Inter-Agency Task Team on HIV and Young People

GUIDANCE BRIEF

Overview of HIV Interventions for Young People

Purpose

A series of seven Guidance Briefs has been developed by the Inter-Agency Task Team (IATT) on HIV and Young People[1] to assist United Nations Country Teams (UNCT) and UN Theme Groups on HIV/AIDS[2] in providing guidance to their staffs, governments, donors and civil society on the specific actions that need to be in place to respond effectively to HIV among young people.[3] This Brief provides a global overview and is complemented by a separate Brief for most-at-risk young people and five others on HIV interventions among young people provided through different settings /sectors: community, education, health, humanitarian emergencies and the workplace.

The purpose of these Briefs is to help decision makers understand what needs to be implemented, based on the latest global evidence on effective interventions for young people. The Briefs provide an overview of evidence-informed interventions (not a blueprint for national programmes) in response to specific epidemic scenarios in different countries.[4] Special attention should be directed to young people most at risk of HIV in all countries. In generalised and hyperendemic settings, interventions to prevent HIV also need to be directed to the general population of young people.[5]

The Briefs do not say "how to" implement the interventions outlined, but key resources are listed to provide further guidance. The Briefs also do not attempt to address the many cultural, institutional and structural specificities and factors that confront decision makers in different countries. They are therefore likely to require further adaptation and translation if they are to be used by national counterparts. The engagement of young people in the adaptation of the materials will enhance their usefulness.

Introduction

These Briefs are aligned with UNAIDS cosponsoring agencies' strategic plans for young people, including those most at risk of HIV. While each agency has a specific focus (such as education for UNESCO and health services for WHO)[6] they all promote a comprehensive and multi-sectoral approach to HIV prevention, treatment, care and support among young people.[7] We know what works in preventing HIV among young people,[8,9] and an essential package of HIV prevention, treatment, care and support interventions should now be in place as part of efforts to ensure universal access. In some countries where these services are accessible, reductions in HIV prevalence rates among youth 15 to 24 years of age are beginning to be observed.[10]

Why focus on young people?

Young people are at the centre of the global HIV epidemic. It is estimated that 5.4 million youth are living with HIV; about 59 per cent of them are female and about 41 per cent are male.[11] In 2007 about 40 percent of new infections among people 15 and over were in youth 15 to 24 years of age.[12] Sub-Saharan Africa is home to almost two-thirds (61 per cent) of all youth living with HIV (3.28 million), 76 per cent of them female. Southeast Asia and the Pacific have the second highest prevalence with an estimated 1.27 million youth living with HIV, 70 per cent of whom are male.[13] In Central and Eastern Europe, the Russian Federation and Ukraine have the fastest growing epidemics in the world, and young people account for a large proportion of the number of people living with HIV.

Despite the high numbers of young people living with HIV, there still remains insufficient attention directed towards preventing future transmission of HIV among this population. For youth who are HIV-positive, many have inadequate access to health and social support services and face considerable stigma and discrimination. For these reasons, the UN has renewed its commitment to focus on HIV and young people.

Ensuring an HIV-free future generation – A UN-convened High Level Meeting on AIDS resulted in governments agreeing on the need "to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence and skills-based youth specific HIV education, mass media interventions, and the provision of youth friendly health services."[14]

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[1] The Inter-Agency Task Team on HIV and Young People was established in 2001 to enhance the effectiveness of the global response to AIDS in the context of young people. Further information about the IATT on HIV/YP is contained at the end of the document.

[2] This includes Joint UN Teams on AIDS (JUNTA) and/or Technical Working Groups (TWG) on AIDS.

[3] The UN defines young people as age 10 to 24 years, youth as age 15 to 24 years and adolescents as 10 to 19 years.

[4] Detailed information on what actions (for populations of all ages) should be taken for each stage of the epidemic can be found in UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS, Geneva.

[5] Information and education about HIV should be available to all young people, irrespective of the stage of the epidemic. There are global indicators to monitor the percentage of youth age 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

[6] Consistent with the UNAIDS Division of Labour - see UNAIDS (2005) UNAIDS Technical Support Division of Labour: Summary and Rationale. UNAIDS, Geneva.

[7] UNICEF, UNAIDS, WHO (2002) Young People and HIV/AIDS: Opportunity in Crisis; and UNAIDS/WHO (2000). Second Generation Surveillance for HIV: The Next Decade. UNAIDS, Geneva.

[8] UNAIDS (1998) Expanding the Global Response to HIV/AIDS through Focused Action: Reducing Risk and Vulnerability: Definitions, Rationale and Pathways. UNAIDS, Geneva.

[9] WHO (2006) Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries. Eds. Ross, D., Dick, B., and Ferguson, J. WHO and Inter-Agency Task Team (IATT) on HIV and Young People, Geneva.

[10] HIV prevalence among pregnant women age 15 to 24 attending antenatal clinics has declined since 2000/2001 in 11 of the15 most-affected countries. Preliminary data also show favourable changes in risk behaviour among young people in Botswana, Cameroon, Chad, Haiti, Kenya, Malawi, Togo, Zambia and Zimbabwe. These trends suggest that prevention efforts are having an impact in several of the most affected countries. UNAIDS (2007) AIDS epidemic update. UNAIDS, Geneva.

[11] UNAIDS/WHO unpublished estimates, 2007 -data are not available for young people 10 to 24 years.

[12] UNAIDS (2007) AIDS epidemic update: Core slides: Global Summary of the HIV and AIDS epidemic. UNAIDS, Geneva. http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi_slides.asp

[13] UNAIDS/ WHO unpublished estimates 2007.

[14] UNGASS (2006) Political Declaration on HIV/AIDS. UN New York - Paragraph 26.

The need to focus on HIV among young people has been endorsed by governments and a range of international fora,[15] and specific targets have been agreed to:

- Reduce HIV prevalence among young men and women (15-24) by 25 per cent globally by 2010 (UNGASS)
- Reduce prevalence among young people to 5 per cent in the most affected countries and by 50 per cent elsewhere by 2015 (HIV/AIDS Task Force for the Millennium Project)[16]
- By 2010, ensure that 95 per cent of youth 15-24 years of age have information, education, services and life skills that enable them to reduce their vulnerability to HIV infection (UNGASS)

Risk and vulnerability

Behaviours that put people at greater risk of HIV infection include unprotected sex, in particular with multiple partners, and injecting drugs with non-sterile equipment.[17] The contexts and populations of particular concern in relation to HIV risks include sex work, men who have sex with men, bisexual and transgendered populations, and injecting drug users. Some young people are already engaging in such HIV-risk behaviours. Further information is available in the *Global Guidance Brief on HIV and Most-at-risk Young People.*[18]

> Many young people may be ***vulnerable*** to engaging in HIV-risk behaviours. Vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include: (i) personal factors such as the lack of knowledge and skills required to protect oneself and others; (ii) factors pertaining to the quality and coverage of services, such as inaccessibility of services because of distance, cost and other factors; (iii) societal factors such as social and cultural norms, practices, beliefs and laws that stigmatise and disempower certain populations and act as barriers to essential HIV-prevention messages. These factors, alone or in combination, may create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV.[19]

Vulnerability does not automatically lead to HIV-risk behaviour, as there are several protective factors at work (such as education, supportive family and peer networks).[20] However, the absence of protective factors may contribute to adolescents engaging in HIV-risk behaviours. Biological vulnerability is also a factor for young women with immature vaginal epithelia, as abrasions can facilitate the transmission of HIV as can the presence of sexually transmitted infections (STIs).

Young men and women vulnerable to HIV include those who:

- Are peers of most-at-risk young people
- Have parents or siblings who inject drugs or sell/exchange sex
- Live without parental care (on the streets or in institutions)[21] or live with older relatives or guardians or in dysfunctional families
- Have dropped out of school or have limited access to information and education
- Use substances (alcohol and other drugs) that may impair their judgment
- Have limited access to health and social services due to lack of identity documents
- Live in extreme poverty or are unemployed
- Have been displaced through war (internally and externally) or have migrated between rural and urban areas or outside of their country of origin in search of employment (because of forced labour or for sexual exploitation)
- Live in areas of high HIV prevalence
- Are socially excluded (for example, members of national minorities)[22]

Thus responses to HIV for young people need to combine two complementary multi-sectoral strategies: ***risk reduction*** through specific programmes for HIV prevention, treatment, care and support; and the ***mitigation of vulnerability***. In addition, long-term developmental interventions are required to address cultural, economic, political and social change, including changes in gender and power relations.[23]

Gender

Gender inequalities influence a young person's vulnerability to infection and his or her ability to access prevention, treatment, care and support. Gender often dictates that women and girls should not be informed about sex, which constrains their ability to negotiate safer sex or access appropriate services.[24]

In some countries in sub-Saharan Africa, female youth are three times more likely to be infected than male youth as a result of older men having sexual relations with younger women,[25] the younger female age of sexual debut, biological vulnerability and gender-

[15] These include the five-year follow up to the Cairo International Conference on Population and Development (ICPD +5), the Millennium Summit, the 2001 UN General Assembly Special Session (UNGASS) on HIV/AIDS and its five-year review, as well as the 2002 UNGASS on Children (World Fit for Children) and the 2002 Youth Employment Summit.

[16] United Nations (2005) Combating AIDS in the Developing World - Achieving the Millennium Development Goals. UN, New York.

[17] UNAIDS, UNICEF, WHO, United States Agency for International Development, Centre for Diseases Control, Measure Evaluation and Family Health International (2007). A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. UNAIDS, Geneva. UNAIDS/07.15E/JC1338E.

[18] The particular HIV interventions that need to be in place for these young people are discussed in more detail in the Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Most-at-risk Young People.

[19] UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards universal access. UNAIDS, Geneva.

[20] WHO (2002) Broadening the Horizon: Balancing protection and risk for adolescents. WHO, Geneva.

[21] Reference to children living/working on the streets and in juvenile detention facilities is made in the Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Most-at-risk Young People.

[22] Homans (2008) Regional Guidance Manual on Programming to Prevent HIV in Most-at-risk Adolescents. UNICEF Central and Eastern Europe and the Commonwealth of Independent States, UNICEF, Geneva.

[23] UNAIDS (2005) Intensifying HIV Prevention. UNAIDS, Geneva.

[24] UNAIDS (1999) Gender and HIV/AIDS: Taking stock of research and programmes. UNAIDS, Geneva and WHO (2003) Integrating Gender into HIV/AIDS Programmes: A Review Paper. WHO, Geneva.

[25] UNAIDS and UNICEF databases (2007).

based violence. Adolescent girls between the ages of 15 and 19 accounted for two-thirds of all new infections in this age range.[26] For boys and young men, there may be social pressures to take risks and prove their manhood by having sex with multiple partners or through drug use.[27] In Eastern Europe and Central Asia, where injecting drugs is the main mode of transmission, male youth are 2.3 times more likely to be affected than young women.[28]

It is therefore essential to understand the gender dynamic of sexual relations and risk-taking behaviours before implementing interventions and to monitor programmes by sex to ensure that gender inequalities are not ignored.

National AIDS Responses

Young people need special and urgent attention. Despite the large numbers of young people infected with HIV, their needs are often overlooked during the development of national HIV strategies and policies and the allocation of budgets. This exclusion is compounded by the fact that the young are over-represented among the world's poor and unemployed. They may also lack a "voice" by which to express their concerns, and they often are not included in the planning and design of interventions targeted to them. Their engagement in the development of HIV-prevention programmes is critical to programme success.

Absent or insufficient data are major constraints in responding appropriately to young people's needs for HIV information and services.[29] Strategic information on the epidemic and its social drivers should inform and support programmatic and policy decision-making to achieve the goals set in the National AIDS Programme.[30] Information is therefore needed on the following:

- ***Where, among whom and why are HIV infections occurring now?*** Who are the young people with highest HIV prevalence rates (by age, sex and diversity)?[31] What are their risk behaviours, and where are the settings in which these behaviours occur?
- ***How are infections moving among young people?*** HIV may move through a "network" of exposures (i.e. from young sex workers to clients to another sex worker who may transmit HIV to his or her regular partners).
- ***What are the drivers of the epidemic among young people?*** What are the cultural, economic, social and political factors that make young people vulnerable or force them to adopt high-risk behaviours?

Once these data are available, it is important to tailor the HIV response to the context of the epidemic locally. In ***low-level*** and ***concentrated*** epidemics, HIV is primarily transmitted to key populations at higher risk to HIV (sex workers and their clients, injecting drug users and men who have sex with men). In these contexts, special attention needs to be focused on these key populations. In ***concentrated*** epidemics, information is also needed on HIV transmission patterns and sexual and drug injection networks.[32] In ***generalised*** epidemics, the focus should remain on young people engaging in HIV-risk behaviours as well as on ensuring that all young people have access to HIV and sexually transmitted infection (STI) prevention information (condom use, reduction of number of partners, concurrent partners) and treatment services. This requires addressing barriers related to age[33] and socio-economic factors that limit access to information and services.[34] In addition, life skills programmes and voluntary HIV testing should be part of the HIV response for young people.

Hyperendemic refers to areas where HIV prevalence exceeds 15 per cent in the adult population, a rate driven by extensive heterosexual/multiple/concurrent partner relations with low and inconsistent condom use.[35] This scenario is prevalent in Southern Africa,[36] and vulnerability of young people in this situation requires particular attention. This is because partner and spousal transmission of HIV is more likely within such contexts.

Sufficient evidence exists of the effectiveness of specific interventions to prevent HIV among young people.[37] [38] There are four core areas of action that target both risk and vulnerability reduction and are reflected in global goals for HIV prevention, treatment, care and support among young people. Evidence shows that all four core areas of action need to be provided simultaneously through behaviour change communication strategies and that implementing a single action on its own is not sufficient to effect change.

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[26] Data from 11 countries with nationally representative surveys of HIV prevalence cited in WHO (2006) Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries. Eds. Ross, D., Dick, B., and Ferguson, J. WHO and UNAIDS IATT on Young People, Geneva.

[27] UNAIDS (2000) Men and AIDS - A gendered approach. World AIDS Campaign. UNAIDS, Geneva.

[28] UNAIDS/UNICEF databases (2007) 71% of youth living with HIV in Central and Eastern Europe and the Commonwealth of Independent States are male, 66% in Latin America / Caribbean, and 62% in South Asia.

[29] Countries in which national prevalence exceeds 3% were asked to provide data on HIV prevalence and/or sexual behaviour trends among young people. Almost two-thirds of countries studied had insufficient, or no data - UNAIDS (2007) AIDS Epidemic Update: Briefing Booklet. UNAIDS, Geneva.

[30] UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards universal access. UNAIDS, Geneva.

[31] Diversity includes factors such as displacement, national ethnic minorities, married and unmarried young people and rural/urban areas.

[32] UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards universal access. UNAIDS, Geneva.

[33] See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Most-at-risk Young People for a discussion of challenges in working with minors.

[34] In none of 18 countries surveyed between 2001 and 2005 did knowledge levels about HIV in young people exceed 50%: far short of the 95% target for 2010 - UNAIDS (2006) AIDS Epidemic update 2006. UNAIDS, Geneva.

[35] UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards universal access. UNAIDS, Geneva.

[36] Southern Africa Development Community (SADC) Secretariat (2006) Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa Report (10-12 May 2006).

[37] UNAIDS (1998) Expanding the Global Response to HIV/AIDS through Focused Action: Reducing Risk and Vulnerability: Definitions, Rationale and Pathways. UNAIDS, Geneva.

[38] WHO (2006) Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries. Eds. Ross, D., Dick, B., and Ferguson, J. WHO and UNAIDS IATT on Young People, Geneva.

The four core areas are:

- Information to acquire knowledge
- Opportunities to develop life skills
- Appropriate health services for young people
- Creation of a safe and supportive environment

1. ***Provide young people with information to acquire knowledge*** on how to protect themselves from HIV transmission. Information on HIV must be timely, age and sex appropriate and relevant to the sociocultural context of the individuals, their families and their communities. There are a number of channels through which information can be provided to young people, including parents, teachers, peers, workplaces and job centres, health service providers and the media. The effectiveness of each of these channels has been assessed.[39 40]

What information do young people need?

- All young people need:
  - Correct information about HIV prevention, modes of transmission and common misconceptions about HIV and AIDS
  - Information about sexual and reproductive health (sexuality and intimacy, contraceptive use for dual protection, safer sex, sexually transmitted infections) and where to obtain sexual and reproductive health services
- Young people who inject drugs, or who may be at risk of injecting drugs, need information on the use of sterile injection equipment and where to access harm-reduction services.
- Young males who have sex with males and young men and women involved in sex work need information on the dangers of unprotected sex and where to obtain male and female condoms for anal and vaginal sex and services for the treatment of STIs. Those involved in sexual exploitation need to know where they can access the appropriate services.
- Young people living with HIV or those who have a parent, relative or friend living with HIV need information about positive living (good nutrition and healthy lifestyles), the likely progression of disease, treatment and care options, and how to prevent transmission to others, including mother-to-child transmission of HIV.

2. ***Provide opportunities for young people to develop life skills,*** as information-only approaches are insufficient to change young people's attitudes and behaviours.[41] Interventions linked with life-skills-based education have proved effective in delaying first sexual intercourse and, among sexually experienced young people, in increasing condom use and decreasing the number of sexual partners.[42] Recent evaluations have shown that life-skills interventions for HIV prevention are most effective when directed specifically to skills related to HIV risk reduction.[43] Young people therefore need skills to be able to refuse sex; to use condoms correctly and consistently; to communicate with their partners and other adults about sex, condoms and contraception; and to know how to avoid situations and places that might expose them to unsafe behaviours.

What types of life skills do young people need?

- Communication skills to discuss sex, contraception and condoms with partners, parents and other adults
- Self-efficacy to:
  - Recognise the risk of different behaviours, including having unprotected sex, having multiple partners and having sex with older, more powerful males
  - Recognise in advance the situations that might lead to HIV or STI risk behaviours
  - Use condoms and contraception correctly and consistently
- Negotiation skills to be able to refuse or delay sex or negotiate condom use
- Positive values and attitudes towards the use of male and female condoms and contraception

3. ***Provide young people with access to health services and commodities for HIV prevention and treatment, care and support.*** Health services should be receptive and responsive to the specific needs of young people. They should provide an evidence-informed package of interventions delivered in an adolescent- or youth-friendly[44] manner. This requires that: health service providers are adequately trained; facilities ensure privacy and confidentiality; services are affordable and appropriately located with convenient hours of operation;[45] and communities are aware of their existence.[46] Outreach approaches[47] and local media (including the Internet) should be used to reach young people and provide them with basic information about the services, their location and availability.

The services should include: sexual and reproductive health information and counselling; condoms for sexually active adolescents for protection against HIV, STIs and pregnancy; diagnosis and treatment of STIs; access to male circumcision services where HIV prevalence is high and male circumcision prevalence is low; voluntary and confidential HIV testing and counselling; referral to treatment, psychosocial support and care

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[39] ibid

[40] UNAIDS (1997) Impact of HIV and sexual health education on the sexual behaviour of young people: A review update. UNAIDS Geneva.

[41] Boler, T. and P. Aggleton (2005). Life skills education for HIV prevention: A critical analysis. Save the Children and ActionAid International, London. http://www.aidsconsortium.org.uk/Education/Education%20downloads/life_skills_new_small_version.pdf

[42] Moya, C. (2002) Life Skills Approaches to Improving Youth's Sexual and Reproductive Health. Issues at a Glance. Advocates for Youth, Washington DC.

[43] Kirby, D., Laris, B. and Rolleri, L. (2006) Impact of Sex and HIV Education Programmes on Sexual Behaviours of Youth in Developing Countries. Family Health International, Washington DC.

[44] Adolescent services cover young people up to the age of majority (18 in most countries) whereas youth-friendly services tend to cover young people up to age 24.

[45] See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Young People in the Health Sector for more information on an evidence informed package of interventions and the most appropriate methods for delivering such services in different country contexts.

[46] See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on Community-based HIV Interventions for Young People.

[47] See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Most-at-risk Young People.

services for young people living with HIV;[48] and referral to HIV-prevention services if HIV-negative. In addition, young injecting drug users require harm-reduction services,[49] and young pregnant women need referral to services for prevention of mother-to-child transmission of HIV.

4. ***Create safe and supportive environments.*** Individual empowerment of young people can only be achieved within the context of a safe and supportive environment that does not discriminate against those who are living with HIV or engaging in HIV-risk behaviours. Stigma and discrimination are often cited as the most important barriers to services by people living with HIV, injecting drug users, men who have sex with men and sex workers.

For young people to be able to access and use information, skills and services, they need to live, learn and earn in environments that are free from abuse, conflict and exploitation-and in a context that prepares them appropriately for adult life.

Social environments can be divided into three levels: those that are close to the young person (parents, peers and teachers); the community (religious leaders, civil society organizations, youth centres, schools, workplaces and other institutions);[50] and the wider environment of the media, social norms and policies. HIV programmes and policies need to address all of these levels to maximise the positive influence they have on young people's lives.

In addition to health services, young people need services in other sectors to reduce their vulnerability to HIV. These include legal services (to ensure their rights are protected), employment and income generation opportunities, youth clubs and faith-based organizations. In many countries, young people who are most at risk and those in humanitarian emergencies are often overlooked[51] and unable to access HIV protection and care, along with education, employment and recreational services.

A broader approach to vulnerability reduction involves including HIV interventions for young people in national Poverty Reduction

Partnerships and Multi-Sectoral Approaches

Participation of young people in the planning, design, implementation, monitoring and evaluation of all interventions is critical.

The development of comprehensive HIV programmes for young people across different sectors and organizations requires collaboration and partnerships between adults and youth and among different organizations, providing sustainable funding and a national coordination mechanism. Different sectors need to be clear about how they can contribute to achieving the global goals in terms of providing HIV information, skills and services for young people, thus decreasing their vulnerability.

Some organizations may require technical capacity-building to work effectively with young people. Numerous global, regional[52] and national networks of young people engaged in HIV prevention and treatment activities exist, and these networks should be included as partners in the national response. Coordination of all relevant youth organizations and networks at country and regional levels should also be facilitated and strengthened as part of a comprehensive ***Youth Policy and Strategic Plan***.

Monitoring and Evaluation

Programmes should include a monitoring and evaluation plan to track progress against milestones and universal access targets identified in the National HIV Programme. Data need to be disaggregated by age, sex, diversity and use of services[53] to show whether the interventions are having the intended effect and to make appropriate changes based on the results.[54]

Several tools have been developed to assist countries with monitoring indicators for young people consistent with the UNGASS core indicators[55] and for tracking most-at-risk populations.[56] Tools have also been developed to evaluate HIV education programmes[57]

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