Supplementary Report

Investigation of relationship between GOs and NGOs in the UK and Canada

~through analysis of HIV/AIDS related government reports~

A. United Kingdom

Background

Although the number of deaths from HIV is decreasing in the UK, as in other developed countries, due to HAART, the number of new infections is increasing. MSM have been considered one of the main high risk groups up until now, and although the total number of HIV infections from homosexual contact is still higher than from heterosexual contact, there has been a very large increase in heterosexual infections during the 1990s. Many of these infections are in people who acquired them in high prevalence countries, especially sub-Saharan Africa. Thus ethnic minorities are now also considered a group that needs special attention. There is also evidence of inequality of access to medical and social services in particular populations-for example, black Africans are more likely to be diagnosed HIV positive when their immune system is already badly damaged and they are already becoming ill, suggesting that they cannot access testing or medical facilities. Empowering these people and making a system that is equally accessible to all-particularly those considered high risk- is one of the major issues in the UK.

Epidemiology of HIV in the UK

- An estimated 30,000 people are living with HIV in the UK, of whom a third are

undiagnosed.

- The number of people diagnosed with HIV living in London is projected to increase by 40% between the end of 1999 and the end of 2003, from 13,000 to 18,000.
- The number of children living with HIV infection in London will rise from 550 in 2000 to about 640 in 2003.
- In 1999, nationally, the number of newly diagnosed infections in heterosexual men exceeded those in men who have sex with men (MSM) for the first time and this trend is continuing. Many of these infections are in people from or who have acquired HIV in higher prevalence areas of the world, especially sub-Saharan Africa.
- Gonorrhoea rates are a key indicator of levels of risk behaviour. In male heterosexuals gonorrhoea has increased by 85% since 1995, in female heterosexuals by 75% and in male homosexuals by 46% with the largest increases seen in 1999 to 2000.
- In spite of this trend, the numbers of prevalent infections remain higher in men who have sex with men than in heterosexuals.
- Almost half of new HIV diagnoses in London are made among people with a CD4 cell count of less than 350.
- Patterns of late diagnosis vary between population groups. 1 in 4 HIV diagnoses in black African people and 1 in 6 diagnoses in gay men are made at a CD4 count of less than 100.
- 1 in 5 people with HIV who died over the period 1998 to 2000 were within 3 months of their HIV diagnosis.
- The number of London residents dying with HIV has decreased from 950 in 1995 to 200 in 2000.

<from *Modernising HIV Services in London. A Strategy for HIV prevention, treatment and support services in London 2002/2005* (Draft) Nov 2001, p3-4>

Structure of government organizations related to HIV/AIDS

The National Health Service (NHS) is at present undergoing significant restructuring, the aim of which is to increase efficiency and equality of access and service and to decentralise power to local authorities.

The NHS in England from April 2002

<from *Guide to the new NHS*, June 2002, p1-5>

Department of Health (DoH)

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Regional Offices (Regional Directors)

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Strategic Health Authorities (StHA)

28 StHAs are responsible for the performance of the local NHS and for setting strategies within which the national framework set out by the DoH can be achieved.

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Primary Care Trusts (PCT)

303 PCTs provide primary care and commission hospital services. They are responsible for building strong links with the local health and social care community. They develop the Health Improvement and Modernisation Plan (HIMP) in conjunction with other local health care providers. The local StHA checks the PCT's performance. PCTs are the lead NHS organisation and are expected to become responsible for 75% of NHS funding by 2004, increasing their responsibility for commissioning of services.

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Care Trusts and Local Authorities

Care trusts coordinate local health and social care services. They deliver and commission primary/community health care and social care for various client groups.

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NHS trusts-hospital services

There are approximately 275 NHS trusts in England, each run by its own board of directors. Types include: Acute hospital trusts, community trusts, mental health trusts etc. Trusts must match national targets and work in partnership with other primary care providers.

Costs

Treatment and care costs for PLWH/A are increasing as treatments become more complicated and expensive and people are living for longer and also the number of new infections is increasing. The financial situation is likely to become severe as PCTs try to cope with these increases as the AIDS Support Grant decreases. Finding new ways to provide services more efficiently is indeed a major issue, especially at the PCT level. At the same time, preventing HIV infection saves potentially huge sums in treatment and funding effective prevention programs is also extremely important.

- Increased numbers of people with HIV seeking NHS treatment will result in an increase of more than £40 million in hospital-based costs from 2001/02 to 2003/4 (over 25%)
- This will require a further investment from PCTs of over £20 million per annum by 2003/4 (not taking into account costs for extra staff etc.)
- Local Authorities in London received a decrease in their AIDS Support Grant allocation of over £500,000 in 2001/2. The future of this grant will have potential impact on local authorities' investment in HIV Services. *1
- The average life time treatment cost for an HIV positive person is calculated at between £135,000 and £181,000. The monetary value of preventing a single onward transmission is estimated to be between £0.5 million and £1 million in terms of individual health benefits and treatment costs. *2

*1 from *Modernising HIV Services in London. A Strategy for HIV prevention, treatment and support services in London 2002/2005* (Draft) Nov 2001, p 5

*2 from *Effective Commissioning of Sexual Health and HIV Services*, Jan 2003

National HIV Strategy

- **Reasons for/Necessity of National Strategy**

With drug therapies becoming more complicated and expensive, and the number of HIV infections and vulnerable groups increasing, there is a realization in the UK that no one organization can effectively deal with HIV alone. All elements of society, political, administrative and civil must cooperate. The National Strategy is the basic document, the cornerstone that gives all groups goals to move toward together in a coordinated way.

By setting broader goals, each group can realise their role in achieving them.

Process of creating National Strategy

The first national Strategy for sexual health and HIV was published for consultation in November 2001. Members of the Sexual Health and HIV Strategy Integrated Steering Committee numbered 23. Six NGO representatives were included as well as doctors, HA directors, etc. There were also various sub-groups and working groups. The consultation process is set out in the Code of Practice for Written Consultations published by the Cabinet Office and this code was of course followed in creating the Strategy (see Appendix).

The Strategy was followed by the publication of several other reports, including the 'Commissioning Toolkit' (January 2003), which give concrete ways in which the Strategy can be implemented.

· **Goals of the National Strategy for Sexual Health and HIV**

The National Strategy sets out very clear goals, which provide the basis for policy and programs at the local level. Not only are these goals expressed as broad aims, many of them also include specific numerical targets to be reached in specific periods of time. In order to be able to set such goals, it is essential that all organizations, both GOs and NGOs have a part in making the goals and that they own them and are committed to them.

Goals set out in the National Strategy for Sexual Health and HIV

- To reduce the transmission of HIV and STIs;

  ***Specific target**: to reduce by 25% he number of newly acquired HIV infections and gonorrhoea infections by the end of 2007*
- To reduce the prevalence of undiagnosed HIV and STIs;

  ***Specific target**: by the end of 2004, all Genito-Urinary Medicine (GUM) clinic attendees should be offered an HIV test on their first screening for STIs with a view to:*

· *increasing the uptake of the test by those offered it to 40% by the end of 2004 and to 60% by the end of 2007*

· *reducing by 50% the number of previously undiagnosed HIV infected people*

attending GUM clinics who remain unaware of their infection after their first visit by the end of 2007

1) To reduce unintended pregnancy rates;
2) To improve health and social care for people living with HIV; and
3) To reduce the stigma associated with HIV and STIs

· **HIV Voluntary Organisations (NGOs)**

The National Strategy acknowledges the valuable contribution of the voluntary sector, but mentions the need for review so that services provided by NGOs accurately reflect needs and are more equally accessible to users. The Strategy mentions the following needs:

- Focused investment in a sustainable and stable voluntary sector;
- Contracts for clearly specified services;
- Better integration of social care and clinical treatment;
- Better knowledge among clients about the range of services available so that uptake is improves; and
- Culturally appropriate services that are responsive to high need groups.

Also specifically mentioned is the need for local health authorities to coordinate with the voluntary sector and other groups to provide more efficient and complete services.

Commissioning

The National Strategy for Sexual Health and HIV includes an entire chapter on 'Better Commissioning' and in January 2001, a 'commissioning toolkit' was published, suggesting that commissioning is considered an important element of health service provision. Health authorities commission services to a variety of organizations including NGOs. The National Strategy sets out basic guidelines and systems for commissioning and the 'Toolkit' gives more details and practical examples. The Strategy sets out the following basic principles for commissioning:

- Use a multi-agency and multi-disciplinary steering group to develop and implement a local action plan (This group and the local action plan is coordinated by a 'lead commissioner');
- Understand local needs and identify priority population groups;

- Link to wider policy concerns;
- Work in partnership with other agencies and with users;
- Be centred transparently on community and patient;
- Identify current resources, including those that need development;
- Set clear local targets for monitoring the development, implementation and outcomes of plans.

The Strategy also makes specific mention of including voluntary organisations in partnerships, which should be at the root of all commissioning, and encouraging smaller NGOs to contribute. The Department of Health will support development programmes that help to build capacity in the voluntary sector.

Effective Commissioning of Sexual Health and HIV Services or the 'Commissioning Toolkit' is designed for use by PCTs, which are the main NHS organisation responsible for commissioning (They are expected to become responsible for 75% of NHS funding by 2004-see above explanation 1.1.2). While it is recognised that many PCTs already have well-functioning commissioning systems, many newly created PCTs are in need of detailed instruction on how to effectively commission services. Thus the 'Commissioning Toolkit' does not aim to provide single answers, but a broad range of options so that each PCT can adapt basic principles and best practice guides to their own situation. In this document, too there is an extensive section on commissioning the voluntary sector, which is seen as 'having an important contribution to make to the modernisation of sexual health services because of:

- Their in depth expertise and knowledge of sexual health and HIV;
- Their reputation with patients and consumers, and the confidence which they are held in by these groups;
- Their efficiency, as many voluntary organisations do not have the same level of overheads and infrastructure costs as larger NHS organisations, many make use of volunteers, and some raise money from charitable sources to support local services.

The Toolkit goes on to list areas in particular where Voluntary and Community Organisations (VCO) can make contributions:

- Delivery of health promotion services such as community based HIV prevention services.

- Delivery of social care services such as signposting, advice, information and advocacy.
- Delivery of clinical support services such as pre and post HIV test counseling, counseling for PLWH/A, treatments information and support, etc.
- Delivery of peer support services.
- Support to the commissioning and planning process. VCOs have a lot of information about local needs and the views of local patients and 'at risk' groups. To make best use of this information, these organisations should be involved in local commissioning and planning work. Indeed they should be 'encouraged and supported' to participate in various planning teams 'on the same basis as statutory agencies.' VCOs should also compete on an equal footing as government organisations in terms of bidding for tenders under a transparent commissioning process.

The Toolkit also gives specific checklists for commissioning as well as case studies, best practice lists and other tools that PCTs will be able to use to efficiently and effectively commission services. One of the key points is to have a multi-agency commissioning group that can bring the experience of many different segments of society, especially from the point of view of the patient, to the group, and to build plans which really do represent the community and fulfil its needs.

Evaluation

***<Advertising Awareness -Evaluation of CHAPS national HIV prevention adverts and leaflets targeted at gay men 1996 to 2000* April 2001, Sigma Research>**

With such specific targets and goals set, it is vital to be able to tell when and if these goals have been reached and how far progress has been made. Evaluation must be built into all of the programs that are commissioned and ways to evaluate projects are suggested in the 'Commissioning Toolkit.' (see ASTOR and activity grid example)

Other evaluations are also carried out on a larger scale and one example is the evaluation of CHAPS (Community HIV and AIDS Prevention Strategy) an advertising campaign targeted at gay men which was coordinated by Terrence Higgins Trust (THT), the largest NGO in the UK and funded by the Department of Health. This evaluation

was carried out largely by Sigma Research, which is based at the University of Portsmouth and has been involved with many different evaluations of HIV/AIDS related programs.

The CHAPS project was carried out between 1996 and 2000 and involved a leaflet and media advertising campaign aimed at gay men in six towns and cities in the UK with the largest numbers of homosexually acquired HIV diagnoses. NGOs from each of those cities were asked to participate and the project was coordinated by THT. In this project, 17 CHAPS produced leaflets and ads and 8 non-CHAPS ads were evaluated.

Types of Evaluation:

1) Process Evaluation

To explain how certain results were brought about by looking at factors both internal to CHAPS and in the wider context of HIV health promotion. Process Evaluation sought the following types of information:

- The history of the CHAPS partners and their inter-relationships
- The roles adopted by partners and staff
- Organisational models
- Social and political context of CHAPS

Methods: document review, observation (members of process evaluation teams were present at CHAPS meetings), 6 rounds of semi-structured interviews with at least one member of each partner agency (NGO) over the 3 year period.

2) Making it Count (MiC)

This is a collaborative planning framework where the partner agencies all agreed on the objectives and how they would achieve them. MiC provides the basis for evaluation. It also sets out 7 qualities of interventions that evaluations may consider:

Feasibility-if it is possible to carry out the intended intervention in the given setting and budget;

Cost;

Access-how many of the target group are exposed to the intervention;

Acceptability-how acceptable the intervention is to both the target and the health promoters delivering it;

Needs-if the men whom the intervention is aimed at need that information;

Effectiveness-if the intervention changes what it was supposed to change;

Efficiency-how much of a change occurs relative to the amount of resources the intervention took to deliver.

3) Pre-testing

A national media campaign targeting gay men and funded by the Department of Health was politically sensitive, so it was important to assess the response of those who might see the ads-both target and non-target groups. Thus, as in all marketing, the CHAPS ads were also tested before they were officially launched.

4) Coverage Surveys

Approximately 300 men were recruited at gay pride events each summer over the 3 year period and answered a structured questionnaire administered face to face by an interviewer.

There was also analysis of cost effectiveness of interventions.

5) Structured Surveys

221 men were interviewed from 1997-2000. They were recruited with assistance from CHAPS partners from the 6 towns or cities where they are based. Interviews took 30-60 minutes. Men were shown the leaflets and ads and were asked a range of questions concerning their response to them. They were also asked demographic questions.

Conclusions

Detailed data regarding each of the 7 qualities mentioned above was gathered for each of the CHAPS leaflets and ads which has provided valuable evidence on which interventions were effective, cost efficient, etc. This study and 'Making it Count', which as explained above, provides the fundamental planning framework for evaluation, has become an important basic document for evaluations of many HIV/AIDS programs in the UK and use of its basic principles is encouraged by the Department of Health and other GOs in evaluations of programs on many different levels. That the original program was coordinated by THT, an NGO, and its members were comprised of other NGOs is highly significant. Also the evaluation was carried out by academics in equal partnership with well-established NGOs, and funded by the Department of Health. This represents a meaningful and effective partnership of key organisations.

B. Canada

Background

In Canada, too, the number of deaths from HIV is decreasing, but newly diagnosed infections are increasing. Here, also, heterosexual transmission is increasing, especially amongst aboriginal populations and young women.

Epidemiology of HIV in Canada

<from *HIV/AIDS Lessons Learned Reframing the Response*, Canadian Strategy on HIV/AIDS/Health Canada, 2002>

- The Canadian Centre for Infectious Diseases Prevention and Control (CIDPC) estimates that 49,800 people in Canada were living with HIV at the end of 1999.
- Of these about one third, approximately 15,000 people are unaware of their infection.
- About 4,200 new infections are occurring each year, including 370 aboriginal people.
- MSM and injecting drug users still account for the largest number of HIV positive tests and AIDS case reports, but data for 2001 show that heterosexual transmission is increasing.
- Increasing infection in women aged 15 to 29 is of particular concern.

Structure of government organizations related to HIV/AIDS

Canadian Strategy on HIV/AIDS (CSHA)

In 1990, the federal government established the National AIDS Strategy (NAS) to help coordinate the various players involved in Canada's HIV/AIDS response. In 1998 the Canadian Strategy on HIV/AIDS (CSHA) was launched after extensive stakeholder consultations. Health Canada, the lead federal department for issues related to HIV/AIDS, coordinates the CSHA and several departments within Health Canada are government partners (for example: Departmental Program Evaluation Division, First Nations and Inuit Health Branch (FNIHB) etc.) as well as other government

departments such as Correctional Service Canada (CSC) and regional offices. Non-governmental stakeholders are also considered full partners in the CSHA (NGOs such as the Canadian AIDS Society, Canadian Treatment Action Council, Canadian HIV/AIDS Legal Network etc.)

Although Health Canada is ultimately responsible for HIV/AIDS policy, as the federal government ministry, the organisation which is formulating and implementing Canadian HIV/AIDS policy and programs is a coalition of GOs and NGOs that work together in full and equal partnership.

Ministerial Council on HIV/AIDS

This Council was established on the recommendation of national stakeholder groups working with Health Canada to create the CSHA. The role of this Council is to advise the Minister of Health on issues related to HIV/AIDS, often at the Minister's request. Five of the 15 members of Council are PLWHAs and the most of the members have a background in NGOs. There are 7 Committees within the Council:

Executive Committee

Championing Committee (identifies current and emerging issues on HIV/AIDS)

Communications Committee

Monitoring and Evaluation Committee

Research Committee

Special Working Group on Aboriginal Issues

Ad Hoc Committee on Visioning and Strategic Planning

There are also several other advisory committees such as the Federal / Provincial / Territorial Advisory Committee on AIDS, which provides policy advice to the Conference of Deputy Ministers of Health; Federal/Provincial/Territorial Heads of Corrections Working Group on Infectious Diseases which advises federal and provincial governments on issues related to infectious diseases in prisons etc; a new national advisory committee was created in May 2001-the National Aboriginal Council on HIV/AIDS (NACHA) in response to concerns about the escalating vulnerability of Aboriginal populations.

While the structure of government administration in the UK is somewhat hierarchical, with relationships between GOs and NGOs most strong at the local PCT level, the large

number of councils with large NGO membership advising directly to Ministers in Canada seems to suggest a more direct link with NGOs and the higher levels of government.

Federal HIV/AIDS Funding

Initial NAS annual budget (1990): $37.3 million

Renewed NAS annual budget (1993): $42.2 million

CSHA annual budget (1997): $42.2 million

Funding allocations are as follows: (millions of dollars)

Prevention:	$3.90
Community Development and Support to National NGOs:	$10.00
Care, Treatment and Support:	$4.75
Legal, Ethical and Human Rights:	$0.70
Aboriginal Communities:	$2.60
Correctional Service Canada (CSC):	$0.60
Research:	$13.15
Surveillance:	$4.30
International Collaboration:	$0.30
Consultation, Evaluation, Monitoring and Reporting:	$1.90

In addition, several federal departments and agencies provide supplemental funding to address HIV/AIDS.

- CSC invests $3 million annually in federal penitentiaries.
- FNIHB invests $2.5 million annually to provide HIV/AIDS education, prevention and related health care services to Inuit and First Nations people.

Canada is also committed to international funding for HIV/AIDS, including a $150 million contribution to the Global Fund to Fight AIDS, TB and Malaria.

Capacity Building

The 2002 Report on HIV/AIDS in Canada (*Lessons Learned, Reframing the Response*) devotes an entire chapter to community capacity building. The federal government supports NGOs to build their capacity through funding, the largest proportion of which

is administered by the AIDS Community Action Program (ACAP). ACAP's principles are as follows:

- A community development approach is critical to the long-tern sustainability of any program;
- Health promotion enables people to increase control over and improve their health;
- Meaningful partnerships and collaboration help ensure the long-term sustainability of community-based initiatives.
- HIV/AIDS programming needs to work in a broad social context and address the determinants of health (population health approach)
- All organizations that receive ACAP funding are required to develop an evaluation plan to help ensure broad-based learning from community-based initiatives across Canada.

Under the CSHA, scholarships are awarded to full-time masters and doctoral students who apply a community-based approach to HIV/AIDS research. Summer Training Awards also provide support to Aboriginal undergraduate students to participate in community-based research. In these ways, research capacity building for community projects is also being supported. Capacity building for PLWH/As to do their own research on treatment and information issues is also being offered.

These are very practical ways that government funding supports NGOs working in the field and individuals who are working in their communities.

Population Health Approach

The Canadian government has been committed to population health approach for a number of years. In 1974, the Canadian government proposed that changes in lifestyles or social and physical environments would likely lead to more improvements in health than would be achieved by spending more money on existing health care delivery systems. For example, the most important public health gains in the past have been achieved not through spending more on the formal health care sector, but as a result of clean drinking water and improved food safety, improved living conditions, higher income/less disparity between rich and poor, etc. In other words, the social, economic and physical environments play a crucial role in determining health, so concentrating on these factors is essential. Reducing inequalities in health status between population groups is a key factor in the population health approach. This is perhaps one of the

reasons why NGOs are so important for the Canadian government-to implement strategies that will affect entire populations, it is vital that there are strong links with that community and NGOs provide these links.

CASE STUDY: Vancouver, British Columbia

In September 1998, the BC provincial government published *British Columbia's Framework for Action on HIV/AIDS*. In November 2000, a report from the Interministry Committee on HIV/AIDS, *British Columbia's Action on AIDS* was released. This report shows in detail that no less that 7 ministries (eg: the Attorney General, Ministry of Women's Equality, etc) are directly involved in HIV/AIDS projects and the progress that is being made in trying to coordinate them.

Another important organization is the Vancouver HIV/AIDS Care Coordinating Committee (VHACCC). This brings together three levels of government (federal, provincial, city), health authorities and approximately 50 community organizations. This Committee enables not only governments to coordinate, but large numbers of stakeholders to coordinate policy, goals and projects. For example, through long discussion, the VHACCC as a whole has committed to reducing new infection rates in Vancouver by 50% by 2007.

One example of a project that grew out of VHACC is the Three Bridges Community Health Centre. This Health Centre is jointly managed by the government authority, AIDS Vancouver (NGO), gay and lesbian organizations and a youth organization. The aim of this was to provide health services which targeted vulnerable groups. Volunteers from these various NGOs come and help out at the Health Centre and there are special services designed so that these groups can access them more easily. For example, part of the youth services is to have flexible scheduling-the doctors time is lightly booked so that youth can drop in between 1.00 and 8.00 pm. Doctors can provide drug addiction assessments and if appropriate, outpatient opiate detoxification. There is also an alcohol and drug counselor available and a needle exchange. 'Pride Health Services' are also offered, targeting the lesbian, gay and transgendered community who had not previously accessed health services effectively.

This is one example of a very strong partnership between NGOs and GOs, where the 2 are able to actually manage a health centre together and where volunteers actually come and help out. NGOs are able to make direct suggestions about client-friendly services and implement them. They are also able to be present at the Health Centre as volunteers to make clients feel welcome.

C. Conclusion/Summary

Importance of National Strategy

National Strategy documents published by the Health Ministries in both countries are a key in the relationship between GOs and NGOs. In the creation process of these documents, NGOs and GOs get together to discuss every element of HIV/AIDS strategy and how they can both work together to contribute to an effective response. Also, once this document has been created, it provides guidelines and practical advice for all local health GOs on how they can access and utilise NGOs. It also includes concrete goals and evaluations so both NGOs and GOs can see how they are progressing, if they need to modify their programs if they are not working, and improve accountability.

Reasons for GO/NGO partnerships

a) Economic

In developed countries all over the world the health budget is increasing rapidly. This is also true for HIV/AIDS. Both UK and Canada recognise that utilising NGO's experience and abilities, especially through commissioning services is more economically efficient than trying to perform all services by themselves.

b) Social

It is vital that the community as a whole responds effectively to HIV/AIDS. All elements of society must be included in the reponse and for this reason it is vital that NGOs be included as a link to GOs, to inform them of community needs and to be supported to address those needs which NGOs are particularly suited to. Through NGOs, GOs can gain meaningful contact with the larger community and build an effective team to fight HIV/AIDS.

第 3 部

AIDS-NGOによる若者相互の啓発プログラム

厚生労働科学研究費補助金（エイズ対策研究事業）

分担研究報告書

エイズに関する普及啓発における非政府組織(NGO)の活用に関する研究

AIDS-NGOの実施する若者相互の啓発プログラム（Young Sharing Program:YSP）における、評価及びNGOとGOの連携に関する研究

主任研究者	五島真理為	特定非営利活動法人HIVと人権・情報センター理事長
分担研究者	新庄文明	長崎大学大学院医歯薬学総合研究科　教授
	山本　勉	岡山県立大学　教授
	廣瀬弘忠	東京女子大学　教授
	伊藤葉子	中京大学社会学部　講師
協力研究者	木下ゆり	エイズ予防財団リサーチレジデント
	ケイトリン・ストロネル	エイズ予防財団リサーチレジデント
	伊藤麻里子	HIVと人権・情報センター名古屋支部
	堺本哲司	岡山理科大学

研究要旨　YSP参加者を対象とする調査により、プログラム実施を通してAIDS-NGOが関わる若者相互の活動により理解と態度の変化が得られることが、昨年度のパイロットスタディ同様に、示唆された。調査結果は、1）HIV感染に関する知識・理解の向上、2)AIDSを自分自身の問題と考える者の割合の増加、3)AIDSや性について友達と話したい者の割合の増加、4）PWAに対する姿勢の向上、などが得られることを示している。また、事例検討の結果、YSP講演実績を通じたGOとNGOの連携のひろがりも得られ、2000年度の全国22か所における延べ1450名を対象とした24回のYSPのうち18か所において事業への進展がみられた。全国組織のAIDS-NGOがGOと連携をとることにより、啓発だけに限らず、現任者研修、ケアサポートにおける連携など他の関連事業に発展/継続的なかかわりが可能であることも示唆された。

A．研究目的

本研究は、HIV感染予防及び人権に関する啓発を国民レベルで進めるために、NGO（非政府組織）が行政、教育機関等との連携のもとに進める啓発活動の可能性を探り、実際に展開されている取り組みの評価を行うことを目的として実施した。さらに、NGOと行政、教育機関等との連携を個別事例に応じて分析し、その後の連携の広がりについて検討を行った。

B．研究方法

（1）対象

２００１年度に保健所、教育機関ならびにNPO法人HIVと人権・情報センターの連携のもとに実施されたYSPの取り組みに参加した中学、高等学校学生を対象として実施した。合計22カ所。対象は、中学、中高合同、高校などの集団で参加者は合計2,044名であった。

連携についての分析ケースは、2000年度のYSP実施実績、全国22カ所、24回、参加者1450名のうち、18カ所であった。

（2）方法

YSP実施の実施前と実施後に、同一項目のアンケートを実施した。また、実施後には実施した感想についての回答を求めた。

アンケートは実施前後とも無記名にて実施され、回答者が自由に選択した４桁の番号の記入を求めてIDとすることにより、前後を確認した。

アンケートの内容はAIDSに関する知識、意識、態度等について11項目からなり、事後アンケートには、感想に関する７項目を加えた。

分析にあたっては、回答者が自由に選択した４桁の

IDによって実施前後の番号が一致した1609名の回答内容を対象とした。

連携についての分析は、活動実績をケース事に分類し、考察を加えた。

（3）Young Sharing Program（YSP）の内容

①事業の目的

地域保健法に明記されているように、保健所はＡＩＤＳに関して、地域住民の保健衛生サービスを行う重要な拠点である。ＨＩＶ抗体検査実施や相談等、個々人にたいするサービスとともに、これ以上感染拡大が起きないように、予防や人権にたいする配慮を含んだＡＩＤＳ啓発活動を行うことが保健所の重要な任務である。特に新感染症法の予防指針にあるように、個別施策層として若者が定められており、若者への啓発が将来のＡＩＤＳの動向と深く関わりあっている。

若者が互いの生命を大切にしあい、あらゆる人々と共に生きていくことを目指した「ヤング・シェアリング・プログラム」を実施することで、次世代を担う若者のＨＩＶ感染拡大の防止と人権教育を行う。また、学校、地域の保健所、ＮＧＯが準備からフォローアップまで共に取り組む中で、地域全体が課題や目標を共有し、より効果的に若者を育成していくことを目指す。

②プログラムの企画の留意点

プログラム実施前に、対象者の背景やニーズを把握し、より効果的なプログラムの企画、準備、実施を行うために、学校と保健所とＨＩＶと人権・情報センターの三者が共通理解をもつことが重要となる。

実際に学生たちの通う学校（会場校）で打ち合わせを行い、性に関わるデリケートな問題ということを十分に認識し、対象者が個人として尊重される存在であることを確認する。

対象者の状況についての情報を共有した上で、プログラムを行う目的、ねらい、短期的な目標から最終的なゴールを設定し、具体的なプログラムの検討・企画を行う。また、評価の基準についても確認しておく。

確認する内容としては、以下のようなものがある。

・プログラムの概要説明
　目的、内容、留意点、効果、ねらい、生徒たちの反応
・地域の特徴について確認
　人口、高齢化率、産業、文化的娯楽、交通の便等
・学校の特徴について確認
　教育方針、学科・専攻・クラス、学生数、学生の入学前の状況、進路状況、部活動への参加、卒業後の居住地等
・対象となる生徒の様子について確認
　人数・クラスの規模、授業・講演会での態度、生活状況、人間関係、養護学級の有無、保健室の利用状況、性・ＡＩＤＳ学習のレベル、性にたいする関心、性行動の状況等
・学校、保健所の要望について確認
・学校、地域の保健所、ＮＧＯの役割とフォローアップについて検討
・目標（長期、中期、短期）設定
・具体的なプログラムの検討
・プログラムの評価基準について検討
・会場見学

さらに、担当者事前研修の内容として、以下のものに取り組む。

・世界と日本のＡＩＤＳの状況、最新情報
・若者の間で拡がる性感染症、ＨＩＶ感染
・若者の性行動の実態
・ＡＩＤＳ学習の指針、ＡＩＤＳをどう教えるか
・生命・人権・共生の視点にたったＡＩＤＳ教育の必要性
　（性犯罪被害者、性への抵抗を持つ生徒、病気や障害を持つ生徒への配慮、ＨＩＶ感染者を含む障害者等あらゆる人との共生）
・若者相互（ピア）の関わりの意義と効果
・学校、保健所の役割と地域への広がり

（倫理面への配慮）

本研究は、感染者や当事者によるプライバシーに関する助言を得て研究を進め、主にYSP参加者を対象にプログラムの効果に関する調査を行ったものである。また、調査の回答は匿名で行われ、生徒それぞれの自発的な判断を前提としているため、人権上の問題が生じる可能性はない。

C．研究結果

前後のIDが一致した学生数は、1609名であった。

（1）確実な知識の獲得とPWA/Hに対する態度の変化

図1「感染の可能性のある体液」に関する知識の獲得

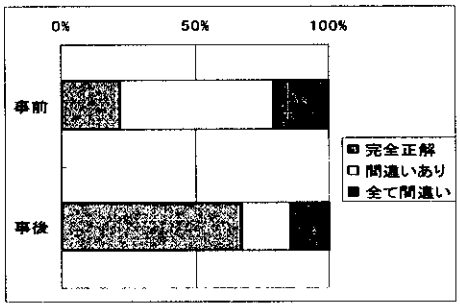

図2「感染の可能性のある行為」に関する知識の獲得

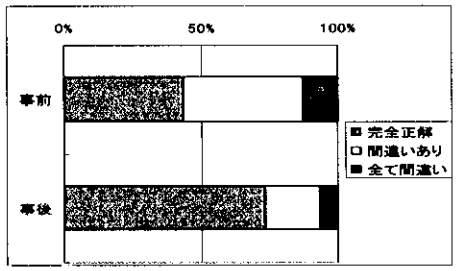

図3「HIV感染の可能性のある体液」の正解率の変化

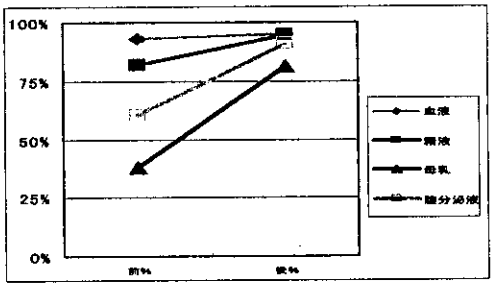

図4「HIV感染の可能性のある行為」の正解率の変化

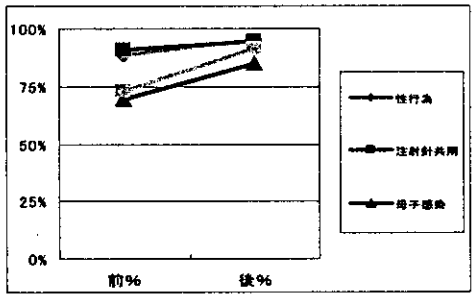

図5 HIV感染に関する知識の変化

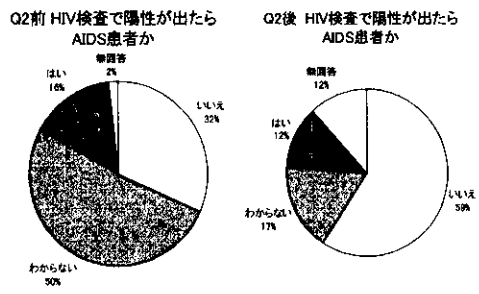

図6 身近な人およびHIV感染者に対して「できる」の回答者の割合の変化