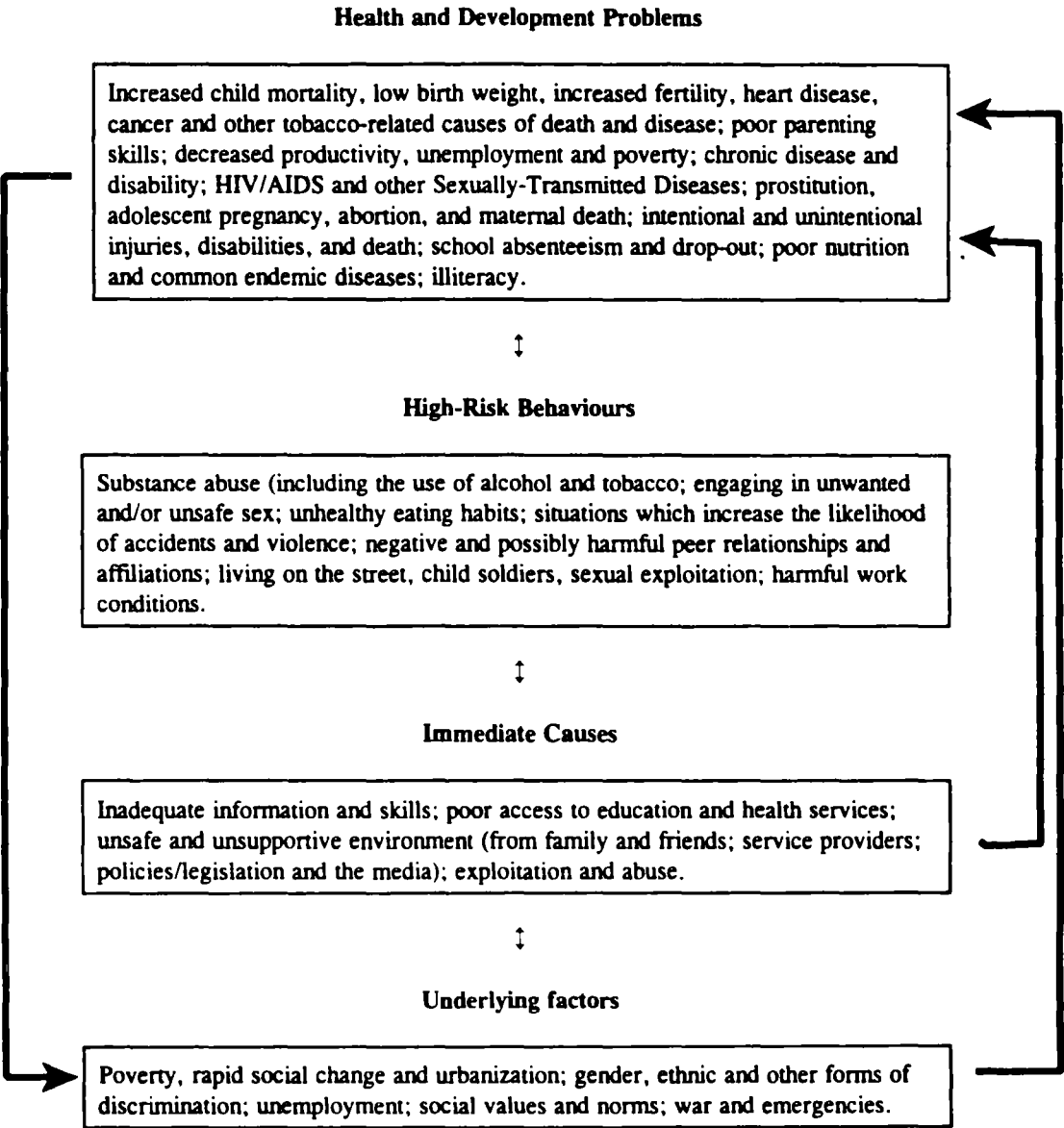
3.1 Youth health and development

Just as the health of young people is intrinsically and reciprocally linked to the socioeconomic development of societies, so is it linked to their individual development. Adolescents undergo

a very rapid process of physical, emotional, psychological, social and spiritual development, more than in any other phase in life. Meeting their need for development is crucial to present and future health. Likewise, their health and health problems, such as malaria or HIV, also influences their development potential and opportunities.

The health and development of young people is complex and it is important to understand the different levels of causation for the implication for programme design. The analytical model presented in Figure 2 helps to see the different levels and relationships between them.

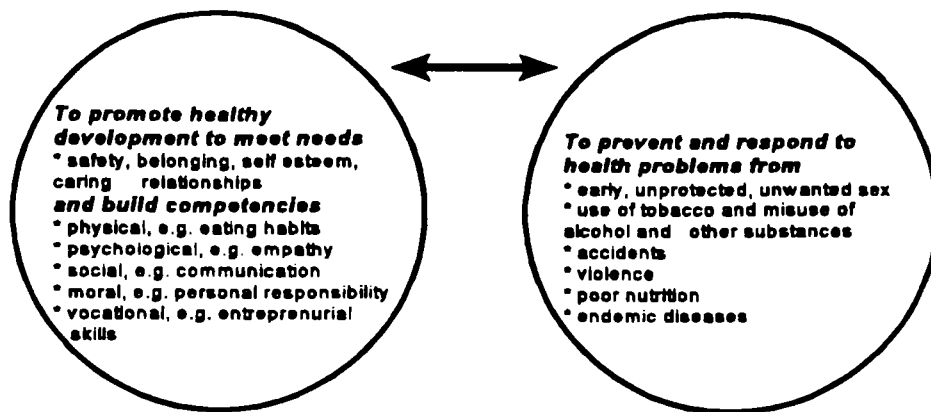
Figure 2. **YOUTH HEALTH AND DEVELOPMENT - LEVELS OF CAUSATION AND IMPACT⁴**



This model not only highlights that the young people's health problems have common roots, but also that they are frequently linked together. For example, alcohol and illicit drug use gives rise to accidents, violence and unwanted and unsafe sex. Understanding this interrelatedness of health problems and their common roots has profound implications for programming for youth health:

programmes that address the common roots normally aim at improving skills and competencies and do not target specific problems (see 3.3 and 3.4). Most resources for the health of young people are still designated to reducing health problems such as HIV/AIDS or adolescent pregnancy. The challenge for programme designers (and funders alike) will be to make youth development the central to their work.

Gender considerations are crucial to understand the health and the development of young people. Adolescent females and males develop differently, and are generally treated differently by each other and by adults, are prone to somewhat different behaviours and relationships, whether culturally or otherwise determined, and are unequally vulnerable to health problems because of both biological and psychosocial factors. In this context, special attention is required for the vulnerability of girls to sexual abuse and violence as well as to harmful cultural practices such as FGM.



When programming for youth health and development there are two mutually reinforcing objectives which together form a strategy to meet their rights for health and development:

- 1 to meet young people's rights for safety, belonging and self esteem and build their competencies or skills which will help young people to build or strengthen 'resiliency', the ability to cope with adverse circumstances throughout their lives.
- 2 to prevent health problems and respond to them when they arise. Both the community and health systems need to be prepared to deal with health problems when they arise.

3.2 Interventions to promote youth health and development

There is consensus about five major intervention areas through which youth health can be promoted. From a programming perspective they are profoundly interlinked: interventions in each of these five areas will be more effective if accompanied by the other interventions and the synergy resulting from combining these interventions will promote youth health more effectively.

Create a safe and supportive environment: The social environment of young people extends from the family and community, including community organizations and the school, to the policy and legal environments. There is increasing recognition of the role of the family and a feeling of connectedness to the parents, an adult or school seems to be a strong protective factor for many risk behaviours. Young people themselves can make important contributions to their social environment which improves their own development. Laws and policies play a clear role in providing access to information and services and in creating protective environments for young people.

Major interventions:

Create a safe and supportive environment
Provide information
Build skills
Provide counselling
Improve health services

Provide information: Young people need relevant and age and gender-specific information about healthy lifestyles and the prevention of health problems. They also need information about health services, where to find them and what to expect there. However, information alone is not enough.

Build skills: Young people also need skills, practical skills such as how to make Oral Rehydration Salt or where to buy contraceptives, life skills like how to communicate and negotiate with peers and adults and marketable skills for economic survival. These skills will help them to apply some of the information they have received.

Provide counselling: Provide counselling in moments of crisis or to assist young people in making the right choices with regard to their health and development.

Improve health services: Improve health services to make them youth friendly. Health services are not being used by young people for a variety of reasons, such as young people's perception of a lack of confidentiality. Health workers often lack the knowledge and skills to work with young people and the improved organisation of the services can promote their accessibility.

Intervention settings:

home
school
health centre
workplace
street
community organisation
residential centre
media entertainment
political & legislative
systems

The most successful programmes not only combine interventions but also reach young people in a variety of settings. It is important to remember that in order to reach all youth through interventions different settings should be targeted.

3.3 Keys to success

The experiences from efforts to improve the health and development of young people have demonstrated that the following principles are critical for ensuring the effectiveness of programming:

Put young people at the centre of programming: The active involvement of young people is one of the most important principles of successful programming. Such involvement goes far beyond token efforts to merely seek the opinions of young people on the problems they face.

Their involvement in planning, implementing and evaluation ensures relevance of programme activities to the real needs of young people, commitment to the programme objectives, and significantly contributes to the development of those young people, who are actively involved. Contributing in such ways to the "social good" (family or community) and being recognized for such contributions reinforces self-esteem – selflessness being associated with emotional stability and positive social relations.

Address multiple health problems simultaneously: As discussed in section 3.1, many health problems have common roots and are interrelated. Interventions that focus only on a specific problem behaviour, like drug use or too-early unsafe sexual activity, are less effective because they do not address the antecedents or determinants of the behaviour. They also ignore the fact that the same young person might suffer from various health problems or unhealthy behaviours. More generic approaches address some of the underlying or predisposing factors that increase the likelihood that a young person will engage in high-risk or problem behaviours. These factors include low self-esteem, underdeveloped interpersonal and decision-making skills, lack of interest in education, inadequate information regarding health matters, low perceptions of opportunities, the absence of dependable and close human relationships, and meagre incentives for delaying short-term gratification.

Combine interventions: Young people have diverse health and development needs which change over time and may differ according to their sex, and circumstances. At various times they will need (or are likely to benefit from) information, acquisition of skills, counselling, and health services. Programming that encompasses a range of interventions, i.e., interventions which promote a safe and supportive environment; provide information; build skills; provide counselling and health services for a range of adolescent health needs, is more likely to have a positive impact on their health.

Build upon and link existing interventions in various settings: Many different sectors have important contributions to make in promoting and safe-guarding the health and development of youth. Here, not only traditional sectors such as health and education are meant but also the private sector. Each sector typically has a distinctive set of competencies and perspectives, which if employed within a common framework, is more likely to deal with the multifaceted nature of youth issues through greater consistency of goals and approaches. Moreover, although the fundamental character of the interventions they deliver are similar, their activities usually take place in different settings thereby having the potential to reach young people in differing circumstances. The issues which need to be addressed in promoting the health and development of youth are often controversial and enlisting the support of various sectors can be extremely valuable. The reluctance of young people to seek assistance and use services can be minimized by improving the functional linkages among programme activities in various sectors thereby providing them with safety nets.

Respect cultural diversity: There is an important relationship between cultural identity and adolescent development – understanding one's culture is an important part of exploring personal identity; this in turn is part of the overall developmental process. Young people's understanding of who they are and where they fit into their surroundings and social environment, allied to an awareness of culture can greatly enhance a sense of belonging; one of the basic needs of youth

that programming aims to achieve.

Encourage positive adult attitudes and behaviours: Adults play a vital role in the healthy development of young people, and can contribute to a supportive climate for positive behavioural choices through relationships that express love and concern and through communication on important health and development topics. A sense of connectedness by young people to the family and other significant adults have shown to be strong protective factors against certain risk behaviours, including substance use and suicide attempts.

Strengthen programme management: Ensuring that programmes fully addresses the characteristics discussed above involves some special challenges. These challenges involve dealing with controversies that often arise about sensitive topics dealt with in the programmes; engaging, collaborating with, and often coordinating activities in multiple sectors; assuring that the differences in developmental perspective between young people and adults are attended to when young people are part of the planning and delivery of programme activities; identifying the aptitudes, skills and training of human resources needed to carry out a combination of interventions, and recruiting people with these qualities.

3.4 Vulnerability

While there is a core set of characteristics and developmental needs that can be attributed to all adolescents, there are certain groups within the adolescent population that have specific needs and/or vulnerabilities. In order to provide equitable opportunities and services to adolescents, focused efforts need to be made to reach those who are especially vulnerable and in special circumstances of disadvantage, so as to ensure that their problems can be understood and their needs met. The differences within adolescent populations may be due to environmental factors and/or individual characteristics, but as a consequence the rights of these young people, for protection and development, have not been met.

For the purposes of assessment and the consequent design of appropriate and meaningful interventions, it may be necessary to categorize the circumstances in which some young people live, even though such categorization can lead to the highly negative labelling of some groups. These circumstances include:

- temporary or permanent loss of family and /or primary caregivers
- sexual abuse and/or exploitation
- disability
- warfare and other emergencies
- extreme poverty, especially when this leads to work in hazardous situations.

Operationally, programming for adolescent health and development addresses the needs of all young people by maintaining and strengthening their development, and by enhancing prevention. Special efforts however, are necessary to reach adolescents in these vulnerable circumstances and additional targeted interventions will need to be developed for their specific situations.

4. Examples of effective approaches to working with youth

There are many exemplary programmes implemented by NGO's or Governmental organisations that bring into practice the key principles and lessons learned mentioned in para 3.3¹⁵. Using participatory approaches like peer education, combining interventions and linking to other organisations and are some of the most outstanding features. Many of these programmes are based on a developmental approach to young people's health.

Peer education to young people in school: The PACT (Peer Approach to Counselling by Teens) programme in Botswana aimed to reach 13-19 year olds both in and out of schools with the provision of information, skills building opportunities and counselling. The purpose of the programme is to enable youth to make healthy decisions about their own sexuality, to avoid unwanted pregnancy and infection by HIV/STD, and especially to enhance their own confidence and self-esteem.

Adolescent development programme: In this programme run by SERVOL in Trinidad self-development is the key approach. 40 Life Centres have been founded throughout the country where adolescents gain the sense of support and structure- from staff members and from fellow participants. Young people (ages 16-19) attend 3 and one-half month, 40 hours per week where they take literacy courses, and learn self-awareness and self-esteem. Information and skills training related to the use of substances, sexuality and prevention of health problems associated with sexual behaviour. Six to eight months is then spent focussing on vocational skills related to specific trade. Both girls and boys also learn basic knowledge about child development, nutrition and parenting skills. The programme costs \$US 9/month per participant and a total of 3,000 adolescents benefit from it each year. This model has been widely replicated throughout the Caribbean

Addressing multiple health and development needs:

Project Alternatives, Honduras works with street and working children and provides community-based health care, targeted food supplementation, basic and health education (including adolescent sexuality and reproductive health and substance abuse) and psychosocial counselling.

Centre for Population and Development, in Philippines initiated three urban youth centres with that provide personalized counselling, education on sexuality and reproductive health and referral to health centres. It uses multiple media channels such as TV (including a serial TV drama with positive health messages on responsible youth behaviour), radio and a heavily utilized telephone hotline service. The centres now function independently and are self supporting.

Culturally acceptable counselling to prevent STD/HIV: In Uganda The AIDS Support Organization (TASO) began a counselling programme built on the cultural tradition of young girls talking to "aunties" - trusted older women in or outside the family - about sex and reproductive health. The "Aunts Project" selects and trains women to be counsellors, as well as to work as prevention educators in the villages. It aims to prevent HIV infection by helping girls explore this risk through counselling on a broader range of issues which affect them personally

including relationships, personal goals, and other concerns.

Quality health services for youth:

The **Youth Friendly Health Services Project in Zambia** is being implemented in Lusaka urban district, by a consortium of NGOs working in conjunction with the health department of the district council and the country office of UNICEF. The project was developed with the active involvement of both health care providers and young people. Activities consist of sensitizing and training health care providers and involving young people in the work of the health centres: youth working for NGOs participating in the project are 'posted' at health centres serving to bridge the gap between young people in the community and health care providers. In addition, these youth workers provide health information to adolescents in the community and advertise the health services.

The **National Adolescent Health Programme in Brazil** maintains that successful implementation relies on the orientation and training of personnel at all levels. Its training strategy involves three stages: 1) Sensitization workshop to orient professionals to adolescence; 2) Capacity Building of health care providers which focuses on specific adolescent concerns such as growth and development issues, mental health, reproductive health, etc.; and 3) Course for Facilitators designed to train skilled professionals on how to train others and is often conducted in cooperation with the universities.

Involving Parents: In the Philippines the Foundation for Adolescent Development (FAD), with UNFPA support, produced a video to show parents that their communication with adolescents shapes the way the young people communicates with others. In Zimbabwe, the National Family Planning Council (ZNPC) has offered a parent-education programme to help parents educate their youth about human sexuality and reproductive health.

5. The UN role in youth health and development

Many recent international conferences recognised the fact that young people need special attention and that resources need to be devoted to especially the most disadvantaged young people. These include the International Conference on Population and Development (Cairo), The Fourth World Conference on Women (Beijing) and the Social Development Summit (Copenhagen), the first International Congress on the Commercial Sexual Exploitation of Children (Stockholm), the Graça Machel Report on the Impact of Armed Conflict on Children and the International Conference on Child Labour (Oslo). Cairo provided the UN with the mandate to safeguard and promote young people's sexual and reproductive health. Another powerful tool for promoting young people's health and development rights is provided by the Convention of the Rights of the Child (CRC) that defines basic health needs as rights and requires countries to ensure that young people (below 18) enjoy civic political, economic and social rights without discrimination. The convention. In a broader context covering all youth, the UN agencies work is guided by the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the Universal Declarations on Human Rights.

In 1995 the United Nations strengthened its commitment to young people by adopting the World Programme of Action for Youth to the Year 2000 and Beyond (WPAY). Among its 10 priorities,

the WPAY promotes special attention to health, drug abuse and girls and young women. The UN agencies involved in youth health and development address these priorities according to their specific mandate as presented below.

UNAIDS prioritizes young people because of the great impact HIV/AIDS has on their health and development and the critical role young people play in changing the course of the epidemic. UNAIDS has four main strategies for working with HIV/AIDS and young people. 1) UNAIDS serves as a vocal advocate, speaking to governments, NGOs, and the private sector about the urgency of working with young people to reduce the spread of HIV infection and to strengthen support for young people infected and affected by HIV/AIDS. 2) UNAIDS monitors how the world is preventing new infections, ensuring that infected young people have access to youth friendly health services, and supporting those who are affected by the epidemic. 3) UNAIDS serves as a policy think-tank and a source of knowledge about best practice. It tries to analyse the successes and failures of HIV/AIDS programmes for young people in schools and in communities so that effective initiatives can be shared and expanded. 4) UNAIDS serves a facilitator, coordinator and source of technical support. At the country level, UNAIDS has developed multi-sectoral, multi-agency responses to HIV/AIDS, and is using the 1998 World AIDS Campaign to promote young people's participation in planning, implementing and evaluating programmes for young people.

UNFPA accords high priority to promoting adolescent reproductive health, by supporting efforts to provide young people with reproductive health information and services. The World Programme of Action for Youth specifically encourages UNFPA to continue meeting the health needs, including reproductive health needs, of young people. Furthermore, UNFPA pays special attention to promoting gender equality and equity by improving the status of young women and increasing young men's involvement in family matters, including family planning. UNFPA also advocates for basic education for all, particularly girls. UNFPA attaches great importance to working with young people and their organizations and seeks to involve their families and the community. UNFPA also works closely with Governments and with UN organization and interested parties.

UNICEF works with Governments and key technical partners, both UN and non-governmental to meet young people's rights and needs to information and life skills and to provide access to services, to a safe and supportive environment free from exploitation and abuse and to opportunities to participate in civil society and decisions that affect their lives. Of special concern are their disadvantaged young people, such as those living on the streets or in extreme poverty or suffering from gender, ethnic and other forms of discrimination or marginalization; being exploited sexually, economically or in other ways; physically or mentally disabled or caught up in emergencies wars and other situations of rapid social change where they lack family and community support. Key programme areas include national planning and policies, school based interventions and youth friendly health services, outreach through NGO, religious organs and other civil society organizations and working with the mass and entertainment media.

World Health Organization works with Governments and key technical partners to promote the health of adolescent and youth. Based on its research into many aspects of adolescent and youth health done by different parts of WHO, such as the Special Programme on Human

Reproduction's work on sexual and reproductive health, the Programme on Substance Abuse and the programme on Mental Health, and the Adolescent Health and Development Programme, WHO has strongly advocated to put adolescent and youth health on the agenda of countries and UN partners. WHO has promoted the creation of adolescent health policies and of health programmes in many countries and provides norms, standards and guidelines on various aspects. WHO developed interventions and tools in the areas of comprehensive school health, building life skills and counselling provision and the prevention and treatment of health and social consequences of substance use. Current focus of the Adolescent Health and Development Programme is on improving the response of the health sector to the needs of adolescents, measurement of effective interventions and the role of the family and community.

6. The way forward

The health of young people is primordial to the development of countries and societies around the world. Over the last decade progress has been made in promoting the health of young people. The lessons learned in programmatic interventions for adolescents and youth by Governments, UN agencies and NGOs over the last decade were synthesized during the joint WHO/UNFPA/UNICEF Study Group and distilled into a Framework for Country Programming and a Common Agenda. These tools will provide the basis for coordinated action for young people through these UN agencies. Central to these tools is the importance of adopting a broad developmental approach to promoting the health of young people.

In this context of promoting youth health and development, the UN agencies would like to suggest that Ministers responsible for Youth consider the following recommendations:

- Marshall the political will to place youth including youth health, higher on the national agenda, securing adequate human and financial resources with a view to meeting the health and development needs of youth.
- Support the implementation of a package of five critical and mutually reinforcing intervention areas for health and development:
 - Creating a safe and supportive environment
 - Providing information
 - Building skills
 - Providing counselling
 - Improving health servicesat national and sub-national levels to ensure an expanded coverage of the adolescent and youth population.
- Support the routine collection and dissemination of data on health status by relevant age cohorts (at least 10-14, 15-19 and 20-24) and by sex and utilised to inform policy and programme formulation. Suitable indicators should be identified in order to monitor and evaluate interventions addressing youth health and development concerns.
- Improve coordination among government ministries and departments that affect youth health and development, and between the governmental and non-governmental sectors,

including NGOs. Better definitions of each sector's responsibilities will facilitate a multi-sectorial approach to youth health.

- Identify, promote and support effective mechanisms for the participation of young people in programme planning, implementation and monitoring which will not only improve the relevance of interventions but also contribute to the healthy development of young people.
- Guarantee the health rights of all young people, including those of especially vulnerable young people, to opportunities to be adequately informed, build skills, have access to health and counselling services and to live in a safe and supportive environment.

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Framework for Country Programming for Adolescent Health

Challenges

Building political commitment

- * "youth are healthy"
 - but behaviours starting during adolescence are crucial to current & future health
- * "the issues are too sensitive"
 - but the stakes are too high to ignore & there are those able to act
- * "youth make economic & political demands"
 - they are also a great resource for social & economic progress
- * "there's no money"
 - much can be done with better use of existing resources

Challenges

Monitoring & evaluation

- * establish & use indicators
- * track quality & coverage in multiple settings
- * understand the impact of youth participation throughout programming

Guiding Concepts

- adolescence - a time of opportunity & risk
- not all youth are equally vulnerable
- adolescent development underlies prevention of health problems
- problems have common roots & are interrelated
- social environment influences adolescent behaviour
- gender considerations are fundamental

Programming to

Promote healthy development

to meet needs

*Safety, *Belonging, *Self-esteem,

*Caring relationships

& build competencies

*Physical eg eating habits,

*Psychological eg empathy,

*Social eg communication,

*Moral eg personal responsibility,

*Vocational eg entrepreneurial skills.

Prevent & respond to health problems

from

*Early, unprotected, unwanted sex,

*Use of tobacco & misuse of alcohol & other substances,

*Accidents,

*Violence,

*Poor nutrition,

*Endemic diseases.

Keys to Success

- * put youth at the centre
- * address multiple health problems
- * build on & link existing interventions in various settings
- * combine interventions
- * respect cultural diversity
- * strengthen programme management
- * encourage positive adult attitudes & behaviours

Major Interventions

- * create safe & supportive environment
- * provide information
- * build skills
- * provide counselling
- * improve health services

Challenges

Identifying priorities for action

- * collect & analyse data by age & sex
- * compile data from different sectors
- * involve youth systematically
- * determine target groups

Challenges

Maintaining implementation

- * foster adult-youth partnerships
- * reorient & sustain existing interventions through training
- * coordinate activities in multiple settings
- * continually recruit young people as human resources
- * achieve large-scale programming

Key Health Problems: unwanted, unsafe pregnancy; maternal mortality and morbidity; infant mortality, abortion, STDs, HIV, RTI; cancers; homicide; suicide; injuries; disabilities; anaemia; obesity; dental caries; tuberculosis; malaria; schistosomiasis; intestinal helminths.

Summary Booklet of Best Practices

*Examples
of Best Practice
for young people*



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ID #:	293
Name	Youth Peer Education Programme on Reproductive Health, STDs, and HIV and AIDS
Country	International (Asia)
Volume	#1
Topic Areas	Children and Youth Reproductive Health Sexually Transmitted Diseases NGOs and Networks
Target Group	Young people aged 15-25 years
Implementers	Asian Red Cross and Red Crescent AIDS Task Force (ART)
Objectives	To combine clear and accurate information on reproductive health, STDs and HIV/AIDS with participatory activities to equip and empower young people with skills, motivation, and support to sustain existing safe sexual behaviour and change unsafe behaviour.
Description	The Asian Red Cross/Red Crescent AIDS Task Force (ART) initiated a single collaborative Youth Peer Education Programme on Reproductive Health, STDs, and HIV and AIDS in 1995. The programme was taken up by the 12 countries participating in the ART (Cambodia, China, India, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, Nepal, The Philippines, Thailand, Republic of Korea, and Viet Nam.)
Main activities	The key training tool for the youth-peer-education programme is a common core manual developed with the participation of young people, and from which manuals reflecting each country's language, culture, and socio-economic circumstances have been developed and pre-tested. The manuals cover the following topics: sexual health and reproduction; personal capacity-building; support from friends; societal norms; STDs and HIV/AIDS; other health issues; and factors affecting risk behaviour. In each participating country, young people have been selected and trained as core trainers, facilitators, and peer educators. Young people themselves are implementing the training programme among their peers with an emphasis on equal participation of men and women.
Results	As of mid-1998, ART in-country organizations report having trained a total of 300 core trainers, 1206 facilitators, and 9002 peer educators. A total of 42 031 youth have been educated about reproductive health, STDs, and HIV/AIDS. Training manuals have been pre-tested and produced in nine countries. More generally, outcomes have included: (1) increased collaboration and exchange of experiences among Red Cross/Red Crescent organizations in the region. Common and unique issues have been identified; skills and knowledge have been transferred by more experienced ART members to their peers; there has been collaboration on training of youth peer educators; awareness and sharing of available resource materials has increased; and collaboration has been strengthened with other agencies.

- (2) There has been increased skills-building on prevention and care/support components in programmes, along with greater commitment toward encouraging participation of project beneficiaries.
- (3) There has been development of regional/local capacity and increased self-reliance, along with growing sense of ownership of the national programmes.

Lessons learned

Pre-testing of manuals with different youth groups in various setting is essential. The evaluations identified the training approaches and methodologies appropriate to each group. In addition, the words used to describe sensitive issues must be culturally and socially acceptable. Effective ways to recruit youth volunteers include:

- one-day AIDS awareness workshops that provide an opportunity to assess participants and select those with potential to be core trainers/facilitators;
- attractively designed advertising and posters which provide valuable publicity for the AIDS programme; and
- care trainers who encourage their friends to become facilitators. Peer motivating can be a useful means of recruiting.

Constant evaluation and review of care trainers following their own training are important, along with follow-up workshops and practice sessions. Continual monitoring of the needs of youth care trainers and facilitators permits provision of appropriate incentives and rewards. Finally, flexible timing for training sessions is essential while working with volunteers, since they may have difficulties scheduling the rest of their activities around the training.

ID #:	304
Country	Kenya
Name	Mathare Youth Sports Association (MYSA)
Volume #	1
Topic Areas	Children and Youth Sexually Transmitted Diseases * Community Mobilization
Target Group	Children and young people in slum areas of Nairobi.
Implementers	In addition to its Sports Council, which is responsible for all MYSA's sports programmes, the association also has a Community Service Council consisting of local community and youth leaders, an executive council, and a joint coordination committee. The chairman of the AIDS Committee reports to the Community Service Council.
Objectives	MYSA's original objectives were to clean up the environment and to organize sports activities. Following the death of one of its members from AIDS, it introduced an HIV-prevention programme. The programme's aims are twofold: to equip young people with the information and communication skills needed for peer education, and to help change the values and attitudes of young people.
Description	Mathare is the largest slum area in the Kenyan capital, Nairobi. MYSA began in 1987 with the formation of a football club. By 1988, MYSA had established 120 football teams of 10 to 18-year-old boys. By 1997, it was Africa's largest football clubs with 410 boys' teams and 170 girls' teams. Their aim is to promote social responsibility and leadership both on and off the field.
Main activities	MYSA has been training its footballers to be peer educators about HIV since 1994. This effort began with members of the senior squad who were well known and respected and therefore influential in their communities. Young boys and girls were trained as peer educators. Programme officers were hired to expand activities, helped by outreach, particularly at football matches and also in schools. The adolescents stress abstinence from sex until young people are physically and emotionally mature and, for those who are sexually active, the importance of using condoms and staying faithful to one partner. MYSA peer educators talk about the problems of boy-girl relations; the problems that arise when boys base their self-esteem on sexual conquests and girls base theirs on having boyfriends.
Results	The MYSA AIDS Programme is estimated to have reached some 20 000 young people between 1994 and 1997. The first 25 peer educators were trained in 1994. In 1996, 25 girls were trained as peer educators for the first time. By 1997, 25 girls and 51 boys had completed advanced courses. A small AIDS reference library has been started for materials that are being used in training and programme planning.

Lessons learned

Adolescents are effective peer educators for HIV prevention. Hence, mobilizing more adolescents and training them for this role is an effective strategy. Through sports and community service, young men and women are developing their self-esteem. Adequate training and materials are essential to support the work of peer educators and help maintain their motivation. The focus of peer education must go beyond prevention messages (i.e. the physical "mechanics" of prevention). Instead, it must deal with the questions and anxieties that most young people have about their social lives and sexual identities.

ID #:	334
Country	Netherlands
Name	Sexplain: Peer Education on Sexual Health for Young People.
Volume #	1
Topic Areas	Children and Youth Communications Programming Male Condoms
Target Group	Young people aged 15 to 21 years
Implementers	Rotterdam's Municipal Health Service Rotterdam, using trained peer educators.
Objectives	• To inform young people age 15 to 20 about HIV, STDs and birth control • To promote a positive attitude towards safer sex among young people • To teach young people skills in condom use and negotiation
Description	The project trained and employed 12 peer educators with a variety of backgrounds and characteristics (age, gender, ethnicity, education, religion and sexual preference) to run workshops on sexual health at community centres, youth group meetings and at other projects for young people.
Main activities	The workshops were each led by two peer educators who had received a three-day training session at the start of the project, which concentrated on knowledge, attitudes towards sexuality, and communication skills. An interactive format was used in the workshops, which included group discussion, games, and practical exercises emphasizing the main themes of improved knowledge, attitudes, and skills. In addition, peer educators participated in monthly meetings for supervision, feedback, and continuing education.
Results	In 1996 and 1997, 60 workshops were carried out with 450 participants. Outcomes include: • a significant increase in participants' knowledge; • a significant change in attitude towards AIDS and homosexuality; • the participants say they would behave more safely in concrete ways such as condom use with a new partner and in a relationship, as well as visiting a doctor when they suspect they may have an STD.
Lessons learned	Young people appreciate and are influenced by a peer-led intervention. Working with peer educators with different backgrounds is feasible, and peer educators themselves appreciate the variety of backgrounds to which the recruiting strategy exposed them. Adequate training and constant support for peer educators are necessary to ensure the quality of the intervention and to support the peer educators in their work, especially in unexpected situations.

ID #:	282
Country	Thailand
Name	Thai Youth AIDS Prevention Project (TYAP)
Volume #	1
Topic Areas	Children and Youth Schools Community Mobilization
Target Group	Young people both in and out of school
Implementers	Thai Youth AIDS-Prevention Project (TYAP)
Objectives	• to promote AIDS prevention and care among young people in Northern Thailand; • to encourage behaviours that will protect young people from HIV infection • to reduce discrimination against people living with HIV/AIDS
Description	The Thai Youth AIDS Prevention Project (TYAP) was established in Chiang Mai as a nongovernmental organization (NGO) in September 1995 to target youth AIDS prevention and care in Northern Thailand. TYAP's philosophy includes promoting long-term interactive life-skills education, providing the tools and skills necessary for young people to protect themselves in modern times, training young people to teach other young people about HIV/AIDS, working with people affected by HIV/AIDS, and challenging young people to be involved in effecting policy change. Plans for 1997-1998 included continuation of educational and outreach activities, creation of a video compilation of TYAP's activities, "Right to Participate" Youth Rights campaign and the opening of a multi-focal youth centre at TYAP headquarters.
Main activities	(1) Training of AIDS educators: each semester 25 youth volunteers aged 17 to 23 receive an intensive one-month training session, followed by weekly training and planning sessions throughout the semester. (2) Outreach: AIDS educators teach an eight-week, two-and-a-half hour a week series of workshops to young people aged 10 to 18 in middle schools, vocational schools, orphanages, and the streets of Chiang Mai. (3) Camp Sanook! Sanook!: a week-long camp for 30 children aged 4 to 11 from families with HIV-positive and HIV-negative members. It provides the children with a chance to build support networks, and aims to reduce community discrimination against children affected by HIV. (4) Train-the-Trainer Programme: TYAP trains staff for 18 NGOs in northern Thailand and provides continuing support during their initiation of HIV-related activities with youth groups in communities and schools.
Results	In the first two years over 1000 young people participated in TYAP activities.

Lessons learned

TYAP reports:

Continuous weekly training sessions were critical for the peer educators. One long intensive training was not enough. It takes people a long time to process all the information, skills, and teaching techniques. Weekly training sessions provide a good opportunity for the educators to come together and solve problems thereby offering the educators a support group that they can count on for their work.

It was found useful to ask the educators to take time to invent their own games, based on the knowledge and skills they had acquired from their training. This approach was valuable because they were then not just participants in workshops, but had to learn in order to either produce HIV-prevention material or to teach others in their communities. In addition, some excellent new ideas were created from such exercises. It is important to hear what the educators are saying, both through formal and informal evaluation. It is equally important for them to be listening to what their groups in schools are saying. Although it was a difficult decision to make, TYAP decided to pay the educators because it wanted street youth to be educators and these youth need sources of income. It also gave a financial value to their work, so that it would be perceived as professional training, not just volunteerism. This became a source of pride for them and made the time spent legitimate in the eyes of their parents (in those cases where they were living with them).

ID #:	284
Country	Thailand
Name	Youth Career Development Programme (YCDP)
Volume #	1
Topic Areas	Children and Youth Workplace
Target Group	Rural young people, aged 16 to 20 (mostly girls)
Implementers	Pan Pacific Hotel Bangkok and UNICEF. Additional hotels now involved include the Regent Bangkok, Shangri-la Bangkok, Fortune Hotel, Grand Hyatt Erawan, Royal Orchid Sheraton Hotel & Towers, and the Sheraton Grand Sukhumvit.
Objectives	To assist rural youth who have little access to educational and vocational training To ensure long-term social and economic security for the participants
Description	The Youth Career Development Programme was initiated by the Pan Pacific Hotel Bangkok and UNICEF in 1995 to assist rural youth who have little access to educational and vocational training. Its goal is to ensure long-term social and economic security for the participants, and thus help them escape entry into prostitution and child labour. From 10 participants and one hotel in 1995, the programme has expanded over the years. In 1998 a total of 47 youth and 8 leading Bangkok hotels took part in the five-month training programme. The 47 participants, between the ages of 17 and 19, come from various provinces in the north and northeast, including Nakhai, Yasothon, Srisakes, Maehongson, Payao, Lamphun, Chiang Mai and Chaing Rai. The programme was endorsed at the 50th anniversary Congress of the International Hotel & Restaurant Association, a global network of independent and chain operators, national associations, hospitality suppliers and educational centres in the hotel and restaurant industry. As a result, the programme will be implemented on a worldwide basis by members.
Main activities	In addition to vocational skills, including food and beverage, housekeeping, kitchen and laundry, the girls are provided with supplementary training and orientation on relevant issues, particularly children's rights and protection, HIV/AIDS, and community development.
Results	To date, altogether 85 youth have completed the training programme and are being employed in leading hotel or restaurant establishments both in Bangkok and in their home provinces.
Lessons learned	Partnerships and alliance-building among the various sectors of a country is a critical and necessary resource for the promotion of child development and protection. YCDP provides an opportunity for young people at risk to explore their options through career development, professional experience, income, and the enhancement of self-esteem and self-confidence.

ID #	254
Country	Brazil, Pernambuco (state), Recife and Olinda (cities)
Name	Coletivo Mulher Vida (Women's Life Collective)
Topic Area	Sexual health; sexually transmitted diseases; psychological health; young girls
Target Group	Adolescent and young girls at risk of violence and sexual abuse
Implementer	A nongovernmental organization, Women's Life Collective;
Objectives	The overall aim is to strengthen the self-esteem of adolescent and young girls at risk of violence and abuse, to equip them with skills for conflict resolution, and to provide them through discussion with realistic expectations in their daily lives. Within this context, there are two main objectives: • prevention of violence against adolescent girls aged 12-18 at the community level; • prevention of violence among young girls aged 7-12 living or working in the streets who are at high risk of being sexually abused and treatment of the consequences of violence and abuse.
Description	The NGO aims through educational processes to develop a new relationship between men and women in which pleasure, happiness, solidarity and growth replace exploitation, violence and oppression. The initial focus of the group of social workers and psychologists who founded the collective in 1991 was on helping women who were physically or psychologically abused. Subsequently they have focused their attention on the prevention of violence and abuse against adolescent girls and on the treatment of the consequences of these abuses. The NGO currently receives funding from UNICEF, European NGOs and church-related organizations. Through specially designed questionnaires administered in public schools to 12–16-year-old girls, adolescent and young girls at risk of violence and sexual abuse are identified. These girls are invited to join a mutual support group that contains an adult educator and a teenage monitor. The girls are helped to confront and modify their own familial situations and, if this is not possible or successful, they are offered temporary accommodation until other suitable living arrangements can be made. In addition the girls receive individualized and group psychological assistance as well as skills training.
Main activities	(1) The organization works with groups of up to 20 adolescent girls within the community through regular weekly meetings. Each session has a special subject of discussion including family relations, work, school, drugs and sexuality.

Whenever a girl has a specific problem such as the threat of violence within the home, abandoning school, sexual abuse or drug use, the monitor refers the adolescent to specialist organizations where she can receive support from professionals such as psychologists, social workers, physicians and educators.

After an adolescent participates in these groups for six months she is offered courses of varying duration in such areas as theatre, handicrafts, and foreign languages. Once they have completed two years in the programme, the girls can follow professional courses, such as computer assembly and repair, offered directly by the NGO or they are referred to other professional courses given by specialized institutions with which the NGO has service contracts. In addition, those girls who complete the programme are encouraged, when necessary financially, to finish secondary school.

(2) In the case of the younger children, the organization finds them in the streets of Recife and establishes contact with their families. With the agreement of the family the children are offered accommodation within the organization. The children attend the programme in the afternoon; they can take showers, have a meal, and then receive academic coaching in addition to arts and crafts activities. The mothers, who are usually illiterate or semi-literate, are also offered a literacy programme and are encouraged and supported to follow professional training courses given by local institutions.

Results

(1) Within the programme for adolescent girls, groups were established in 10 poor communities. About 1100 girls have enrolled in the project and some have gone on to pass university entrance exams. According to the most recent reports, none of 850 adolescents who have gone through the programme has returned to street gangs or have entered prostitution or the sex trade.

The long-term approach taken by the institution has provided the girls with a broad personal and professional development. In addition, the psychological support has been sufficient to meet the long-term needs of the girls in most cases.

Through the programme adolescents receive an integrated approach towards sex education, probably better in quality than that received by their middle or upper income colleagues at school.

(2) Among the young girls the programme has strengthened school performance and reduced repetition of studies and absenteeism. At the same time it has provided the girls with after-school activities that have improved their self-esteem as well as academic performance. A special feature of this component is the inclusion of the mothers in literacy and professional programmes. This has strengthened the desire of the girls to continue in the programme.

Lessons learned

The main positive features of this programme include:

- the long-term support and care given to the young girls and adolescents;
- the multi-faceted approach including psychological attention, social work, and academic and professional training;
- the fact that, as soon as the girls acquire the capacity for taking responsibilities, they are given the opportunity to do so;
- the inclusion of mothers in the programme, thereby creating mutual support among children and parents;
- the incorporation of sexuality education and HIV-prevention activities within the larger approach of life-skills training and community development action, and
- the low cost of the programme.

In the case of the programmes for both the adolescent and young girls, a formal evaluation is needed. Such an evaluation would identify quantitative achievements as well as areas in which activities or operations could be improved.

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The Second Decade



Improving Adolescent Health and Development



Adolescent Health and Development Programme
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