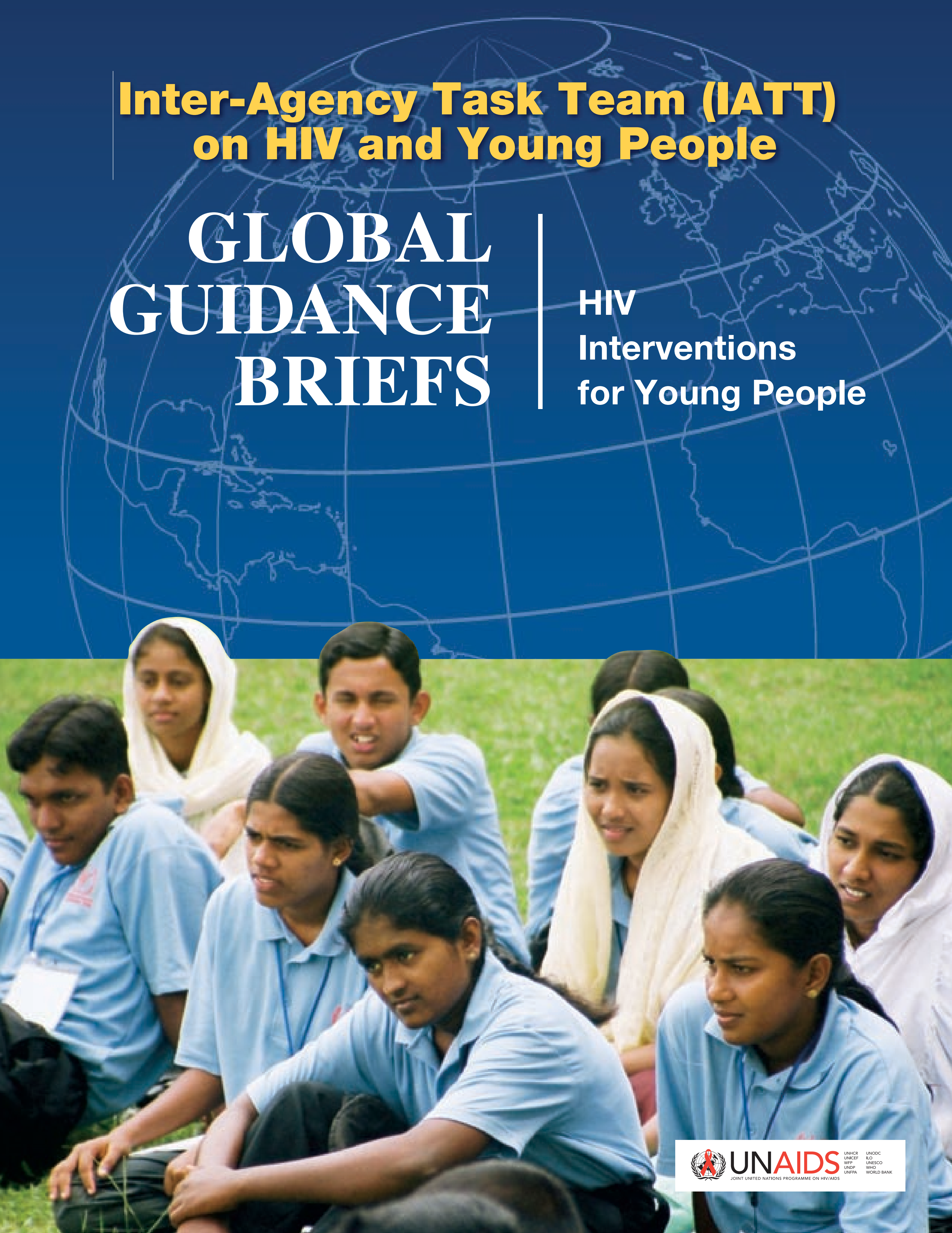
Inter-Agency Task Team (IATT)
on HIV and Young People
GLOBAL
GUIDANCE
BRIEFS
HIV
Interventions
for Young People
UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR
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Foreword

Young people are at the centre of the global HIV epidemic. It is estimated that 5.4 million youth are living with HIV. In 2007, about 40 per cent of new HIV infections among people 15 and over were in youth from 15 to 24 years of age. Despite the high numbers of young people living with HIV, insufficient priority is given to preventing future HIV transmission among this population group. Many of those who are HIV-positive face considerable stigma and discrimination, with inadequate access to health and social services or livelihood support.

In 2001, governments declared that "by 2005, at least 90% and by 2010 at least 95% of young men and women, 15-24, would have access to information, education including peer and youth specific HIV education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection". Yet as of 2007, only 40 per cent of young men and 36 per cent of young women had accurate knowledge about HIV, showing that even basic HIV awareness programmes have had inadequate reach.

There is some progress but it is not adequate. It is essential that we sustain the efforts being made as well as scale up the response. In recent years, the UNAIDS Secretariat and the ten UNAIDS Cosponsors have sought to strengthen their technical support to national AIDS programmes and extend partnerships to national leaders and governments, development partners, researchers, non-governmental organizations, associations of people living with HIV and other stakeholders—especially young people. Towards this end, the Inter-Agency Task Team on HIV and Young People has developed a series of Global Guidance Briefs to help United Nations Country Teams and UN Theme Groups on AIDS provide guidance to their staff members as well as governments, development partners, civil society and other implementing partners on the specific actions that need to be in place to respond effectively to HIV among young people. We hope that these Briefs will be useful at the country level to accelerate the response.

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Global 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.

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.

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]

> **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]

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.

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

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.
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.

available in the *Global Guidance Brief on HIV and Most-at-risk Young People.*[18]

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]

> 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]

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- 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

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).
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.

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 socioeconomic 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.

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

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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.

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 youthfriendly[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.

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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.*

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 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 Strategy Papers and UN Development Assistance Frameworks, as well as ensuring that the national legal framework does not discriminate against them and that social norms do not promote gender-based violence.

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

48 WHO (2004) *Protecting Young People from HIV/AIDS: The Role of Health Services*. WHO, Geneva.
49 Harm reduction comprises three principles: i. reaching out to injecting drug users; ii. discouraging the use of non-sterile injecting equipment and providing sterile equipment and disinfectant materials; and iii. making substitution treatment available.
50 For each of the briefs included in this package, specific guidance is presented on the types of interventions that should be implemented and scaled-up, based on the known evidence. See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Briefs on Community, Education, Health, Humanitarian Emergencies, the Workplace and Most-at-risk Young People* for more information.
51 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Most-at-risk Young People and Global Guidance Brief on HIV Interventions for Young People in Humanitarian Emergencies*.
52 See Useful web pages for some examples.
53 Such as uptake of VCT services and the percentage of most-at-risk young people who received an HIV test in the last 12 months and who know the results.

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] and general life-skills-based education programmes.[58]

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- Support governments to implement key recommendations from UNAIDS[59] and the Inter-Agency Task Team on HIV and Young People's Global Guidance Briefs on HIV and Young People into concrete plans of action. This should include development of national norms and standards, support for technical capacity-building, sharing of best practices and other programme guidance, and advocacy for better coordinated responses to develop policies and programmes with and for young people.
- Review the Joint UN Implementation Support Plan to ensure that UN agencies are providing technical support and capacity-building related to the implementation of HIV interventions for young people. Based on the review results, adjust the UN HIV Joint Implementation Support Plan and budget to fill programme and policy gaps, identify new resources and ensure a well-coordinated and harmonised UN response for HIV and young people.
- Advocate for cost assessment of HIV-prevention interventions for young people, and use the data to prioritise cost-effective interventions for young people as part of the national HIV Strategic Plan.
- Advocate with relevant key donors for resource allocation by supporting a focus on universal access to HIV prevention, treatment, care and support for young people; submit proposals to the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR) and bilateral donors with a component on universal access to HIV prevention, treatment, care and support for young people.
- Promote gender equality and support interventions to reduce the inequalities between young women and men, and young women and older men.
- Advocate for HIV interventions for young people to be included in Poverty Reduction Strategy Papers and the United Nations Development Assistance Framework.
- Support research and the collection of programmatic data on sexual, drug use and HIV-risk behaviours and networks among young people to inform national HIV programming, monitoring and evaluation.
- Support the development of a national monitoring and evaluation system with age and sex disaggregated data and some specific indicators on young people as an integral part of the national monitoring and evaluation system, in accordance with the "Three Ones[60]."

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54 UNAIDS (2007) *Practical Guidelines for Intensifying HIV Prevention: Towards universal access*. UNAIDS, Geneva.

55 WHO et al (2004) *Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People*. WHO, Geneva. http://www.who.int/hiv/pub/me/en/me_prev_intro.pdf and Family Health International (2000) *Monitoring and Evaluating Adolescent Reproductive Health Programmes*. FHI, Arlington, VA. http://www.fhi.org/en/Youth/YouthNet/Research/monitoringevaluation.htm

56 UNAIDS et al (2007) *A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations*. UNAIDS, Geneva. UNAIDS/07.15E/JC1338E.

57 Centres for Disease Control (2005) *Handbook for Evaluating HIV Education*. CDC, Washington, DC. http:// www.cdc.gov/HealthyYouth/publications/hiv_handbook/index.htm

58 UNICEF (2002) *Measures and Indicators for Evaluating Life-Skills-Based Education Programmes*. UNICEF, New York. http://www.unicef.org/lifeskills/files/MeasuresAndIndicatorsLifeSkills.doc

59 Such as UNAIDS (2007) *Practical Guidelines for Intensifying HIV Prevention: Towards universal access*. UNAIDS, Geneva.

60 The "Three Ones" are principles for the coordination of national AIDS response. See http://www.unaids. org/en/country responses/Making The Money Work/Three Ones.

KEY RESOURCES:

Aggleton, P., Chase, E. and Rivers, K. (2004) *HIV/AIDS Prevention and Care among Especially Vulnerable Young People: A Framework for Action.* Thomas Coram Research Unit, Institute of Education, University of London, London. ISBN 0 85432 807 6 *http://www.safepassages.soton.ac.uk/pdfs/evypframework.pdf*

Family Health International (2000) *Monitoring and Evaluating Adolescent Reproductive Health Programmes.* FHI, Arlington, VA. *http://www.fhi.org/en/Youth/YouthNet/Research/monitoringevaluation.htm*

UNICEF (2008) *Draft 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. Draft document available from: *mbelgharbi@unicef.org*

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, Arlington, VA.

UNAIDS (1997) *Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A review update.* UNAIDS Geneva.

UNAIDS (2007) *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access.* UNAIDS, Geneva.

UNAIDS et al (2007) *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-risk Populations.* UNAIDS, Geneva. UNAIDS/07.15E/JC1338E.

WHO et al (2004) *Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People.* WHO, Geneva. *http://www.who.int/hiv/pub/me/en/me_prev_intro.pdf*

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.

USEFUL WEB PAGES:

Global

United Nations Population Fund
http://www.unfpa.org/hiv/people.htm

UNICEF
http://www.unicef.org

World Health Organization
http://www.who.int/hiv/en

Family Health International
http://www.fhi.org/en/Youth/YouthNet

Global Coalition on Women and AIDS
http://data.unaids.org/GCWA/GCWA_BG_prevention_en.pdf

Population Services International
http://www.psi.org/

Global Youth

Global Youth Coalition on HIV/AIDS
http://www.youthaidscoalition.org, http://gyca.takingitglobal.org/

Living Positively
http://www.youthaidscoalition.org/living.html

Youth Coalition for Sexual and Reproductive Rights
http//www.youthcoalition.org

Youth R.I.S.E. (Resources. Information. Support. Education). An International Network for Reducing Drug-Related Harm
http://projects.takingitglobal.org/harmreduction

Regional Youth

Africa Alive
http://www.africaalive.org/youthaids.htm

African Youth and Adolescent Network on Population and Development (AfriYAN) *www.afriyan.org*

Network of Asia-Pacific Youth
info@networkofasiapacificyouth.org

Youth AIDS Action (Americas)
http://www.paho.org/english/ad/fch/ca/adol-yan.htm

Further information and responsible agencies under UNAIDS Technical Support Division of Labour on HIV and Young People

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.

The **UNFPA** is the convener of this Task Team.

The IATT on HIV/YP is now being expanded to include partners from civil society, research institutions, youth networks/associations, the private sector and the donor community.

UNFPA is the lead agency for the prevention of HIV transmission in vulnerable groups, including out of school young people.

The main partners on this effort are: **ILO, UNESCO, UNICEF, UNHCR, UNODC, WFP** and **WHO.**

UNFPA is the lead agency on condom programming. The main partners on this effort are: **WHO, the World Bank** and **UNHCR**. http://www.unfpa.org/hiv/iatt

There is as yet insufficient evidence of the effectiveness of some of the interventions outlined in the Briefs and for the use of some of the interventions outlined for certain target populations. Similarly, many of the studies of effectiveness do not disaggregate the research findings by sex. Where there is insufficient evidence, the interventions that are described are based on good practice, and it is recommended that in addition to monitoring coverage and quality, such interventions be evaluated and the results of their effectiveness fed back into the global evidence base.

THE WORLD BANK

For more information on the Inter-Agency Task Team on HIV and Young People visit: http://www.unfpa.org/hiv/iatt

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Global Guidance Brief

HIV Interventions for Young People in the Education Sector

Purpose

This Brief 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, development partners, civil society and other implementing partners on effective HIV interventions for young people[3] in the education sector. It is part of a series of seven global Guidance Briefs that focus on HIV prevention, treatment, care and support interventions for young people that can be delivered through different settings for a range of target groups.

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 deal in any depth with "how to" implement the interventions outlined, although 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.

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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 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 aged 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Introduction

The education sector plays a critical role in preventing HIV among young men and women and in mitigating the effects of HIV and AIDS on individuals, their families and communities.[6] The Global Campaign for Education has estimated that universal primary education would prevent 700,000 new cases of HIV each year,[7] and the World Bank states that education is an effective "social vaccine" against HIV.[8]

Education is essential for HIV prevention

The role of education in HIV prevention among young people can be summarized as follows:

- A good basic education itself is a strong protective factor for preventing HIV risk behaviour among young people.
- Girls' education contributes to a number of factors that are thought to decrease vulnerability to HIV infection, such as female economic independence, delayed marriage, use of family planning and work outside the home.[9]
- Studies have shown that girls who have completed secondary education have a lower risk of HIV infection and are more likely to practice safer sex than girls who have only finished primary education.[10]
- Pregnancy is a major cause of school dropout for girls in many countries. Sex and relationships education can reduce girls' chances of an unwanted pregnancy or sexually transmitted infection, including HIV, and may thereby increase their chances of staying in school. In turn, staying in school will provide greater protection from HIV for girls
- School-based HIV and AIDS education can reach many children and young people with HIV information and equip them with the skills they need to protect themselves before they become sexually active[11 12] or begin to experiment with psychoactive substances, such as alcohol and illicit drugs.
- Pupils attending secondary school are undergoing a process of preparation for adulthood. Behaviour patterns that are established during this process can have long-lasting positive or negative effects on future health and well-being.
- Schools and teachers often play an influential role in community life and act as a trusted source of information for young people.[13]
- Schools have an important role in delivering care, support and treatment to young people living with and affected by HIV.[14 15]

Education also contributes to economic prosperity and the reduction of global poverty and is central to the achievement of several of the Millennium Development Goals. The number of children starting primary school has increased sharply since 2000; there are more girls in school than ever before, and spending on education and aid has risen.[16]

Evidence of effectiveness of school-based HIV interventions

There is strong evidence from around the world that learning about reproductive and sexual health does not increase the likelihood that young people will start having sex earlier.[17] Research shows that learning about sex and HIV before young people start sexual activity reduces their risk of contracting HIV.

A large number of sex education and HIV education programmes are being implemented in schools worldwide. They vary widely in terms of objectives, structure, length, content, quality, implementation strategy and other characteristics and can be categorised according to at least three different dimensions:

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6 UNAIDS (2004) *Towards an AIDS-Free Generation: A Global Initiative to Expand Prevention Education against HIV/AIDS*. Twenty-third meeting of the Committee of Cosponsoring Organisation, Livingstone. http://unesdoc. unesco.org/images/0013/001340/134043e.pdf

7 Global Campaign for Education (2004) *Learning to survive: How education for all would save millions of young people from HIV/AIDS*. http://www.campaignforeducation.org

8 World Bank (2002) *A Window of Hope*. World Bank, Washington and HIV/AIDS and Education webpage http:// www.worldbank.org/ and see also Vandemoortele, J. and E. Delamonica (2000) "Education 'vaccine' against HIV/AIDS," *Current Issues in Comparative Education* 3(1) and UNAIDS (2002) *HIV/AIDS and Education: A Strategic Approach*. UNAIDS, Geneva.

9 World Bank (2002) A Window of Hope. World Bank, Washington, DC.

10 ActionAid International (2006) Girl Power: *The impact of Girls' Education on HIV and sexual behaviour.* http://www.actionaid.org.uk/doc_lib/girl_power_2006.pdf

11 Kirby, D., Laris, B. A. and Rolleri, L. (2005) *Impact of Sex and HIV Education Programmes on Sexual Behaviours of Youth in Developing and Developed Countries*. Youth Research Working Paper, No. 2, Family Health International, Arlington, VA. http://www.fhi.org/en/Youth/YouthNet/Publications/ YouthResearchWorkingPapers.htm

12 Kirby, D., Obasi, A. and Laris, B. (2006) "The Effectiveness of Sex Education and HIV Education Interventions in Schools in Developing Countries" in *Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries*. Eds. Ross, D. et al., WHO and Inter-Agency Task Team on HIV and Young People, Geneva.

13 World Bank (2002) *A Window of Hope*. World Bank, Washington, DC.http://www1.worldbank.org/education/ pdf/Ed%20&%20HIV_AIDS%20cover%20print.pdf

14 Boler, T et al. (2007) *School-centred HIV and AIDS Care and Support in Southern Africa*. Technical Consultation Report, May 22-24, 2007, UNESCO, Gaborone.

15 Inter-Agency Task Team (IATT) on Education (2008) *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies*. UNESCO, Paris. http://unesdoc.unesco. org/images/0015/001566/156673E.pdf

16 UNESCO (2007) *Education for All: Will we make it?* Global Monitoring Report for 2008, UNESCO, Paris.

17 Kirby, D., Laris, B. and Rolleri, L. (2005) *Impact of Sex and HIV Education Programs on Sexual Behaviours in Developed and Developing Countries*. Family Health International, Arlington, VA.

1. Curriculum-based versus non-curriculum-based
2. Interventions with and without characteristics of effective curriculum-based interventions (see listed characteristics below)
3. Adult-led versus peer-led interventions

There is sufficiently strong evidence of the effectiveness of HIV interventions in educational settings, particularly sexual relationships and HIV education interventions. A review of school-based HIV interventions conducted in 2006 revealed that curriculum-based interventions incorporating key characteristics and led by adults had the strongest evidence of effectiveness and showed positive reports of behaviour change.[18] Specifically, these types of interventions found that school-based sex education and HIV education:

- Reduce sexual risk behaviours
- Increase knowledge
- Increase skills and develop positive attitudes towards changing HIV-risk behaviours[19]

Schools provide opportunities for young people to develop life skills. 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.[20] Recent evaluations have shown that life skills interventions for HIV prevention are most effective when directed specifically to skills related to HIV risk reduction.[21] Evaluations of substance-use prevention programmes in secondary schools found they can produce significant and durable reductions in tobacco, alcohol and marijuana use if they 1) teach a combination of social resistance and general life skills, 2) are properly implemented and 3) include at least two years of booster sessions.[22 23]

National AIDS Responses

Addressing HIV prevention

There are several key elements for an education sector-wide response to have maximum effect. These include a supportive policy environment, educator training and curriculum development. In addition, the recently published Toolkit for Mainstreaming HIV and AIDS in the Education Sector defines a set of principles to ensure that pupils' rights to and needs for education are respected. These include:[24]

- Providing education within ***enabling and protective learning environments*** that are healthy and safe for all children to participate in, with policies and ground rules for class involvement, protection, positive recognition and reinforcement
- Providing an ***education that is child-centred, participatory and skill-building,*** that is gender-responsive, scientifically sound, culturally appropriate and adapted to the age and group of learners, including pupils living with or affected by HIV and those who are especially vulnerable
- Ensuring provision of ***social and health services*** either directly or through linkages to the community
- Providing ***comprehensive and correct information*** to all children, which includes knowledge about ways of preventing HIV infection and dispels major misconceptions about HIV
- Addressing ***psychosocial factors*** that affect behaviour, such as values, attitudes, norms and self-efficacy, or the extent to which a young person is able to control the factors that put him/her at risk of HIV (for example, sexual coercion)
- ***Monitoring effectiveness*** in shorter-term knowledge and life skills acquisition, medium-term behavioural intentions and outcomes, and potential long-term contribution to health goals

Addressing HIV treatment, care and support

Schools play an important role in delivering treatment, care and support to young people living with and affected by HIV. They can identify pupils made vulnerable by HIV, involve them fully in school activities, monitor their well-being and provide a sense of community. Schools can also ensure that young people living with or affected by HIV:[25 26]

18 Kirby, D., Obasi, A. and Laris, B. (2006) "The Effectiveness of Sex Education and HIV Education Interventions in Schools in Developing Countries" in *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries.* Eds. Ross, D. et al., WHO and UNAIDS Inter-agency Task Team on Young People, Geneva.

19 Six studies found that school-based interventions improved skills (self-efficacy to refuse sex and obtain condoms), values about sex and pressuring someone to have sex, attitudes towards condoms and towards people living with HIV, perceptions of peer norms of condoms, and intention to discuss condom use or use a condom.

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

21 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, Arlington, VA.

22 National Institute on Drug Abuse (2003) *Preventing Drug Use among Children and Adolescents: A research-based guide for parents, teachers and community leaders.* Second edition, United States Department of Health and Human Services, Bethesda, Maryland. http://www.drugabuse.gov/pdf/prevention/redbook.pdf

23 Health Canada (2001) *Preventing Substance Use Problems among Young People - A Compendium of Best Practices,* Health Canada, Ontario. http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/prevent/index_e.html

24 Inter-Agency Task Team (IATT) on Education (2008) *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies.* UNESCO, Paris.

25 Boler, T. et al. (2007) *School-centred HIV and AIDS Care and Support in Southern Africa.* Technical Consultation Report, May 22-24, 2007, UNESCO, Gaborone.

26 Inter-Agency Task Team (IATT) on Education (2008) *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies.* UNESCO, Paris.

- Continue to access schooling through the abolition of school fees and indirect education costs
- Have access to alternatives to quality education, including non-formal approaches, flexible instruction hours, and acceleration and catch-up programmes
- Access psychosocial support or are referred to psychosocial support services and counselling
- Learn how to cope with loss and live with HIV, developing communication and negotiation skills and empathy
- Facilitate access to HIV-prevention health services, including voluntary counselling and testing[27]
- Facilitate access to treatment education, including education about antiretroviral therapy (ART), how to access and take medication, and the need to follow treatment regimens
- Facilitate home-based care and education; older students and teachers can support ill community members and provide home-based care
- Respond to basic needs, such as nutrition through school feeding programmes or the creation of vegetable gardens
- Develop livelihood and vocational skills to increase employment opportunities[28]

Challenges

Although there is clear evidence that education can avert HIV through the application of effective school-based interventions — and also mitigate the impact of the pandemic-there are several challenges to be overcome.[29]

First, not all children are in school. A substantial number of children still do not access primary education,[30] especially in countries where there is conflict and displacement.[31 32] Even if children are in school, less than 63 per cent of pupils reached the last grade of primary school in 17 sub-Saharan African countries with data, while under 80 per cent did so in half the countries of South and West Asia.[33] Girls and children with disabilities are less likely to be in school than boys and able-bodied children.

Secondly, not all schools are safe places for young people. Education systems can contribute to gender inequalities in society, which in turn fuel the feminisation of the epidemic. Pregnant students in some countries are expelled from school with little, if any, follow-up support, while the male partner is not excluded from education or employment. Sexual exploitation of pupils by teachers is not uncommon in some countries and can be a very difficult topic to address because of moral, social, cultural and political barriers. Not all staff in key positions are aware of the UN Convention on the Rights of the Child.[34]

Thirdly, sex, drug use and HIV education can be sensitive issues, and opposition to teaching these subjects in school can stem from teachers and school officials who lack adequate training to teach sex and drug use education or lack sufficient understanding of the subjects.[35] Opposition can also come from parents or traditional and religious leaders who want to uphold community values.[36]

The fourth challenge is that the capacity of the education sector to deliver the "social vaccine" is reduced by the impact of AIDS. In many high-prevalence countries, the epidemic is killing teachers, increasing rates of teacher absenteeism, and creating orphans and vulnerable children who are more likely to drop out of school or not attend school at all.[37]

Efforts to overcome challenges

Many of the barriers related to education on sex, drug use and HIV have been overcome in countries[38] through

27 For more information about the role of health services in HIV prevention and treatment 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*.

28 For more about the role of the workplace in HIV prevention interventions for young people see Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Young People in the Workplace*.

29 Clarke, D. and Bundy, D. (2004) EFA FTI: *Responding to the Challenge of HIV and AIDS to the Education Sector*. www.fasttrackinitiative.org

30 The Education for All Development Index (EDI), calculated for 129 countries, shows that 25 are far from achieving EFA. About two-thirds of these are in sub-Saharan Africa, but Bangladesh, India, Nepal, Mauritania, Morocco and Pakistan are also included. Fifty-three countries are in an intermediate position. It is projected that 58 of the 86 countries that have not yet reached universal primary education will not achieve it by 2015. This is attributed to poor quality education, the high cost of schooling and persisting high levels of adult illiteracy. UNESCO (2007) *Education for All: Will we make it?* Global Monitoring Report for 2008. UNESCO, Paris.

31 Martone, G. (2007) *Educating Children in Emergency Settings: An Unexpected Lifeline*. International Rescue Committee, New York.

32 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Young People in Humanitarian Emergencies*.

33 UNESCO (2007) *Education for All: Will we make it?* Global Monitoring Report for 2008, UNESCO, Paris.

34 Inter-Agency Task Team on Education (2008) *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies*. UNESCO, Paris.

35 Smith, G.S., Kippax, S., and Aggleton, P. (2000) HIV and Sexual Health Education in Primary and Secondary Schools: Findings from Selected Asia-Pacific Countries. National Centre in HIV Social Research, University of New South Wales, Sydney.

36 Katz, K. and Finger, W. (2002) *Sexuality and Family Life Education Helps Prepare Young People*. Youth Lens on Reproductive Health and HIV/AIDS, Arlington. http://www.fhi.org/en/Youth/YouthNet/Publications/ YouthLens+English.htm

37 World Bank (2002) *A Window of Hope*. World Bank, Washington, DC.

38 Rosen, J., Murray, N., and Moore, S. (2004) *Sexuality Education in Schools: The International Experience and Implications for Nigeria*. Policy Working Paper Series, No. 12.

strong leadership from national governments and community-based initiatives involving parents, teachers, community and religious leaders and the media.[39 40 41] Lessons learned have shown that the following efforts are needed to introduce culturally acceptable education on sex, relationships and HIV in accordance with the developmental needs of learners:[42]

- Conduct assessments of the students' needs and sexual risk patterns to ensure that learning about sexually transmitted infections and HIV is suited to their specific contexts
- Focus on specific behaviours that lead to or prevent sexually transmitted infections; this will depend on clear, consistent and scientifically accurate discussion of the sexual transmission of HIV
- Actively involve parents and communities to diminish resistance to the introduction of the topics within the school curriculum
- Support teachers through pre-service and in-service training on how to teach such sensitive issues as gender, sex, relationships, substance use, sexually transmitted infections and HIV
- Deliver messages that are sensitive to ethnicity, local culture and traditions, language, age and sex
- Provide a range of options for young people to choose how to reduce their risk to HIV

Partnerships and Multi-Sectoral Approaches

It is clear that the education sector has a central role to play in the multi-sectoral response to HIV and AIDS. At the UN level, the Inter- Agency Task Team (IATT) for Education was established to promote and support good practices and encourage alignment and harmony within and across agencies (UNAIDS cosponsors, bilateral donors and civil society organizations) to support global and country-level actions. Various tools have been developed to assist in the process.[43 44 45]

In 2002, the IATT established a Working Group on Young People and Education, coordinated by the World Bank, with the specific aim of helping countries to "Accelerate the Education Sector Response to HIV/AIDS in Africa."[46] More recently in 2004, EDUCAIDS, a UNAIDS initiative led by UNESCO, was established to assist governments and other key stakeholders in implementing comprehensive, scaled-up education programmes on HIV and AIDS, ensuring that the education sector is fully engaged and contributing to the national response to the epidemic.

Partnerships also need to be strengthened among schools and colleges, young people and the communities they serve.[47] Support from parents, community and religious or traditional leaders, and young people themselves is critical in creating successful school-based HIV-prevention programmes.

Monitoring and Evaluation

Countries are requested to report on core indicators agreed upon by the UN General Assembly Special Session (UNGASS) on HIV/AIDS. Those that specifically relate to interventions in the education sector are as follows:[48]

- Percentage of schools that provided life-skills-based HIV education in the last academic year
- Current school attendance among orphans and non-orphans 10 to 14 years of age
- Percentage of young people age 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Target: 90 per cent by 2005; 95 per cent by 2010)
- Percentage of young women and men age 15 to 24 who have had sexual intercourse before the age of 15

In addition, attention should be paid to monitoring the achievement of the Millennium Development Goal target for education: to ensure that by 2015 children everywhere,

39 ibid
40 Greene, M., Rasekh, Z. and Amen, K. (2002) *Sexual and Reproductive Health Policies for a Youthful World*. Population Assistance International, Washington DC.
41 See also Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on Community-based HIV Interventions for Young People*.
42 UNESCO (2008) EDUCAIDS Resource Pack. Technical brief on HIV/AIDS education in primary schools. UNESCO, Paris.
43 Inter-Agency Task Team on Education (2008) *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies*. UNESCO, Paris.
44 Inter-Agency Task Team on Education (2008) *Improving the Education Sector Response to HIV and AIDS: Lessons of partner efforts in coordination, harmonisation, alignment, information sharing and monitoring in Jamaica, Kenya, Thailand and Zambia*. UNESCO, Paris. http://www.unesco.org/aids/iatt
45 UNESCO (2008) EDUCAIDS *Resource Pack: Towards a Comprehensive Education Sector Response to HIV and AIDS*. UNESCO, Paris. http://www.educaids.org/
46 Key elements of this activity are sub-regional and national workshops that bring together education, health and AIDS teams to share good practices and develop more effective strategies that result in implementation at the school level. The initiative has established networks of focal points from ministries of education. http:// www.schoolsandhealth.org/IV-AIDS&Education-Accelerate/HIVIDS&Education-Accelerate.htm
47 For more about the role of the community in HIV prevention interventions for young people see Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on Community-based HIV Interventions for Young People*.
48 UNGASS (2007) *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators: 2008 reporting*. UNAIDS, Geneva.

boys and girls alike, will be able to complete a full course of primary schooling.

The Fast Track Initiative (FTI) is a partnership between developing countries and donors to support education sector plans and provide the opportunity to review how HIV and AIDS are addressed within the overall education sector plan. Guidelines have been developed with benchmarks and indicators on HIV and AIDS that are useful when reviewing existing education plans.[49] [50]

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- Support mainstreaming of HIV and AIDS in education sector-wide approaches to ensure inclusion of sex, relationships and HIV education in formal curricula and teacher training.
- Advocate for the protection and inclusion of adolescents living with and affected by HIV within the school setting and workplace policies, ensuring access to care and treatment.
- Advocate for the inclusion of HIV and AIDS as part of a wider discussion on sex and relationships education in the main curricula, building on existing curricula rather than out-of-school activities.
- Support initiatives to scale-up access among young people to HIV, sex and relationship education and other prevention measures, paying particular attention to girls, young people with additional vulnerabilities (such as those affected by HIV and AIDS) and humanitarian emergencies.
- Advocate with governments for an assessment of existing HIV prevention and treatment programmes in the education sector to (1) ensure that they respond to the needs of young people and (2) that a system is in place to monitor students' participation in school HIV prevention and treatment interventions (broken down by age, sex and diversity).
- Advocate for programmes to reduce sexual harassment and gender-based violence within the school setting.

49 Education for All (EFA) - Fast Track Initiative Secretariat (2006) *Guidelines for the Appraisal of the Primary Education Component of an Education Sector Plan.* EFA FTI Secretariat, Washington, DC. //http://www.fasttrackinitiative.org/library/Appraisal_guidelines_March_2006.pdf

50 Clarke, D. and Bundy, D. (2006) *The EFA Fast Track Initiative: An Assessment of the Responsiveness of Endorsed Education Sector Plans to HIV and AIDS.* http://www.fasttrackinitiative.org

Key resources:

ActionAid International (2006) *Girl Power: The Impact of Girls' Education on HIV and Sexual Behaviour.* ActionAid, London.
http://www.actionaid.org.uk/doc_lib/girl_power_2006.pdf

Global Campaign for Education (2004) *Learning to Survive: How education for all would save millions of young people from HIV/AIDS.* Global Campaign for Education, Johannesburg.
http://www.campaignforeducation.org

Kirby, D., Laris, B. A. and Rolleri, L. (2005) *Impact of Sex and HIV Education Programmes on Sexual Behaviours of Youth in Developing and Developed Countries.* Youth Research Working Paper, No. 2, Family Health International, Arlington, VA.
http://www.fhi.org/en/Youth/YouthNet/Publications/YouthResearchWorkingPapers.htm

Kirby, D., Obasi, A. and Laris, B. (2006) "The Effectiveness of Sex Education and HIV Education Interventions in Schools in Developing Countries" in *Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries.* Eds. Ross, D. et al., WHO and Inter-Agency Task Team on HIV and Young People, Geneva.
http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf

Inter-Agency Task Team (IATT) on Education (2008) *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies.* UNESCO, Paris.
http://unesdoc.unesco.org/images/0015/001566/156673E.pdf

Inter-Agency Task Team (IATT) on Education (2008) *Improving the Education Sector Response to HIV and AIDS: Lessons of partner efforts in coordination, harmonisation, alignment, information sharing and monitoring in Jamaica, Kenya, Thailand and Zambia.* UNESCO, Paris.
http://www.unesco.org/aids/iatt

UNESCO (2007) *Education for all: Will we make it?* Global Monitoring Report for 2008, UNESCO, Paris.

UNESCO (2008). EDUCAIDS Resource Pack. Technical brief on HIV/AIDS education in primary schools, UNESCO, Paris.

UNESCO EDUCAIDS (2008) *Resource Pack: Towards a Comprehensive Education Sector Response to HIV and AIDS,* Paris.
http://www.educaids.org/

UNODC/Global Youth Network (2004) *School-based education for drug abuse prevention.* United Nations, New York.
http://www.unodc.org/pdf/youthnet/handbook_school_english.pdf

Useful web pages:

Global Campaign for Education
http://www.campaignforeducation.org

UNAIDS Global Initiative for Education and HIV & AIDS
http://www.educaids.org

UNAIDA Inter-Agency Task Team on Education
www.unesco.org/aids/iatt

Further information and responsible agencies under UNAIDS Technical Support Division of Labour on HIV and Young People

UNESCO is the lead agency for the HIV prevention in the education sector. The main partners in this effort are: **ILO, UNFPA, UNHCR, UNICEF, UNODC, the World Bank and the WFP.** http://www.unesco.org

There is as yet insufficient evidence of the effectiveness of some of the interventions outlined in the Briefs and for the use of some of the interventions outlined for certain target populations. Similarly, many of the studies of effectiveness do not disaggregate the research findings by sex. Where there is insufficient evidence, the interventions that are described are based on good practice, and it is recommended that in addition to monitoring coverage and quality, such interventions be evaluated and the results of their effectiveness fed back into the global evidence base.

For more information on the Inter-Agency Task Team on HIV and Young People visit: http://www.unfpa.org/hiv/iatt

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Global Guidance Brief

HIV Interventions in the Health Sector for Young People

Purpose

This Brief has been developed by the Inter-Agency Task Team (IATT) on HIV and Young People[1] to assist United Nations Country Teams (UNCTs) and UN Theme Groups on HIV/AIDS[2] in providing guidance to their staffs, governments, development partners, civil society and other implementing partners on HIV interventions for young people in the health sector.[3] It is part of a series of seven global Guidance Briefs that focus on HIV prevention, treatment, care and support interventions for young people that can be delivered through different settings and for a range of target groups.

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 deal in any depth with "how to" implement the interventions outlined, although 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 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.

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 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.

Introduction

The health sector has a vital role to play in HIV prevention, care and treatment for young men and women, as well as an important contribution to make in achieving the global goals endorsed during UNGASS that relate to young people's access to health services. Key activities include:

- Collecting, analysing and disseminating the data that are needed for advocacy, policy and programme development, monitoring and evaluation
- Synthesising and strengthening the evidence and good practice that are needed to inform the development of policies and programmes
- Increasing young people's access to quality health services for the prevention, care and treatment of HIV and AIDS
- Mobilising and supporting other sectors and partners to strengthen their contribution to achieving the global goals and to play their part in supporting health-sector actions

If young people are to benefit from the contribution that health services can make to HIV prevention, treatment, care and support, these services need to be provided in ways that respond to their specific age and gender needs. This does not mean that young people need a parallel system of services to those provided for adults and children, but it does mean that existing services must be able to respond to the specific needs of young people, that they are "adolescent or youth-friendly."[7]

Adolescent/youth-friendly services are:

- ***Available, accessible and equitable,*** so that the core interventions for HIV are provided in ways that all young people, including those most at risk of HIV,[6] can use them
- ***Acceptable,*** with health and related staff trained to provide services for young people with dignity and respect, also ensuring privacy and confidentiality
- ***Appropriate and effective,*** so that the necessary skills, equipment and supplies are available to provide quality services for HIV prevention, treatment, care and support for young people

Evidence of Effective Health-Sector Interventions

Effectiveness of HIV prevention and treatment interventions for young people

There is a growing body of evidence[8] that demonstrates the effectiveness of interventions delivered through health services for the prevention and treatment of HIV among young people. These include interventions that provide:

- ***Information and counselling*** to help young people develop the knowledge and skills required for them to delay sexual initiation, limit the number of their sexual partners, use condoms correctly and consistently, and avoid substance use or, if injecting drugs, to use sterile equipment
- ***Condoms,*** both male and female, for those young people who are sexually active[9]
- ***Harm reduction***[10] for those young people who inject drugs
- ***Diagnosis and treatment of sexually transmitted infections,*** to decrease HIV infection and identify individuals who require HIV information, condoms and provider-initiated HIV testing and counselling[11] because they have had unprotected sex
- ***Male circumcision,*** particularly in those communities where HIV prevalence is high and male circumcision rates are low;[12] adolescent boys and young men are a key group for male circumcision

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

7 The term adolescent-friendly is used to describe those services that are designed primarily for minors (under the age of 19) whereas youth-friendly services usually cover young people up until age 25 years. For a description of the features of such services see WHO (2003) *Adolescent Friendly Health Services: an Agenda for Change*. WHO, Geneva. http://www.who.int/child-adolescent-health/publications/ADH/WHO_FCH_CAH_02.14.htm

8 WHO, UNFPA, UNODC, UNAIDS, YouthNet (2004) *Protecting Young People from HIV and AIDS: The Role of Health Services.* WHO, Geneva. http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_159247_8.htm WHO, UNFPA, UNAIDS, YouthNet (2003) Achieving the Global Goals: Access to Services, *Technical Report of a Global Consultation on the Health Services Response to the Prevention and Care of HIV/AIDS among Young People.* WHO, Geneva. http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_159132_3.pdf

9 Condoms are also important for the prevention of sexually transmitted infections and pregnancy: they provide *dual protection.*

10 Harm reduction includes interventions that primarily aim to reduce adverse health, social, and economic consequences of drugs, rather than focusing only on reducing consumption of these drugs. Sterile injecting equipment and substitution therapy have proved effective amongst adult injecting drug users. Evidence of the effectiveness of harm reduction interventions to prevent HIV in young people can be found in Howard, J., Hunt, N. and Arcuri, A. (2003) *A situation assessment and review of the evidence for interventions for the prevention of HIV/AIDS among occasional, experimental and occasional young injecting drug users.* Background paper prepared for UN Inter-Agency Group and Central Eastern Europe Harm Reduction Network (CEEHRN) Technical Consultation on Occasional, experimental and occasional young injecting drug users in CEE/CIS and the Baltic States, UNICEF, Geneva. See also Hoffman O., Boler T. and Dick B. (2006) "Achieving the global goals on HIV among young people most at risk in developing countries: young sex workers, injecting drug users and men who have sex with men," in *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries*, eds. Ross, D.A., Dick, B. and Ferguson J., WHO, Geneva.

11 http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf

12 There is now compelling evidence that male circumcision is protective against HIV transmission from women to men, and that male circumcision is an important intervention to consider, particularly in countries where there is high HIV prevalence and low circumcision prevalence. However, male circumcision does not provide complete protection against HIV and needs to be part of a comprehensive prevention package, including condoms. There is as yet no evidence that male circumcision prevents HIV transmission for HIV-infected men to their sexual partners, and there is no evidence that it is protective for men who have sex with men. See http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf. Male circumcision among adolescent boys should provide an important entry point for adolescent sexual and reproductive health: see the report from the ESA CMMB/WHO FBO consultation (in press)

- ***HIV testing and counselling,***[13] an important opportunity for reinforcing prevention among young people who are HIV negative and for facilitating prevention, treatment, care and support services for those young people who are found to be living with HIV
- ***Treatment,***[14] ***care and support services*** for young people living with HIV[15 16 17]

Effectiveness of interventions to increase young people's access to health services

From a systematic review of HIV prevention interventions among young people in developing countries,[18] there is strong evidence that it is possible to increase young people's use of health services — provided that:

- Health workers and other clinic staff are adequately trained to work with young people
- Changes are made in the health facilities so that young people will want to use them (they are "adolescent/youth-friendly")
- Information about the services is provided in the community to generate demand and community support

Adolescent/Youth-Friendly Health Services

A number of factors need to be taken into account in the provision of HIV prevention, treatment, care and support services for young people. These have implications both for what is done and how it is done.

General considerations

- ***Target populations.*** Different groups of young people have specific needs; for example, the needs of adolescent boys and girls differ, and the needs of young adolescents 10 to 14 years of age are different from those of young people in their early 20s. Needs vary between married and unmarried young people, between those from rural and urban areas, between adolescents who do or do not live with their parents, and between young people who are or are not already engaging in HIV-risk behaviours. It is therefore important that services are sensitive to the needs of these different groups and that they are accessible not only to the general population of young people but also to those who are most at risk of HIV.[19]
- ***Service providers.*** Many different service providers[20] need to be involved in responding effectively to the specific needs of young people in a respectful manner. These include government health workers (at different levels), NGO staff members, private practitioners,[21] pharmacists[22] and, in some settings, traditional providers. Young people themselves can play an important role in the provision of services, for example, by providing information and support to other young people attending health facilities.
- ***Package of services.*** Evidence-informed interventions should, as far as possible, be provided as part of a comprehensive package so that young people can easily access information, commodities and services. In addition, consideration should be given to a broader set of interventions that focus on young people's general health and development, including, for example, preventing substance use and improving nutrition and mental health. HIV provides an important entry point for focusing on adolescents' sexual and reproductive health (ASRH), and every effort should be made to link HIV and ASRH interventions in the health sector.
- ***Settings for services.*** In addition to a range of public and private health facilities, services and commodities may also be provided through other settings, including pharmacies, schools and universities, and the workplace.[23] Young people who engage in HIV-risk behaviours (such as those who have unprotected sex with multiple partners, those who inject drugs or are involved in sex work, or young men who have unprotected sex with other males) require services provided

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13 WHO (2007) Guidance for Provider Initiated Testing and Counselling. WHO, Geneva.
14 Including the prevention of mother-to-child transmission of HIV in young pregnant women.
15 WHO/UNICEF (2008) *More Positive Living - strengthening the health sector response to young people living with HIV.* WHO, Geneva.
16 WHO (2006) *Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults: Recommendations for a public health approach.* WHO, Geneva.
17 WHO (2006) *Antiretroviral therapy for HIV infection in adults and adolescents: Towards universal access; Recommendations for a public health approach.* WHO, Geneva.
18 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, WHO, Geneva. http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_ 120938_0.htm
19 Homans (2008) *Regional Guidance Manual on Programming to Prevent HIV in Most-at-risk Adolescents*, UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva.
20 In many situations, particularly resource-constrained settings, it is not possible (or even desirable) to have service providers working specifically with adolescents and youth. To this end, training materials have been developed to orient service providers to work more effectively with/for young people (see ref 31), and additional materials are currently under development to assist health care providers respond to the specific needs of young people living with HIV (WHO Optional Adolescent Module for national IMAI/ART training programmes) and most-at-risk adolescents.
21 In many countries young people who can afford to, use the services provided by private clinics and doctors as they feel they will receive more confidential and better quality service. This is not necessarily the case, depending on the training the health care provider has received in relation to HIV interventions and working with the different needs of young males and females.
22 Pharmacists in many countries have been trained to provide health information, counselling and condoms to young people, and sterile injection equipment to injecting drug users.
23 There are many places with examples of good practice in school and university-based clinics. However, in some countries the staff of such institutions have not been properly trained to work with young people and students fear that confidentiality will not be respected.

through both static facilities and outreach if they are to have access to the information, commodities and services that they need.[24]

Health system

- ***Develop supportive and enabling policies and legislation.*** Policies and legislation can be barriers to the provision and use of health services by young people. Policies, for example, may restrict the provision of services and commodities to young people (particularly unmarried adolescents) or limit young people's use of services, such as those relating to informed consent and confidentiality for minors.[25 26]
- ***Develop appropriate and effective strategies.*** While there is no one-size-fits-all approach to the provision of health services for young people, there are some guiding principles to consider. These include: linking prevention and care, linking HIV with other sexual and reproductive health problems and interventions, and integrating a focus on young people into existing services by making services more responsive to their specific needs. Depending on the health infrastructure and the epidemiological characteristics of the epidemic, different strategies for delivering health services to young people will be required, with particular attention on strategies that reach adolescents and young people most at risk. Adequate referral systems are needed both within the health sector (from clinics to hospitals, from general practitioners to specialised services), and between the health sector and other sectors[27] and organizations. Young people's specific needs should receive adequate attention in national HIV/AIDS and reproductive health strategies.
- ***Develop, implement and monitor standards for adolescent/youth-friendly health services.*** Standards can provide clear vision and guidance for the provision of HIV-related services that respond to the specific needs of young people, including ethical issues such as medical interventions for minors. They also form the basis for a quality assurance approach to monitoring the services that are provided.[28 29]

Health facilities

- ***Train service providers.*** The standardised training of service providers is important for a number of reasons, not least because it facilitates the involvement of a range of partners. This can be done by incorporating HIV into existing training programmes for health workers,[30] by including a focus on HIV in ongoing adolescent health and development training programmes that aim to increase health workers' orientation and skills[31] or by including modules on the specific problems of adolescents in ongoing in-service training programmes on HIV for health workers.[32 33a 33b]
- ***Make changes in the facilities.*** Consideration needs to be given to the many factors that may influence young people's willingness to use facilities, ensuring, for example, that they are open when young people are able to use them, that they are affordable (including the possible use of voucher schemes) and that privacy and confidentiality are respected when young people consult health care providers.[34]
- ***Consider other ways of providing services and commodities.*** In addition to static government, private or non-governmental health facilities, other channels for providing young people with the services and commodities they require include pharmacies, hotlines, community-based distribution of commodities and social marketing.

Family and community component

- ***Create demand.*** In addition to improving the quality and provision of HIV-related health services for young people, it is also important to generate demand. Young people need to be informed about the availability of services through a range of channels, including youth groups, the media and schools. This should include details about the availability of the services (when and where), information about why young people should use the services and information to encourage young people to make use of the services that are available.
- ***Generate community support.*** Adolescents' use of health services remains a sensitive issue in many

24 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on Most-at-risk Young People.*
25 See for example the UN (1989) *Convention on the Rights of the Child*. United Nations, New York.
26 WHO South East Asia Regional Office, SEARO (2006), *Consent and Confidentiality: Increasing Adolescents' Access to Health Services for HIV and Sexual and Reproductive Health*, Report of a regional consultation, WHO SEARO, Delhi.
27 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Briefs on the Education Sector and Workplace Settings*.
28 WHO (2008) *Adolescent-Friendly Health Services: Making them happen - Part 1* (Developing national standards). (In press).
29 See *Adolescent and Youth-Friendly Health Service Standards from India, Serbia, Tanzania, United Kingdom and Vietnam*.
30 Pan American Health Organization, PAHO (2005) *Youth-centred Counselling: a Guide for Front-line Providers*. PAHO, Washington, DC.
31 WHO (2007) *Orientation Programme on Adolescent Health for Health Care Providers* see modules on HIV/AIDS and Injecting Drug Use. WHO, Geneva.
32 WHO (2008) *Optional Adolescent Module for national IMAI/ART training programmes*. WHO, Geneva; and training modules on Most-at-risk Adolescents being developed in Vietnam and Ukraine.
33a WHO (2007) *Guidance for Provider-Initiated Testing and Counselling*. WHO, Geneva, and 33b WHO (2006) *Antiretroviral therapy for HIV infection in adults and adolescents: Towards universal access recommendations for a public health approach*. WHO, Geneva.
34 WHO (2008) *Quality Assessment Guidebook. A guide to assessing health services for adolescent clients*. (In press)

communities, particularly in relation to sexual and reproductive health. It is therefore important to contact, inform and involve a range of gate-keepers, from parents and teachers to religious and other community leaders. It may be necessary to find some respected "champions" in the community to support the provision and use of health services for young people.[35]

Treatment, Care, Support and Prevention for Young People Living with HIV

Young people living with HIV (YPLHIV) have specific needs and require special attention. They are also likely to be an increasing group in many countries. More and more children have access to treatment and are surviving into their second decade. At the same time young people will continue to become infected during adolescence. Increasingly, they will know their HIV status as HIV testing becomes more accessible. Strengthening interventions for YPLHIV will help reduce further transmission of HIV, respond to their immediate problems and prepare them to live with a chronic disease.

The involvement of young people living with HIV in programme development and implementation will improve the relevance, acceptability and effectiveness of the programmes that are developed.[36] In several countries, support groups for young people living with HIV have been developed by young people themselves, and YPLHIV are also represented in regional and global networks.[37 38]

Strengthening the health-sector response to the needs of young people living with HIV is a challenge in many countries. Issues that require further development include:

- Standards for the provision of health services for young people living with HIV
- Minimum treatment/care packages
- Psychosocial support, particularly important for disclosure, adherence, responding to stigma/discrimination, coping with isolation and loss, and preventing high-risk behaviours
- Orientation and training of health staff to provide appropriate information and services to YPLHIV
- Training and support for young people living with HIV to strengthen their capacity to contribute to health-sector activities[39]
- Linking with other sectors to strengthen the health-sector response

Young People Most-at-Risk of HIV

The majority of most-at-risk young people do not receive the health services they require, and the core actions that need to be in place are outlined in the *Global Guidance Brief on HIV Interventions for Most-at-risk Young People.*

Ministries of Health should play an overall stewardship and advocacy role, including highlighting the ways in which young injecting drug users, young sex workers and young men who have sex with men are different from adult population groups most at risk of HIV. In addition they should:

- Support the collection and dissemination of strategic information about most-at-risk young people, including promoting the disaggregation of all data by age and sex
- Ensure that there is a supportive policy environment, including links with other sectors, such as criminal justice
- Provide overall guidance and support, standards and training materials for other partners, such as non-governmental organizations, who are in contact with most-at-risk young people, to strengthen their capacity to respond to the needs of young people most at risk of HIV

Partnerships and Multi-Sectoral Approaches

It is important that the health sector interacts with other sectors and partners for two reasons. First, the health sector needs to work with other sectors-for example the education sector and the media-to ensure that they are providing information to young people and community members about the availability of services and when and why young people should use them.[40] Secondly, the health sector needs to collaborate with and support the national responses to HIV that are being implemented by other sectors, providing updated information about the current status of the HIV epidemic and priorities for HIV prevention, treatment and care (including counteracting myths and misconceptions). It also needs to help ensure that information provided through other sectors is technically sound and consistent with other messages that young people are receiving about the prevention of HIV. Furthermore, it should help ensure that the strategies being implemented are evidence-informed. It is also important to work through and build on existing efforts to strengthen collaboration between sectors, such as the Health Promoting Schools and the FRESH initiative.[41]

35 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on Community-based HIV interventions for Young People.*
36 UNAIDS (2007) *Policy Brief on the Greater Involvement of People Living with HIV (GIPA).* UNAIDS, Geneva.
37 Living Positively http://www.youthaidscoalition.org/living.html
38 See work being undertaken by the Global Youth Coalition on AIDS (GYCA).
39 A young people living with and affected by HIV support group has been established in the Republic of Moldova and other countries.
40 Reference has already been made to the important role played by the community.
41 http://www.freshschools.org/

Monitoring and Evaluation

Collecting, analysing and disseminating data on the prevalence and impact of HIV among young people are crucial, not only for the development of policies and programmes, but also for advocacy and for monitoring and evaluating the progress and effectiveness of existing interventions.[42 43 44] One of the global goals endorsed during the 2001 UN General Assembly Special Session (UNGASS) on HIV/AIDS was to ensure, that by 2010, 95 per cent of young people have access to the services they need to decrease their vulnerability to HIV.

Indicators have been promoted by UNAIDS[45] (for HIV programmes in general) and by WHO[46] (focusing on the health-sector response), and these include a focus on young people, either specifically or through disaggregation of data that are being collected for all age groups. These indicators should form the basis for developing and reporting on health-sector interventions directed to young people. Every effort should be made to:

- Have a clear structure for thinking about indicators, in order to differentiate between health outcomes, underlying behaviours, risk and protective factors that affect behaviours and interventions designed to influence these determinants[47]
- Monitor the global goals/targets that relate to young people's access to health services[48] and monitor programmes at district level[49]
- Disaggregate by sex and by age all data that are collected, using 10-14, 15-19, 20-24 age groups, including data that are collected relating to most-at-risk populations; give adequate attention to the marital status of adolescents and youth
- Ensure that adequate attention is given to 10 to 14 year olds[50] when data collection systems are developed and reviewed, since this age group is frequently omitted because of the sensitivities surrounding the collection of data from minors (they are not included in most Demographic Health Surveys)
- Be aware of the differences between young people and adults that may have implications for the data collected, for example concepts of "multiple partners" and "dual protection"

Supporting the adequate evaluation of health-sector interventions is very important, both to demonstrate that interventions that have been successful elsewhere are effective in a different context, and also to contribute more generally to the evidence base for effective interventions to achieving universal access for young people.

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- Advocate with government for a review of existing HIV prevention, treatment and care programmes in the health sector to assess how effectively they respond to the specific needs of young people and whether they promote linkages and convergence with other sexual and reproductive health interventions for young people.
- Advocate with governments for a review of existing policies and legislation to identify any barriers to young people's access to the health services they need for prevention and treatment/care and for any changes that would help to create an enabling and supportive environment for the provision and use of services by young people.
- Ensure that there is a common understanding among the cosponsors about the health-sector contribution to HIV prevention, treatment and care for young people (strategic information, supportive policies, services and commodities, and strengthening other sectors).
- Ensure that there is clarity about priorities for action and about the roles of the different cosponsors in supporting the government and other health-sector partners in achieving universal access for young people, including most-at-risk adolescents and young people living with HIV, to health services for prevention, treatment and care.

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42 For an overview of national level indicators see WHO (2007) *Access to Health Services for Young People for Preventing HIV and Improving Sexual and Reproductive Health.* WHO, Geneva.
43 WHO (2006) *Tool for Assessing Coverage of Health Services for HIV Prevention in Young People*, Report of a global consultation, WHO, Geneva.
44 For further information refer to WHO et al (2004) *National AIDS programmes: A guide to indicators for monitoring and evaluating HIV/AIDS prevention programmes for young people.* WHO, Geneva. http://www. who.int/child-adolescent-health/publications/ADH/ISBN_92_4_159257_5.htm
45 UNAIDS (2007) *United Nations General Assembly Special Session on HIV/AIDS: Monitoring the Declaration of Commitment on HIV/AIDS - Guidelines on construction of core indicators 2008 Reporting,* UNAIDS, Geneva. UNAIDS/07.12E/JC1318E.
46 For further information refer to WHO (2007) *Framework for Global Monitoring and Reporting on the Health Sector's Response Towards Universal Access to HIV/AIDS Treatment, Prevention, Care and Support 2007-2010,* WHO, Geneva
47 See the structure used in the reference above.
48 See WHO (2007) *Access to Health Services for Young People for Preventing HIV and Improving Sexual and Reproductive Health. WHO, Geneva.*
49 *WHO Adolescent-Friendly Health Services: Making them happen - Part 2 (Supporting the implementation and monitoring of national quality standards).* (In development)
50 See WHO (2004) *National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people.* WHO, Geneva, pp 14-15.

Key resources:

WHO (2003) Adolescent Friendly Health Services: an Agenda for Change. *WHO, Geneva. http://www.who.int/child-adolescent-health/publications/ADH/WHO_FCH_CAH_02.14. htm*

WHO, UNFPA, UNAIDS, YouthNet (2003) *Achieving the Global Goals: Access to Services, Technical Report of a Global Consultation on the Health Services Response to the Prevention and Care of HIV/AIDS among Young People.* WHO, Geneva. *http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_159132_3.pdf*

WHO, UNFPA, UNODC, UNAIDS, YouthNet (2004) *Protecting Young People from HIV and AIDS: The Role of Health Services*. WHO, Geneva.

WHO et al (2004) *National AIDS programmes: A guide to indicators for monitoring and evaluating HIV/AIDS prevention programmes for young people.* WHO, Geneva.

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, WHO, Geneva. *http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_120938_0.htm*

WHO/UNICEF (2008) More Positive Living - strengthening the health sector response to young people living with HIV. WHO, Geneva.

WHO (2005 and 2007) Orientation Programme on Adolescent Health for Health Care Providers. WHO, Geneva.

WHO (2007) Access to Health Services for Young People for Preventing HIV and Improving Sexual and Reproductive Health. WHO, Geneva.

Useful web pages:

United Nations Population Fund
http://www.unfpa.org/hiv/people.htm

Preventing Mother-to-Child Transmission of HIV (UNICEF)
http://www.unicef.org/aids/index_preventionyoung.html

Child and Adolescent Health and Development (WHO)
http://www.who.int/child-adolescent-health/publications/publist.htm

Living Positively
http://www.youthaidscoalition.org/living.html

Further information and responsible agencies under UNAIDS Technical Support Division of Labour on HIV and Young People

The World Health Organization is the lead agency for Health Sector HIV/AIDS interventions. The main partners in this effort are: **ILO, UNDP, UNFPA, UNHCR, UNICEF, UNODC,** and **the World Bank.**
http://www.who.int

There is as yet insufficient evidence of the effectiveness of some of the interventions outlined in the Briefs and for the use of some of the interventions outlined for certain target populations. Similarly, many of the studies of effectiveness do not disaggregate the research findings by sex. Where there is insufficient evidence, the interventions that are described are based on good practice, and it is recommended that in addition to monitoring coverage and quality, such interventions be evaluated and the results of their effectiveness fed back into the global evidence base.

For more information on the Inter-Agency Task Team on HIV and Young People visit: http://www.unfpa.org/hiv/iatt

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Global Guidance Brief

HIV Interventions for Young People in Humanitarian Emergencies

Purpose

This Brief 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, development partners, civil society and other implementing partners on effective HIV interventions for young people[3] in humanitarian emergencies. It is part of a series of seven global Guidance Briefs that focus on HIV prevention, treatment, care and support interventions for young people that can be delivered through different settings for a range of target groups.

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 hyper endemic settings, interventions to prevent HIV also need to be directed to the general population of young people.[5]

The Briefs do not deal in any depth with "how to" implement the interventions outlined, although 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.

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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 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.

Introduction

Humanitarian emergencies can be the result of: 1) natural disasters such as earthquakes, floods (quick onset) or droughts (slow onset), and 2) external and internal conflict, also known as complex emergencies. As a consequence of humanitarian emergencies, populations are differentially affected. Some may be internally displaced within national borders; others may remain in their homes but lack access to essential services; and still others may become refugees or asylum seekers by fleeing across borders.

Globally, at the end of 2006 there were estimated to be 14.3 million refugees and 24.5 million internally displaced persons (IDPs).[6] About one quarter were young people, and 80 per cent of conflict-displaced persons are women and children. Many of them reside in countries heavily affected by HIV, and about four million live in sub-Saharan Africa.[7] Internal and external displacement may be long-term (up to 17 years).[8] Those who flee their country are no longer guaranteed protection by their country of origin and may not receive adequate assistance from host countries.

The factors that affect HIV transmission are complex, vary by context and depend upon many dynamic factors; for example, HIV prevalence rates in the area of origin and that of the host population, the level of interaction between the displaced and the surrounding population, the length of time of conflict and in camp settings and the location of camps.[9] The relative importance of each of these factors and the response required varies depending on the phase of the emergency:

- Emergency preparedness
- Emergency phase
- Post-emergency phase involving stabilised situation, transition and recovery programmes[10]

Failure to address the HIV-related needs of emergency-affected young women and men not only denies them their rights, but can undermine the effectiveness of HIV prevention and care efforts for surrounding communities.[11 12]

Emergency-affected young people and HIV

HIV is adversely affecting young people worldwide, and UNAIDS estimates that about 40 per cent, of all new infections are in youth 15 to 24 years of age.[13] The characteristics that define humanitarian emergencies—such as conflict, social instability, poverty and powerlessness—can also facilitate the transmission of HIV and other sexually transmitted infections (STIs).[14] In addition, power imbalances that make girls and women disproportionately vulnerable to HIV infection become even more pronounced during conflict and displacement. [15] Specific factors that can increase young people's vulnerability to HIV in such situations include:

- Lack of protection and separation from or loss of family members
- Breakdown of community cohesion [16] and social and sexual norms regulating behaviour
- Sexual and gender-based violence, including rape and sexual exploitation primarily directed to females [17 18 19] but also affecting boys
- Disruption in education leading to boredom, loss of friends and a supportive school environment as well as reduced access to HIV-prevention information [20 21]

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6 UNHCR (2007) *2006 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons.* UNHCR, Geneva.
7 Seven of the 15 countries with the largest number of people living with HIV were also affected by major conflict between 2002 and 2006.
8 UNHCR (2004) *Protracted Refugee Situations.* Standing Committee 30th meeting, UNHCR, Geneva. EC/54/ SC/CRP.14
9 Spiegel, P. (2004) "HIV/AIDS among conflict-affected and displaced populations: Dispelling myths and taking action," *Disasters*, 28 (3): 322-339.
10 UNHCR also refers to a final phase when durable solutions are secured and refugees return home, are resettled in a third country, or are permanently integrated within their host country. UNAIDS and UNHCR (2007) *Policy Brief: HIV and Refugees,* UNAIDS, Geneva. http://data.unaids.org/pub/BriefingNote/2007/policy_brief_ refugees.pdf
11 ibid
12 HIV was not considered a priority area in emergency settings until the adoption of United Nations Security Council Resolution 1308 in 2000 which called for uniformed personnel to be trained in HIV prevention, and for Member States to create policies and programmes for HIV prevention and treatment of AIDS-related conditions. United Nations Security Council (2000) Resolution 1308 On HIV/AIDS, New York.
13 UNAIDS (2007) *AIDS Epidemic Update: Briefing Booklet.* UNAIDS, Geneva. Out of an estimated 6,800 new infections a day, 34.1% are in youth 15 to 24 years of age and 17.7% in children under 15 years.
14 United Nations Disarmament, Demobilisation and Re-integration Resource Centre (2006). *HIV/AIDS and Disarmament, Demobilisation and Re-integration.* UNDDRRC, New York. http://www.unddr.org/iddrs/05/60. php
15 Inter-Agency Task Team on Gender and HIV/AIDS (2001) *HIV/AIDS, Gender and Conflict Situations.* UNAIDS, Geneva. http://www.unaids.org/fact_sheets/files/GenderFS_ en.pdf
16 More information on the importance of community support can be found in the Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global *Guidance Brief on Community-based HIV Interventions for Young People.*
17 United Nations Disarmament, Demobilisation and Re-integration Resource Centre (2006) states that rape and sexual abuse have often been used as tools of war in Haiti, Liberia and Sudan.
18 UNAIDS, UNHCR and WFP (2006). *The Development of Programme Strategies for Integration of HIV, Food and Nutrition Activities in Refugees Settings.* UNAIDS, Geneva.
19 Inter-Agency Standing Committee (2005) *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies.* IASC, Geneva.
20 Keeping children in school helps protect them against HIV as they are more likely to delay the age of first sex and learn skills to protect themselves from HIV. They are also less likely to join the military and armed groups where sexual abuse can be common. Inter-Agency Standing Committee (2003) *Guidelines for HIV/AIDS interventions in emergency settings,* and UNESCO (2004) *Global Initiative on HIV/AIDS and Education*, UNESCO, Paris.
21 The importance of education and educational interventions is discussed in the Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Young People in the Education Sector.*

- Disruption of health services, including sexual and reproductive health services [22] and access to HIV prevention (including condoms) and treatment services
- Lack of access to basic information about HIV, sexual and reproductive health
- Poverty as a consequence of the loss of livelihoods and lack of employment opportunities,[23] which contributes to involvement in sex work in order to survive, especially among young women
- Exposure to mass trauma, such as conflict, which can increase alcohol and other substance use and, in general, influence young people's attitudes towards risk[24]
- Recruitment as combatants or forced labour. Conflict may mobilise young men and women to become soldiers, and child soldiers can be as young as nine. They are particularly vulnerable to HIV infection, either as a result of sexual violence by older officers, or through peer pressure that promotes risk-taking sexual behaviours. Girl soldiers are often forced to have sex with commanders and other fighters, which renders them vulnerable to HIV and sexually transmitted infections.[25]

The main challenge is that young people do not have the social skills needed to cope with conflict and violence, displacement and uncertainty about the future. They may be separated from their parents and have no access to education, health services and community and social support structures. Thus young people may be more likely to engage in HIV risk behaviours[26] [27] or be coerced into sex work, although the evidence is not routinely available.[28]

Additionally, staff working in humanitarian settings may not have been trained to respond in a gender-sensitive and youth-friendly manner to the HIV-related and psychosocial support needs of young people.

HIV-prevention interventions for young people that have proved effective in developing countries have not been systematically evaluated within the context of emergency situations,[29] and interventions may need to be delivered in a different manner depending on gender dynamics, the stage of the epidemic and phase of emergency.[30] However, there have been some lessons learned from applying these interventions with refugee adolescents and youth.

Lessons learned

Education and life-skills training for refugee youth can promote confidence, health and psychosocial well-being.[31] When peer educators are trained from within the refugee community, they are more likely to provide age, gender and culturally appropriate information to their peers.[32] This is more likely to result in behaviour change.

National AIDS Responses

National AIDS responses should ensure that: the human rights of emergency-affected populations of all ages are protected before, during and after an emergency, especially in countries with high HIV prevalence; the needs of emergency-affected populations are integrated with country policies[33] and programmes that focus on gender and young people; and sub-regional approaches are adopted to ensure continuity in HIV services across national borders.[34] These actions can be best achieved through mechanisms that combine humanitarian and development funding to meet immediate HIV-related needs in combination with development funds for longer-term HIV-related programmes.[35]

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22 The role of the health sector interventions in HIV prevention and treatment is discussed in the Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Young People in the Health Sector.*

23 Some of the consequences are described in the Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Briefs on HIV Interventions for Young People at the Workplace and Most-At-risk Young People.*

24 UNAIDS and UNHCR (2007) Policy Brief: HIV and Refugees, and UNESCO/UNHCR (2007) *Educational responses to HIV and AIDS for refugees and internally displaced persons.* UNESCO, Paris.

25 http://www.aidsandemergencies.org/overview2.html

26 The HIV risk behaviours are: injecting drugs using non-sterile injecting equipment; unprotected anal, oral or vaginal sex; unprotected sex with multiple sexual partners as sex workers or clients of sex workers. See the Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Most at-risk Young People.*

27 Their risk of becoming infected with HIV will largely depended on the HIV prevalence level, the degree of interaction between them and most-at-risk populations (such as injecting drug users and sex workers), and the presence of context specific risk factors such as systematic rape by military and survival sex.

28 In many countries, age, gender and diversity/displacement disaggregated data on HIV risk behaviour and prevalence are not available. This makes evidence-informed planning difficult as the true extent of the problem is not known.

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

30 For a range of effective HIV prevention interventions for young people in different settings see the other Inter- Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Briefs on HIV and Young People.*

31 UNHCR (2001) HIV/AIDS Education for Refugee Youth: The Window of Hope. UNHCR, Geneva.

32 UNHCR (2003) *Right to Play Information Kit.* World Refugee Day 2003, UNHCR, Geneva.

33 In 2007, UNHCR reviewed National HIV/AIDS Strategic Plans in 58 countries and found that 45% did not include refugees and 67% did not mention IDPs at all. UNHCR (2007) Annual 2006 Protection Reports, UNHCR, Geneva.

34 Emergencies may affect more than one country and refugees/IDPs are often mobile. It is vital to prevent HIV transmission and ensure continuity in treatment, care and support services across national borders, see UNAIDS and UNHCR (2007) *Policy Brief: HIV and Refugees.* UNAIDS, Geneva.

35 Such an approach is consistent with the Three Ones and Global Task Team recommendations to harmonise international AIDS funding.

The HIV interventions that need to be in place for emergency-affected young people include: creation of a safe and supportive environment (human rights, protection issues, vulnerability reduction); behaviour change communication; access to education in schools; and access to an essential package of HIV interventions within the health sector.

HIV interventions for young people in emergency settings

A comprehensive approach to HIV prevention must address not only HIV risk behaviour in young people, but also the deep-seated causes of vulnerability that reduce their ability to protect themselves and others against infection. This calls for interventions to address gender inequalities and the prompt normalisation of an emergency situation so young people are able to return to school and be reintegrated with their family and community.

The Inter-Agency Standing Committee (IASC) has identified principles that should guide HIV interventions in emergencies. These include: the need to build on existing national programmes; multi-sectoral responses; establishment of coordination and leadership mechanisms; involvement of the target population in planning programmes (based on cultural sensitivities) and allocating resources; and HIV-related activities for displaced populations that also serve the host population to the maximum extent possible. The IASC Guidelines specify the HIV interventions that should be in place in different sectors by phase of emergency. Specific interventions for young people are identified below.[36] [37]

Creation of a safe and supportive environment — human rights, protection and vulnerability reduction

A human rights approach is central to HIV and AIDS and the protection of young people affected by emergencies. The response should include: non-discrimination of people living with HIV; access to HIV (and related sexual and reproductive health) information, prevention and treatment services that respect confidentiality and privacy; and protection from unlawful restrictions on freedom of movement. There should be freedom from mandatory HIV testing, and quality voluntary (including pre- and post-test) counselling and testing should be provided.[38]

Specific protection measures should be in place for young people affected by emergencies, including unaccompanied minors, orphans and other vulnerable children.[39] Unaccompanied children require special attention to ensure that their best interests are protected and that they are not subjected to unnecessary procedures, such as mandatory HIV testing before being placed in residential care. States have been called on to take special measures to promote and protect the rights and meet the special needs of girls and boys affected by armed conflict and to put an end to all forms of violence and exploitation, including such gender-based violence as rape.[40]

Protection[41]

Emergency preparedness:

- Review existing protection laws and policies relating to young people and pay attention to access to services for minors.
- Analyse the legal and social situation of orphans and vulnerable children/young people.
- Train law enforcement personnel on HIV and sexually transmitted infections (STIs), gender and discrimination, and the specific needs of young people.[42]

Minimum response:

- Protect unaccompanied and separated children.[43]
- Protect people living with HIV, most-at-risk groups and the population at large (including young people) against HIV-related human rights violations.
- Establish a mechanism to protect against gender-based violence.

Comprehensive response:

- Re-establish community support networks and structures for orphans and vulnerable children.
- Strengthen protection for orphans, separated children and young people.
- Ensure release of children used by armed forces/ groups and provide HIV services.
- Train and support relevant key stakeholders, such as community leaders, women's groups, youth associa-

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36 Inter-Agency Standing Committee (2003) *Guidelines for HIV/AIDS Interventions in Emergency Settings*. IASC, Geneva and revised draft Guidelines (2008).
37 Interventions associated with coordination, assessment and monitoring, water and sanitation, shelter and site planning and the workplace are not included, although they should all be reviewed from the perspective of emergency-affected young people.
38 UNHCR (2006) *Note on HIV/AIDS and the Protection of Refugees, Internally Displaced Persons and Other Persons of Concerns*. UNHCR, Geneva.
39 UNAIDS (2006) *Intensifying HIV Prevention*. UNAIDS, Geneva, page 17.
40 United Nations Security Council (2000) Resolution 1325 *On Women, Peace and Security*. UNSC, New York.
41 The following section draws upon the draft revised IASC Guidelines as of April 2008. The Guidelines are due to be finalised by the end of 2008 and should be referred to once they are available.
42 The WHO has developed a set of modules for training health workers in adolescent health and development, including HIV and STIs WHO (2005 and 2007) *Orientation Programme on Adolescent Health for Health Care Providers*. WHO, Geneva. http://www.who.int/child-adolescent-health/publications/publist.htm
43 Consistent with the principles of the UN (1989) *Convention on the Rights of the Child*. United Nations, New York.

tions and networks of people living with HIV (PLHIV) to raise awareness on HIV and human rights.

Behaviour change communication

Emergency preparedness:

- Prepare, adapt and print culturally, age- and gender-appropriate messages in local languages.
- Prepare a behaviour change communication strategy for most-at-risk young people and youth in general, paying attention to the specific needs of minors.

Minimum response:

- Provide information on HIV prevention and care, involving young people as peer educators and outreach workers.

Comprehensive response:

- Scale-up behaviour change communication with young people.
- Monitor and evaluate activities.

Education[44]

Education provides young people with structure, stability and hope for the future during a time of crisis. It also helps to heal the pain of bad experiences, build skills, and support conflict resolution and peace building.[45]

Emergency preparedness:

- Determine emergency education options for boys and girls.
- Train teachers on facilitating interactive discussions on HIV/ STIs, drug use and sexual violence and exploitation.

Minimum response:

- Provide quality formal and non-formal education for all children, with education options for those who are out of school.
- Provide educational opportunities and environments that are protective of all young people, including safe, nondiscriminatory and enabling learning environments.
- Deliver essential services for young people with additional needs, in particular, those affected by HIV and AIDS.
- Mainstream HIV-related issues in national education policies and community programming.
- Include comprehensive HIV content and life-skills building in education, mainstreaming them into the formal curriculum.

Comprehensive response:

- Mainstream HIV and AIDS into education sector-wide approaches and include HIV-specific life-skills education in formal curricula and teacher training.
- Protect young people vulnerable to and infected with or affected by HIV and AIDS.
- Develop workplace policies on access to treatment, care and support for students and staff.

Health[46]

Emergency preparedness:

- Map current health services, including voluntary counselling and testing (VCT), referral services for the prevention of mother-to- child transmission (PMTCT) of HIV, opportunistic infection treatment, antiretroviral therapy and gender-based violence management, bearing the needs of young people in mind.[47]
- Adapt and/or develop protocols and train staff for potential emergency settings and the specific needs of young people.[48]
- Conduct situation assessments of most-at-risk groups, including their locations, population size estimations, age, gender, risk behaviours and coping mechanisms.

Minimum response:

- Establish HIV prevention in health care settings (including post exposure prophylaxis, PEP).
- Maintain basic HIV counselling and testing and PMTCT services.[49]
- Provide clinical management of HIV infection, including opportunistic infections (OI) prophylaxis and treatment continuation of antiretroviral therapy (ART) as appropriate.[50]
- Provide case management for gender-based violence and sexually transmitted infections, with emphasis on young people.
- Provide basic health care and support to most-at-risk groups, such as IDUs, sex workers and MSM, paying attention to the needs of the younger age groups.
- Ensure access to male and female condoms.

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44 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Young People in the Education Sector*.
45 Inter-Agency Network for Education in Emergencies (2004) Minimum Standards for Education in Emergencies, Chronic Crises, and Early Reconstruction, UNESCO, Paris. http://www.ineesite.org
46 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*.
47 WHO (2006) *Tool for Assessing Coverage of Health Services for HIV Prevention in Young People*, Geneva.
48 YouthNet Brief (2006) *Services for Prevention of Mother-to-Child Transmission (PMTCT): Integrating contraceptive information into PMTCT services is challenging, particularly for youth*, Family Health International, Arlington. http://www.fhi.org/
49 ibid
50 WHO/UNICEF (in press) *Strengthening the Health Sector Response to Care, Support, Treatment and Prevention for Young people Living with HIV/AIDS*, Report of a WHO/UNICEF global consultation, WHO, 2006.

Comprehensive response:
- Expand/establish new VCT and PMTCT services.
- Expand/establish new OI and ART services.
- Re-establish home-based care services.
- Develop comprehensive strategies to address HIV among most at-risk groups (with a focus on young people), in collaboration with other sectors.
- Expand condom programming.
- Provide basic home-based care and support for PLHIV.

Food/nutritional support and livelihoods

Emergency preparedness:
- Estimate additional food needs of PLHIV and at-risk populations (e.g. single and child-headed households) in different types of emergencies and plan and stock supplies.

Minimum response:
- Promote and establish appropriate care and feeding practices for PLHIV and orphans, including those on ART.
- Plan and promote food security and livelihood support and protection for affected individuals, households and communities.

Comprehensive response:
- Develop specific livelihood support and HIV-prevention schemes for orphans and vulnerable children (OVCs).

What is Different About the Needs of Emergency-Affected Young People for HIV and Related Services?

Young people affected by emergencies require, by and large, the same range of HIV and reproductive health interventions as adults.[51] [52] However, such interventions may need to be developed and implemented in a different way to meet their specific needs:
- When providing HIV prevention and treatment services to minors, issues of informed consent, the best interests of the child, and rights and responsibilities of parents and health care providers should be taken into account.
- Youth-friendly HIV and sexual and reproductive health services/approaches should be in place to respond to their specific needs, and staff should be trained in adolescent-friendly approaches.
- HIV and sexually transmitted infection (STI) information should be adapted to their needs (cultural, educational level and linguistic) and interests.
- Age- and gender-sensitive counselling services need to be available for traumatised and distressed young people.
- All HIV and AIDS training programmes for health and education staff should have a component on young people, with a specific focus on the needs of minors.
- In accordance with the IASC Guidelines, HIV/AIDS interventions should be developed with the full participation of young people (design, implementation, monitoring and evaluation).

Partnerships and Multi-Sectoral Approaches for HIV Programmes for Young People in Emergencies

Within the "cluster approach" adopted under humanitarian reform, HIV is a cross-cutting issue and the responsibility of all UN agencies working in humanitarian emergencies. This calls for agencies to pool resources and response capacity, working in a coordinated manner to ensure age and gender appropriate responses to HIV in emergency situations.

HIV is clearly interrelated with cultural and social factors, human rights and the long-term economic well-being of young people and surrounding populations affected by emergencies. This calls for broad-ranging partnerships to develop and implement sustainable reconstruction, rehabilitation and income-generation opportunities for young returnees, demobilised child soldiers, girls coerced into survival sex and other emergency-affected young people.[53]

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51 The evidence base for these interventions among young people has been established by WHO (2006) *Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries*; eds. Ross, D., Dick, B., and Ferguson, J. Geneva: WHO and Inter-Agency Task Team (IATT) on HIV and Young People. See also the Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Most at-risk Young People.

52 Inter-Agency Standing Committee (2003) *Guidelines for HIV/AIDS Interventions in Emergency Settings*. IASC, Geneva. Some of these interventions are also included in the Steering Committee for Humanitarian Response (2004) *Minimum Initial Service Package*, UNHCR, Geneva together with related reproductive health interventions such as pregnancy prevention and management of pregnancy and childbirth.

53 The draft IASC (2008) Guidelines state that HIV should be integrated into early recovery activities and networks as minimum response and that a comprehensive response would include wide ranging recovery and livelihood strategies.

Monitoring and Evaluation

The United Nations has set targets to monitor progress of access to HIV prevention intervention and reductions in HIV prevalence by 25 per cent in youth 15 to 24 years of age by 2010.[54] More attention needs to be paid to the collection of age and sex disaggregated data on this indicator for young people in emergency settings. One of the UNGASS core indicators calls for data on the percentage of international organisations that have workplace HIV policies and programmes, including training of staff in HIV and AIDS in emergency settings.[55]

In addition, UNHCR has established a monitoring system to assess the extent to which refugees and IDPs are reflected in National HIV and AIDS Strategic Plans.[56] Continued monitoring of the inclusion of emergency-affected populations within national HIV and AIDS strategies and programmes is called for, with specific emphasis on most-at-risk populations and young people.[57]

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- Advocate with governments to incorporate emergency-affected populations into national HIV policies, with a specific focus on the needs of young men and women. Ensure their access to age appropriate, comprehensive HIV prevention, treatment, care and support services that are designed,[58] implemented, monitored and evaluated with their participation.
- Ensure that HIV and young people (especially the concerns of those with additional vulnerabilities) are factored into contingency plans, humanitarian rapid assessments, appeals and programmes.
- Support the prioritisation of a minimum package of HIV prevention and treatment interventions in the early days of an emergency and its expansion into a comprehensive response during the post-emergency phase, with due attention to young people and survivors of gender-based violence. Advocate that inter-agency technical guidance on HIV and emergencies and gender-based violence in humanitarian settings[59] is used consistently as part of a coherent response.
- Advocate for a system to monitor emergency-affected young people's access to HIV prevention, treatment, care and support services and mechanisms to address violations of their human rights, with special focus on the rights of unaccompanied minors and gender-based violence.
- Advocate for data on emergency-affected populations to be disaggregated by age, gender and diversity. Support operational research on the impact of HIV among emergency-affected young people and the effectiveness of programmes in meeting their needs.
- Develop and sustain sub-regional initiatives to ensure continuity in HIV services for emergency-affected populations (including young people) across national borders involving regional intergovernmental platforms as appropriate.[60]

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54 UN General Assembly Special Session on HIV/AIDS (2001), United Nations, New York.
55 Major international organizations (UN, European Community, bilaterals and other international organizations with global coverage and a development, humanitarian, or emergency mandate) are asked to state if they are implementing personnel policies and procedures that cover a minimum set of interventions, including: Training for HIV/AIDS control in conflict, emergency and disaster situations. See UNAIDS (2007) *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators: 2008 reporting*. UNAIDS, Geneva, UNAIDS/07.12E / JC1318E. www.unaids.org
56 UNHCR (2007) Annual 2006 *Protection Reports*. UNHCR, Geneva.
57 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Most-at-risk Young People*.
58 This includes ensuring that information on HIV and sexually transmitted infections is age, gender and culturally appropriate and in a form and language young people can understand.
59 http://www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf
60 Some of these actions have already been identified in the UNAIDS and UNHCR (2007) *Policy Brief: HIV and Refugees*. They are reiterated here with an emphasis on the specific needs of young people affected by emergencies in mind. http://data.unaids.org/pub/BriefingNote/2007/policy_brief_refugees.pdf

KEY RESOURCES:

Inter-Agency Network for Education in Emergencies (2004) *Minimum Standards for Education in Emergencies, Chronic Crises, and Early Reconstruction*. UNESCO, Paris. *http://www.ineesite.org*

Inter-Agency Standing Committee (2003) *Guidelines for HIV/AIDS Interventions in Emergency Settings*. IASC, Geneva and revised draft Guidelines (2008). *http://data.unaids.org/Publications/External-Documents/IASC_Guidelines-Emergency-Settings_en.pdf*

Inter-Agency Standing Committee (no date) *Workshop on HIV/AIDS in Emergency Settings - Trainer's Guide 1st Edition*. IASC, Geneva. *http://data.unaids.org/pub/InformationNote/2003/IASC_HIVtrainersguide_en.pdf*

Inter-Agency Standing Committee (2005) *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. IASC, Geneva. *http://www.reliefweb.int/library/documents/2005/iasc-gen-30sep.pdf.*

Inter-Agency Task Team on Gender and HIV/AIDS (2001) HIV/AIDS, Gender and Conflict Situations. UNAIDS, Geneva. *http://www.unaids.org/fact_sheets/files/GenderFS_en.pdf*

UNAIDS and UNHCR (2007) *Policy Brief: HIV and Refugees*. UNAIDS, Geneva. *http://data.unaids.org/pub/BriefingNote/2007/policy_brief_refugees.pdf*

United Nations Disarmament, Demobilisation and Re-integration Resource Centre (2006). *HIV/AIDS and Disarmament, Demobilisation and Re-integration*. UNDDRRC, New York. *http://www.unddr.org/iddrs/05/60.php*

UNESCO/UNHCR (2007) *Educational responses to HIV and AIDS for refugees and internally displaced persons*. UNESCO, Paris. *http://unesdoc.unesco.org/images/0014/001493/149356e.pdf*

UNIFEM (2004). *Getting it Right, Doing it Right: Gender and Disarmament, Demobilization and Reintegration*. UNIFEM, New York. *http://www.womenwarpeace.org/issues/ddr/gettingitright.pdf*

USEFUL WEB PAGES:

HIV in Humanitarian Situations
http://www.aidsandemergencies.org/cms/

Humanitarian info.org
http://www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf

Medicins Sans Frontiers
http://www.msf.org/

PlusNews
http://www.plusnews.org/

Joint United Nations Programme on HIV/AIDS
http://www.unaids.org

United Nations Population Fund
http://www.unfpa.org/emergencies/

United Nations High Commisioner for Refugees
http://www.unhcr.org/hivaids

Further information and responsible agencies under UNAIDS Technical Support Division of Labour on HIV and Young People

UNHCR is the lead agency for HIV among displaced populations (refugees and internally displaced populations).

The main partners in this effort are: **UNDP, UNESCO, UNFPA, WHO , UNICEF** and the **WFP**.
http://www.unhcr.org

The UNAIDS Secretariat is the lead agency for addressing HIV among persons affected by natural disasters and uniformed services in partnership with **UNFPA, UNHCR, WHO, UNICEF**, and the **WFP**.
http://www.unaids.org

There is as yet insufficient evidence of the effectiveness of some of the interventions outlined in the Briefs and for the use of some of the interventions outlined for certain target populations. Similarly, many of the studies of effectiveness do not disaggregate the research findings by sex. Where there is insufficient evidence, the interventions that are described are based on good practice, and it is recommended that in addition to monitoring coverage and quality, such interventions be evaluated and the results of their effectiveness fed back into the global evidence base.

For more information on the Inter-Agency Task Team on HIV and Young People visit: http://www.unfpa.org/hiv/iatt

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Global Guidance Brief

HIV Interventions for Most-at-Risk Young People

Purpose

This Brief 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, development partners, civil society and other implementing partners on HIV interventions for most-at-risk young people.[3] It is part of a series of seven global Guidance Briefs that focus on HIV prevention, treatment, care and support interventions for young people that can be delivered through different settings and for a range of target groups.

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 deal in any depth with "how to" implement the interventions outlined, although 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.

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 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 15 to 24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Introduction

Globally HIV adversely affects young people. It is estimated that in 2007 about 40 per cent of new infections among people over the age of 15 were in youth between the ages of 15 to 24 years.[6] *The Global Guidance Brief on HIV and Young People* describes the global targets to reduce HIV prevalence in young people and to ensure their access to information, education, life skills and services. Particular attention is paid in this Brief to the younger age cohort-adolescents and explores what interventions should be in place for young people already engaging in high HIV risk behaviours.

Definitions

Behaviours[7] that put people at greater risk of HIV infection include multiple unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with non-sterile equipment.[8] Thus, the term ***most-at-risk young people*** is used throughout this Brief to include young:

- Male and female injecting drug users (IDUs) who use non-sterile injecting equipment
- Males who have unprotected anal sex with other males
- Females and males who are involved in sex work, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex
- Males who have unprotected sex with sex workers

Further, some young people engage in multiple risk behaviours, such as both injecting drugs and having unprotected sex. It is important to undertake situational assessments of young people's risk and vulnerability to HIV infection and map areas of high HIV transmission ("hot spots")[9] to understand who is at increased risk and where they are located.

Working with most-at-risk young people is challenging, especially if they are below the age of 18, being sexually exploited or engaging in illegal behaviours. Any human being below the age of 18 is defined as a child in the Convention on Rights of the Child, Article 1. For children involved in sex work and injecting drugs, it is not simply a case of providing clean injecting equipment and condoms. It is also important to ensure that these individuals are removed from exploitative situations and referred to appropriate health, legal and social services in accordance with their best interests, as laid out in the Convention on Rights of the Child.

Some young people may be especially vulnerable to HIV, or just one step away from engaging in high-risk behaviour, because of such factors as displacement;[10] ethnicity and social exclusion; having parents, siblings or peers who inject drugs; migration (internal and external);[11] family breakdown and abuse; harmful cultural practice; and poverty. The presence of these factors does not automatically lead to HIV risk behaviour, as there may be several protective factors at work (education, supportive family and peer networks).[12]

However, gender inequality and human rights violations both impede participation by vulnerable populations in sound and timely HIV prevention planning and access to prevention information and services.[13]

"Settings" such as juvenile detention facilities and prisons are places where there is a greater likelihood of HIV transmission through injecting drug use or anal sex. Similarly, young people living without parental care, or on the street, may be pressured to sell/exchange sex or inject drugs.

Young people living or working on the street There are about 120 million "street kids" worldwide: boys and girls living in both rich and poor countries.[14] They are subject to the everyday risk of being sexually abused and experience violence at the hands of both adults (parents, police and others) and their peers. Many of them do not have access to appropriate health services. Their major concern is survival, and they are often involved in theft or sell/exchange sex because they do not have other means of earning money.[15] Many of them use psychoactive substances and may inject drugs. As a result, HIV prevalence rates are worryingly high among this sub-population. Recent research from Saint Petersburg (Russian Federation) found 37.4 per cent of 313

6 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
7 It is the behaviour that puts the young person at risk of HIV. Various different sub-groups of young people may engage in HIV risk behaviours and they will vary from country to country. The need to know "your epidemic" and to identify hot spots where HIV risk behaviours take place is critical.
8 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.
9 For information on how to conduct hot spot mapping see Weir, S.S., Tate, J., Hileman, S.B., Khan, M., Jackson, E., Johnston, A. and Herman, C. (2005) *Priorities for Local AIDS Control Efforts (PLACE): A Manual for Implementing the PLACE Method.* USAID and MEASURE , Carolina Population Centre, Chapel Hill.
10 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Young People in Humanitarian Emergencies* for more information on vulnerability to HIV among young people.
11 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Young People at the Workplace.
12 WHO (2002) *Broadening the horizon: Balancing protection and risk for adolescents.* WHO, Geneva.
13 UNAIDS (2007) *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access.* UNAIDS, Geneva.
14 UNAIDS (2002) *HIV/AIDS stigma and discrimination. UNAIDS Best Practice Collection*, UNAIDS, Geneva.
15 ILO (2001) *In-depth analysis of the situation of working street children in Saint Petersburg 2000.* ILO/IPEC Working Paper, ILO Saint Petersburg.

street children to be HIV-positive with the highest levels among those street children who inject drugs.[16]

Young people in juvenile detention/correctional institutions Overcrowded conditions, drug use and limited adequate services in prisons may adversely affect the health of inmates, including exposure to HIV, hepatitis C and tuberculosis. For young males in prison,[17] there are additional risks, as they are often physically weaker than other inmates and may be forced to take part in drug and/or sex-related activities. Anal sex, forced or consensual, is common in prison and is generally unprotected[18] as is the use of non-sterile needles and syringes. Young people in juvenile detention urgently need HIV interventions, including access to clean needles and syringes, drug treatment services, counselling and health education, both within and beyond correctional settings.[19 20] However, the main intervention should be to prevent juveniles being placed in correctional facilities. Programmes diverting young offenders from the juvenile justice system should be established and, where these programmes do not exist, young people should be placed in custodial care/juvenile detention facilities separate from adults.

Key Issues in Working With Most-At-Risk Young People

The HIV risk behaviour that needs to be addressed when working with most-at-risk young people may be illegal (injecting drugs, selling sex and male-to-male sex), making it more difficult for at-risk young people to access services. Because of legal and other barriers, young people involved in HIV risk behaviours are marginalised and not reached by mainstream HIV prevention and treatment efforts. They may experience stigmatisation, discrimination and social exclusion.[21]

Although young people engaging in HIV risk behaviour need many of the same types of HIV prevention treatment, care and support interventions as their older counterparts, they also require programmes tailored to their specific needs, including those related to age and psychosocial development.

Young men who have sex with other males may be unsure about their sexuality and not have anyone to talk to because of the stigma surrounding homosexuality and bisexuality. In many countries evidence is beginning to emerge that transgendered young people are the most discriminated against and hardest to reach.[22]

Young people who inject drugs are more likely than their older counterparts to be influenced by peers. They are less aware of the dangers of injecting drugs and of HIV, hepatitis B and C and how to reduce their risks. The younger the age, the less likely a person is to understand the consequences of his or her drug use. Early age of injecting drug use is often connected with polysubstance use. There is less access to appropriate,[23] confidential services for young injecting drug users than older users. Young injecting drug users (IDUs) often drop out of (or are expelled from) school, are often unskilled and experience economic instability. This may lead to crime and/or selling sex to obtain money for drugs. They may also lose contact with their families. A lack of money may also prevent them from seeking health care, as they may not be able to afford care or medication. Young IDUs have been found to engage in higher levels of use of non-sterile injecting equipment than older IDUs and they perceive less risk in doing so.[24 25]

In some countries the involvement of young people in sex work is linked with criminal organizations and trafficking in children for the purpose of sexual exploitation. In many countries children and young women who sell sex on the street are the most vulnerable. Most children and young people who sell sex, whether on the street, in brothels, at truck stops or in bars, are subjected to violence by their clients and the police.

Girls involved in sexually exploitative situations are often tightly controlled by managers[26] and criminal gangs. Global research on girls and young women involved in sex work shows that many of them have suffered some form of

16 Kissin, D. M. et al (2007) "HIV sero-prevalence in street youth, St Petersburg, Russia," *AIDS*, 21(17):2333-2340, November.
17 Minors are not always incarcerated separately from adults.
18 International Federation of Red Cross and Red Crescent Societies (2003) *Spreading the light of science: Guidelines on harm reduction related to injecting drug use*. IFRC, Geneva.
19 Shakarishvili et al. (2005) "Sex work, drug use, HIV infection and spread of sexually transmitted infections in Moscow," Lancet, Vol. 366, pp 57-60.
20 WHO Regional Office for Europe (2003) *Promoting the health of young people in custody*. WHO Regional Office for Europe, Copenhagen. http://www.euro.who.int/prisons/publications/20050610_1
21 It is estimated that less than one in 20 men who have sex with men have access to the HIV prevention, treatment and care services they need - UNAIDS (2006) Report on the global AIDS epidemic. UNAIDS, Geneva.
22 Acceptance or societal rejection of transgender people is culturally constructed. In Thailand, for instance, transgendered people face less discrimination than men who identify as homosexual.
23 Health services, treatment and counselling services are often designed for adults or hard-core drug users and the needs of young people, in the early phases of drug use who often do not consider themselves as dependent, are not catered for.
24 UNAIDS and UNDCP (1999). *Drug Abuse - HIV/AIDS: A devastating combination*. UNAIDS, Geneva.
25 UNODC and the Global Youth Network (2004) *HIV prevention among young injecting drug users*. UNODC, Vienna. http://www.unodc.org/pdf/youthnet/handbook_hiv_english.pdf
26 These are colloquially referred to as "pimps": however, the preferred terms are "controllers" or "managers."

sexual abuse (at home, by "friends" or by traffickers) and have low self esteem; in some countries the cultural practice of early marriage is also associated with involvement in sex work. Often recruitment into sex work or trafficking is through family, kin and community members. Recent studies provide evidence that children and young people trafficked into sex work are at increased risk of HIV infection.[27] Similarly, the younger the age of entry into sex work and the greater the number of movements from sex work establishments, the higher the risk of HIV infection.[28] At the time of selling sex, many will use alcohol and/or drugs at the request of clients or managers because of dependence, as self-medication or for recreational purposes. Studies suggest that sex workers who inject drugs may be even younger than those who do not.[29] Also linked with the young age of selling sex are high rates of other high-risk behaviours, for example non-use of condoms, which results in high reported rates of STIs. Both injecting drugs and unprotected sex contribute to high HIV prevalence rates.[30]

For all groups of most-at-risk young people, greater attention needs to be paid to legal and psychosocial support, access to alternative education opportunities and, for those under 18, child protection services.

Effectiveness of Interventions

There is sufficient evidence to show that many risk-reduction efforts do work among young people and merit strengthening.[31 32] These include the following five interventions irrespective of the stage of the HIV epidemic:

- information on HIV prevention and treatment (in a form they can understand); condoms;
- harm-reduction services (if injecting drugs);[33]
- services for the prompt diagnosis and treatment of STIs;
- counselling and testing for HIV, with referral to HIV treatment, care and support services if HIV positive[34] and HIV-prevention counselling if HIV-negative.

Evidence shows that static services will also need to be complemented by outreach services, and separate services may be needed for young women and transgendered young people who inject drugs and exchange sex, as their needs are different from males. Also there is a strong body of evidence concerning the protective factors (such as family, school and community ties) which protect young people against HIV-risk behaviour.

Effectiveness is hindered by the lack of systematic attention to gender in designing programmes for most-at-risk young people. Most countries do not have accurate data on the population of young men and women,[35] nor do they maintain records by sex of young people's use of services.

Knowing your epidemic

In order to develop appropriate HIV interventions for young people, it is critical to "know your epidemic," as programme responses differ according to the stage of the epidemic.[36] Evidence-informed programming requires that data are available on the number of people living with HIV who are young people, how many are male and female, their particular characteristics and HIV risk behaviour. With this information available, interventions can be most effectively targeted towards most-at-risk young people:

- In ***all countries***, targeted interventions for young injecting drug users, young men who have sex with men, and young people involved in sex work and their clients should be in place.
- In ***low-prevalence countries,*** targeted interventions should be in place for young men and women who inject drugs and sell sex and for young men who have sex with males.
- In ***concentrated epidemics,*** targeted interventions for young injecting drug users, men who have sex with men and young people involved in sex work should be in place, as well as targeted interventions for their sexual partners and other country-specific vulnerable groups.
- In ***generalised epidemics,*** targeted interventions should follow those needed for concentrated epidem-

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27 See Silverman reference in reference section.

28 Gray, J. A., Dore, G. J., Li, Y., Supawitkul, S., Effler, P. and Kaldor J.M. (1997) "HIV-1 infection among female commercial sex workers in rural Thailand," *AIDS*, Vol.11:89-94. - article demonstrates that 14 to 19 year old girls and those from the ethnic minority Hill tribes had higher rates of HIV than the older cohorts.

29 Platt, L., Rhodes, T., Lowndes, C.M., Madden, P., Sarang, A., Mikhailova, L., Renton, A., Pevzner, Y., Sullivan, K. and Khutorskoy, M. (2005) "The impact of gender and sex work on sexual and injecting risk behaviours and their association with HIV positivity among injecting drug users in an HIV epidemic in Togliatti City, Russian Federation." *Sexually Transmitted Diseases,* Vol. 32, No. 10, 605-612.

30 Gray, J. A., Dore, G. J., Li, Y., Supawitkul, S., Effler, P. and Kaldor J.M. (1997) "HIV-1 infection among female commercial sex workers in rural Thailand," AIDS, Vol.11:89-94

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

32 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.

33 Harm reduction comprises of three principles: i. reaching out to injecting drug users; ii. discouraging the use of non-sterile injecting equipment and providing sterile equipment and disinfectant materials; and iii. making substitution treatment available.

34 The evidence base for the effectiveness of these interventions among young people has been established by 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, WHO, Geneva. See also IATT on HIV and Young People (2008) *Global Guidance Brief on HIV interventions for Young People in the Health Sector.*

35 It is estimated that in any one country about one-quarter of the total population is between 10 and 24 years, but in some countries this can be much higher.

36 Guidance is provided on the measures that need to be in place based on the stage of the epidemic - *UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access.* UNAIDS, Geneva.

ics, including age- and gender-appropriate HIV information, skills and services for all young people.

Data on HIV and age may not be routinely disaggregated, and international commitments only call for data on the age group 15 to 24,[37] with the result that data for 10 to 14 years are often missing.[38]

A Human-Rights Approach

A human-rights approach is fundamental for effective and sustainable national responses to HIV prevention among most-at-risk young people and those living with HIV. They have the same rights as other adolescents and young people to:

1) Information, confidential counselling and education

2) Privacy so that their personal behaviour, HIV status and health records are not disclosed to anyone without their explicit consent

3) HIV protection for themselves, their families and their sexual partners by taking necessary precautions, such as using sterile injection equipment or male/female condoms.[39] A rights-based approach contains measures to reduce stigma and discrimination against most-at-risk young people, as this clearly affects their access to information and services as well as their ability to participate meaningfully in their care.[40]

However, providing HIV interventions for adolescents below age 18 can be problematic. The Convention on the Rights of the Child (CRC) implicitly acknowledges the evolving capacity of adolescents to make decisions for themselves based on their competency to consent to medical treatment.[41] However, the law dealing with this varies and some countries designate specific ages (ranging from 10 to 18) at which an adolescent is judged to have capacity.[42] In some places not all key stakeholders are familiar with the CRC[43] or with national legislation relating to risk behaviours (drug injection, male same sex relations or sex work), and health care providers may not be familiar with the legal situation regarding performing medical interventions on young people below the legal age of majority.

For any medical intervention, such as an HIV test, informed consent should be obtained. The information should be provided in an easily understood format and be relevant to their age and life circumstances. The provision of information should not end with the intervention but continue to ensure that the adolescent can deal appropriately with the outcome (to avoid becoming infected, begin treatment and avoid infecting others). Informed consent is thus inextricably linked with counselling, and an assessment of "best interests" should be made in pre-test counselling to determine whether it is in the best interests of the adolescent to access services without parental consent.[44]

Issues of child protection arise where adolescents under 18 are in situations of sexual exploitation and abuse. They need to access HIV prevention interventions as well as child protection services and to be removed from the exploitative situation.

Key Interventions

Behaviour change communication (BCC) for most-at-risk young people should promote individual behaviour change such as the use of condoms, use of sterile injection equipment and reduction in number of sexual partners. The intervention needs to be based on sex, age and level of biological and social maturity. For those below the legal age of majority, issues of parental consent will need to be considered. BCC should also promote positive behaviours associated with treatment, care and support, including adherence to antiretroviral therapy and the diagnosis and treatment of sexually transmitted infections (STIs).

Advocacy to raise awareness of the situation of most-at-risk young people and to stimulate increased investments from decision makers on their behalf is also called for. BCC can be effective in promoting broader societal change using advocacy, social and community mobilisation,[45] especially to inform young people about the dangers of trafficking in children for the purpose of sexual exploitation, the unacceptability of gender-based violence and harm associated with injecting drugs.

Participation of young males and females engaging in HIV risk behaviours in the planning of services and decision-making about HIV interventions is critical.

37 Almost two thirds of countries studied by UNAIDS had insufficient or no data on HIV prevalence and/or sexual behaviour trends among young people, including several countries with exceptionally high HIV prevalence in southern Africa - UNAIDS (2007) *AIDS epidemic update: Briefing Booklet*. UNAIDS, Geneva.

38 UNGASS (2007) *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators: 2008* reporting requires governments to disaggregate data for young people under 25 years from data for adults age 25 and over. Some indicators for most-at-risk populations request data for youth age 15 to 19 years and 20 to 24 years.

39 UNDP (2006) *Positive people know your universal human rights*. UNDP HIV/AIDS Regional Programme in the Arab States. http://www.harpas.org

40 An index to measure stigma towards PLHIV has been developed and can be adapted for use with young PLHIV. International Planned Parenthood (IPPF), GNP+, ICW and UNAIDS (2008) *The People Living with HIV Stigma Index User Guide*. IPPF, London.

41 United Nations (1989) *Convention of the Rights of the Child CRC* Article 5. UN, New York.

42 The concept of the "mature minor" standard is adopted by the Court if he or she has sufficient understanding and intelligence to understand fully what is proposed.

43 The WHO training course on Child Rights is intended to provide detailed guidance for training on child rights, WHO (2002) *Child Rights Capacity Building Training Course: Facilitator Guide*. WHO, Geneva.

44 WHO (2005) Increasing access to HIV counselling and testing for adolescents: *Consent and confidentiality*. WHO, Geneva.

45 Family Health International (2005) *Strategic Behavioural Communication*. FHI, Arlington.

They should also be involved in the implementation and monitoring of national and sub-national policies and programmes. National AIDS authorities should include representatives of NGOs working with most-at-risk young people.

Risk-reduction skills are important for most-at-risk adolescents and youth to help them negotiate condom use, develop strategies for refusing unprotected sex and avoid clients who are alcohol/ drug affected and potentially violent. In areas, for example, where injecting drug use is the main driver of the epidemic, a risk-reduction intervention might focus on safer injecting practices as well as skills for safer sexual practices.

Mass media can also be effective in reaching stigmatised young people who are not part of formal organizations, and youth involvement and peer-based media programmes are effective when properly conducted.[46] The Internet is becoming increasingly popular among young men who have sex with men (MSM) as a means of contacting other MSM and accessing information about health, HIV and legal services. The Internet is also being used extensively to provide information on substance use issues among young people.[47] The results of these interventions have yet to be evaluated.

Peer education is an effective mechanism for increasing mostat- risk young people's knowledge and skills about HIV and STIs and contributes to enabling them to be responsible and protect themselves and others from HIV.[48 49] It should be conducted by well-trained and motivated people working with peers (similar to themselves in age, gender, background or interests) over a period of time. Trained peer educators who are themselves young injecting drugs users (or ex-users), men who have sex with men and sex workers are able to provide age, gender and culturally appropriate risk-reduction information to their peers. This is more likely to result in behaviour change, and outreach peer educators[50] have been critical to the success of programmes by mobilising their communities or social networks.

Outreach strategies are essential when working with out-of-school adolescents and youth who engage in HIV-risk behaviours, as they are not likely to seek help on their own and may not be covered by existing health or information services. Outreach aims to take information, commodities, education and services to them in their own milieu, rather than waiting for them to consult static services.[51 52] The most effective outreach programmes create strong partnerships with community-based organizations[53] and utilize peer educators and counsellors. Outreach can also play a critical role in referring most-at- risk young people to static services.[54]

HIV Services For Most-At-Risk Young People

Young people engaging in HIV risk behaviours are often unable to access the prevention and treatment services they need, especially if they are minors. Services designed for young people (such as youthfriendly health services)[55 56] need to be adapted to meet the needs of most-at-risk young people to ensure they are appropriate to their age, sex, level of maturity and legal status and configured around their risk behaviour and vulnerability to HIV infection.

Staff providing harm-reduction services for adult injecting drug users and health workers in STI and HIV testing and counselling services will need training in how to work with adolescents.[57] Health care providers who have been trained in adolescent or youth-friendly approaches may need further training to work with young people who engage in HIV risk behaviours.[58]

Partnerships And Multi-Sectoral Approaches

To address the challenges in working with most-at-risk young people, a broad range of adult-youth, governmental, civil society, private-sector and community partnerships need to be established. These should include staff from health, legal and social services, caregivers, schools,

46 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.
47 Global Youth Network - *Using the Internet for Drug Abuse Prevention* http://www.unodc.org/youthnet/youthnet_action_good_practice_net_for_dap.html.
48 ibid
49 Adapted from United Nations Population Fund and Youth Peer Education Network (Y-PEER) and Family Health International (2005). *Training of Trainers Manual: Youth Peer Education Toolkit.* UNFPA, New York. www.fhi. org/en/Youth/YouthNet/Publications/peeredtoolkit/index.htm
50 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on Community-based* HIV Interventions for Young People.
51 Burrows, D. and Alexander, G. (2001) *Walking on Two Legs.* UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva.
52 UNODC and the Global Youth Network (2004) *Outreach and HIV among young IDUs: A how-to guide.* UNODC, Vienna.
53 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on Community-based HIV Interventions for Young People.*
54 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.*
55 ibid
56 ibid for a description of adolescent/youth-friendly health services
57 Such as, WHO (2005) *Orientation programme on adolescent health for health care providers.* WHO, Geneva.
58 WHO is developing a module on working with most-at-risk adolescents as part of the Orientation programme on adolescent health for health care providers. This should be finalized during 2008. See also http://projects. takingitglobal.org/harmreduction

faith-based and youth organizations, other authorities and communities. Such partnerships should address issues of stigma and discrimination towards most-at-risk young people and those living with HIV. Community development work with families and community leaders is also necessary to enable most-at-risk young people to live in/or return to their home communities. Support networks of young people living with and affected by HIV should be developed as well as capacity building in organizations working with young people engaging in HIV-risk behaviours.[59]

An example of a global partnership against child prostitution in the tourism industry has been promoted by the World Tourism Organization's multi-stakeholder initiative. Tourist industry associations have endorsed the global statement and adopted their own statements or codes to address the issue.[60]

Monitoring and Evaluation

Data need to be disaggregated by age, gender, diversity, HIV risk behaviour and use of services to show whether interventions directed towards most-at-risk young people are reaching them.[61] A framework has been developed for use with most-at-risk populations[62] and can be adapted to the age-specific situation of most-at-risk young people. Health service coverage indicators for most-at-risk young people have also been developed to assist programme managers.[63]

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- Review the national HIV and AIDS Strategy and Plan of Action to assess the extent that interventions are supported for reducing HIV-risk behaviours in adolescents and young people. Where gaps exist, advocate for national HIV/AIDS programmes to integrate most-at-risk young people into a costed national HIV and AIDS Strategy and Plan of Action and mobilise resources as part of the UN Joint Implementation Support Plan.[64]
- Review the Joint UN Implementation Support Plan to ensure that UN agencies are providing technical support and capacity building related to the implementation of comprehensive interventions for young injecting drug users, men who have sex with men and young people involved in sex work.
- Support the development of a national system for ongoing age and gender disaggregated assessment and analysis of HIV risk and vulnerability among young people. This should include most-at-risk young people in national biological and behavioural surveillance and support for operational research on the impact of HIV among young people, the contexts in which risk behaviours occur,[65] and the effectiveness of programmes in meeting the HIV protection, prevention and treatment needs of young people.
- Review and, if necessary, reform legal frameworks to remove barriers to effective, evidence-informed HIV prevention, combat stigma and discrimination,[66] reduce gender-based violence and exploitation of young people, and protect the rights of young people living with HIV[67] or who are at risk of HIV.
- Advocate for most-at-risk young people (including those living with or affected by HIV) to be included in decisions affecting them and in the design, implementation and monitoring of programmes for them; support initiatives to strengthen their capacity to participate.
- Advocate for HIV comprehensive interventions in the health and related sectors to be made accessible and appropriate for most-at-risk young males and females, especially adolescents.
- Support community development approaches that address stigma and discrimination, family attachment and cultural practice to enable young injecting drug users, men having sex with men and young people involved in sex work to live in/or return to their home communities.

59 There are global networks led by and for young people that can provide support see Useful web pages.
60 WTO campaign and statement see: http://www.world-tourism.org/protect_children/wto_statement.htm
61 UNAIDS (2007) *Practical Guidelines for Intensifying HIV Prevention.* UNAIDS, Geneva.
62 UNAIDS et al (2007) *A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations.* UNAIDS, Geneva. UNAIDS/07.15E/JC1338E.
63 WHO (2007) *Access to Health Services for Young People for Preventing HIV and Improving Sexual and Reproductive Health: Data on Coverage Indicators for Most-At-risk Young People.* WHO, Geneva. http://www. who.int/child-adolescent-health
64 An essential policy action for HIV prevention is to promote programmes targeted at HIV prevention needs of key affected groups and populations, UNAIDS (2006) *UNAIDS action plan on intensifying HIV prevention 2006 to 2007.* UNAIDS, Geneva.
65 UNAIDS (2007) *Policy Brief on Men who Have Sex with Men* already advocates for this with MSM. UNAIDS, Geneva.
66 UNAIDS (2006) UNAIDS action plan on intensifying HIV prevention 2006 to 2007. UNAIDS, Geneva.
67 UNAIDS (2007) *Policy Brief on the Greater Involvement of People Living with HIV (GIPA).* UNAIDS, Geneva.

KEY RESOURCES:

Dehne, K. and Riedner, G. (2005) *Sexually transmitted infections among adolescents: The need for adequate health services.* WHO, Department of Child and Adolescent Health and Development and GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit), Geneva. *http://www.who.int/child-adolescent-health and http://www.gtz.de/sexual-health*

European Network of Male Prostitutes. *Manual: Tips, tricks and models of good practice for service providers considering, planning or implementing services for male sex workers.* ENMP, Amsterdam. *http://www.enmp.org/download/MANUAL11.pdf*

UNICEF(2008) *Draft 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. Draft document available from *mbelgharbi@unicef.org*

Network of Sex Work Projects (1997). *Making sex work safe.* NSWP, South Africa. *http://www.nswp.or/safety/msws/index.html*

Jay G. Silverman, PhD; Michele R. Decker, MPH; Jhumka Gupta, ScD, MPH; Ayonija Maheshwari, MD, MPH; Brian M. Willis, JD, MPH; Anita Raj, PhD *HIV Prevalence and Predictors of Infection in Sex-Trafficked Nepalese Girls and Women JAMA.* 2007;298:536-542.

United Nations (1989) *Convention of the Rights of the Child* (CRC) Article 5.

United Nations, New York.

UNAIDS (2006) *UNAIDS action plan on intensifying HIV prevention 2006 to 2007.*

UNAIDS, Geneva.

UNAIDS (2007) *Policy Brief on the Greater Involvement of People Living with HIV (GIPA).*

UNAIDS, Geneva.

UNAIDS (2007) *Policy Brief on Men who Have Sex with Men.* UNAIDS, Geneva.

UNAIDS (2007) *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access.* UNAIDS, Geneva.

UNAIDS et al (2007) *A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations.* UNAIDS, Geneva. UNAIDS/07.15E/JC1338E.

UNDP (2006) *Positive people know your universal human rights.* UNDP HIV/AIDS Regional Programme in the Arab States. *http://www.harpas.org*

UNICEF, UNFPA, UNECSO (2007) *Responding to the HIV prevention needs of adolescents and young people in Asia: Towards (cost-effective) policies and programme.* Paper prepared for discussion within the AIDS Commission in Asia, UNICEF, Nepal. *http://www.unicef.org/rosa/hiv_aids_1986.htm*

UNODC (2004). *A Strong Start: Good practices in using a local situation assessment to begin a youth substance abuse prevention project.* UNODC, New York. *http://www.unodc.org*

UNODC and the Global Youth Network (2004). *HIV prevention among young injecting drug users.* UNODC, New York. *http://www.unodc.org/pdf/youthnet/handbook_hiv_english.pdf*

Weir, S.S., Tate, J., Hileman, S.B., Khan, M., Jackson, E., Johnston, A. and Herman, C. (2005) *Priorities for Local AIDS Control Efforts (PLACE): A Manual for Implementing the PLACE Method,* USAID and MEASURE, Carolina Population Centre, Chapel Hill. *http://www.cpc.unc.edu/measure*

WHO (2000) *Working with Street Children: Module 1- A profile of street children.* WHO Training package in substance use, sexual and reproductive health, including HIV/AIDS and STDs. WHO/MSD/MDP/00.14, Geneva.

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

WHO (2004) *Evidence for Action: Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users.* WHO, Geneva.

WHO (2005) *Toolkit for Targeting HIV/AIDS Prevention and Care in Sex Work Settings.* Department of HIV/AIDS, WHO, Geneva. *http://www.who.int/hiv/en*

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, WHO, Geneva. *http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_120938_0.htm*

WHO (2007) *Access to Health Services for Young People for Preventing HIV and Improving Sexual and Reproductive Health: Data on Coverage Indicators for Most-At-risk Young People.* WHO, Geneva. *http://www.who.int/child-adolescent-health*

USEFUL WEB PAGES:

Global Youth Coalition on HIV/AIDS
http://www.youthaidscoalition.org
Global Youth Network
http://www.unodc.org/youthnet/en/youthnet_youth_drugs.html
International Youth Harm Reduction Network
http://projects.takingITglobal.org/harmreduction
Living Positively
http://www.youthaidscoalition.org/living.html
World Health Organization
http://www.who.int/hiv/en

Further information and responsible agencies under UNAIDS Technical Support Division of Labour on HIV and Young People

UNODC is the lead agency for the Prevention of HIV transmission in injecting drug users and in prisons. The main partners in this effort are: **ILO**, the **UNAIDS Secretariat, UNDP, UNESCO, UNFPA, UNICEF** and **WHO**.

The **UNAIDS** Secretariat is the lead agency for the Prevention of HIV transmission in men who have sex with men. The main partners in this effort are: **ILO, UNESCO, UNFPA, UNICEF, UNHCR, UNODC**, and the **WFP**.

UNFPA is the lead agency for the Prevention of HIV transmission in sex workers. The main partners in this effort are: **ILO**, the **UNAIDS Secretariat, UNESCO, UNODC, UNICEF** and **WHO**.

UNFPA is the lead agency for the Prevention of HIV transmission in vulnerable groups, including out of school young people (except refugees and internally displaced populations). The main partners in this effort are: **ILO, UNESCO, UNFPA, UNICEF, UNODC**, and **WHO**.

There is as yet insufficient evidence of the effectiveness of some of the interventions outlined in the Briefs and for the use of some of the interventions outlined for certain target populations. Similarly, many of the studies of effectiveness do not disaggregate the research findings by sex. Where there is insufficient evidence, the interventions that are described are based on good practice, and it is recommended that in addition to monitoring coverage and quality, such interventions be evaluated and the results of their effectiveness fed back into the global evidence base.

For more information on the Inter-Agency Task Team on HIV and Young People visit: http://www.unfpa.org/hiv/iatt

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Global Guidance Brief

Community-Based HIV Interventions for Young People

Purpose

This Brief 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, development partners, civil society and other implementing partners on community HIV interventions for young people.[3] It is part of a series of seven global Guidance Briefs that focus on HIV prevention, treatment, care and support interventions for young people that can be delivered through different settings for a range of target groups.

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 deal in any depth with "how to" implement the interventions outlined, although 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.

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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 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.

Introduction

Effective HIV prevention measures are those that emphasise human dignity, responsibility, voluntary participation and empowerment through access to information, services and support systems.[6] Individual behaviours and decisions are not made or practised in a vacuum, and social norms, which are formed and enforced in communities, often determine the options available to young people.

Community-based approaches build on shared values and norms, belief systems and social practices, permitting culturally sensitive discussions of HIV and sexual and reproductive health. A thorough understanding of common values and belief systems also helps to identify positive values and practices that can facilitate and more effectively promote HIV interventions. Thus cultural knowledge, awareness and engagement of local communities are vital in advancing effective and sustainable change.

The nature and scale of interventions in the community will vary according to the type of HIV epidemic scenarios. In hyperendemic situations and generalised epidemics, extraordinary efforts are required to mobilise the whole community.[7] In low-prevalence countries and concentrated epidemics, community-based interventions should be focused on reaching those groups most at risk,[8] including vulnerable groups such as children living/working on the streets,[9] as well as efforts to reduce stigma and discrimination towards these groups. Community-based interventions that seek to address social norms related to gender inequality, intergenerational sex and gender-based violence are required in all epidemic scenarios.[10]

Definitions

A ***community*** can be defined geographically (by location) or socially (people with common social attributes and interests[11] or HIV-risk behaviours)[12]. Some "communities," such as those of children living and/or working on the street, are both geographic and social, as they share the same location and social conditions. However, there is not always concurrence between geographic communities and those that are socially defined (such as peer educators networks,[13] community networks and organizations that involve young people living with HIV, young people living/working on the street, those involved in sex work or injecting drugs, and young men who have sex with other males).[14]

The value of ***community involvement*** and the potential for communities to be actively involved in improving their health was recognised 30 years ago.[15] Since then, community involvement has been regarded as a continuum (according to the degree of community members' control and decision-making) that ranges from token representation with no role or power in making decisions to ***community participation*** in which local people initiate action, set the agenda and work towards a commonly defined goal of ***community engagement.*** Such engagement brings together people living with HIV, community stakeholders and health providers to develop partnerships, address gaps and challenges, and support families and individuals, creating a comprehensive community response.

For community HIV interventions to be effective and sustainable, actions need to be developed by the community members and young people themselves.[16 17] Involving them from the outset in planning, designing, implementing, monitoring and evaluating is likely to increase the degree of control that community members have over decision-making.

Methods to maximise community involvement include:

1. ***Community planning*** to identify priority HIV-prevention needs and measures to ensure that HIV-prevention

6 UNAIDS (2007) *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access.* UNAIDS, Geneva.
7 Southern African Development Community, SADC (2006). *Expert Think Tank Meeting on HIV Prevention in High Prevalence Countries in Southern Africa Report.* SADC, Maseru.
8 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Most-At-risk Young People.*
9 For example, 37.4% of 313 street children in Saint Petersburg were found to be HIV positive. Kissin, D. M. et al (2007) "HIV sero-prevalence in street youth, St Petersburg, Russia," AIDS, 21(17):2333-2340, November.
10 UNAIDS (2007) *Expert Consultation on Behaviour Change in the Prevention of Sexual Transmission of HIV: Highlights and recommendations.* UNAIDS, Geneva.
11 Maclean, A. (2006) *Community Involvement in Youth Reproductive Health: A Two-Part Review and Analysis of the Literature.* Family Health International/YouthNet, Washington DC.
12 Some definitions of community embrace both the geographic and social dimensions, for example, a community is "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings." MacQueen, K. M., McLellan, E., Metzger, D. S., Kegeles, S., Strauss, R.P., Scotti, R., Blanchard, L. and Trotter, R.T. (2001) "What is Community? An Evidence-Based Definition for Participatory Public Health." *American Journal of Public Health*, Vol. 91, No. 12, December. The World Health Organization similarly defines community as "a group of people living in the same geographic area with some degree of common interests and an easy means of communication." WHO (2001) *Information, education and communication: Lessons from the past; perspectives for the future*, Department of Reproductive Health, WHO, Geneva.
13 UNAIDS (1997) Community Mobilisation and AIDS. Technical update, UNAIDS, Geneva.
14 International Council of AIDS Service Organizations, the African Council of AIDS Service Organizations, and the International HIV/AIDS Alliance (2007) *Guidelines on the Involvement of the Community Sector in the Coordination of National AIDS Responses Background to Involving Communities.* IHAA, Brighton.
15 WHO and UNICEF (1978) *Primary Health Care: Report of the International Conference on Primary Health Care.* Alma-Ata USSR. 6-12 September, 1978. WHO, Geneva.
16 Donahue, J. and Williamson, J. (1999) *Community Mobilisation to Mitigate the Impact of HIV/AIDS.* USAID, Washington DC.
17 Palmer, A. (2002) *Reaching Youth Worldwide: Working Paper No. 6.* Johns Hopkins Centre for Communication Programmes, Baltimore. http://www.jhuccp.org/pubs/wp/6/6.pdf

resources are targeted to priority populations and interventions in a comprehensive plan.[18]

2. ***Social change communication and mobilisation*** so groups of people become aware of common concerns or needs and decide to take action to create shared benefits.[19] Several guidelines exist on how to mobilise community members to comprehensive action[20 21] with specific reference to HIV and AIDS[22 23] and how to conduct participatory assessments with young people.[24 25 26]

Because of the diverse nature of some communities, any behaviour-change interventions should be based on audience or community segmentation. This enables the identification of primary target audiences, such as young people engaging in HIV-risk behaviour and segmenting them based on age, ethnicity, sex and power relations. It is also necessary to address secondary audiences of people who influence the behaviour of the primary target group. These can be parents, religious and traditional leaders, or in the case of young women involved in sex work, it would need to include their clients and controllers. As the secondary audience can also be diverse in terms of age, gender relations and position within the community, different interventions need to be developed for each sub-group.[27]

Evidence of Effectiveness of Community-Based HIV Interventions for Young People

Communities are unlikely to question their own assumptions–on gender norms, for example–unless prompted to do so, but community-based programmes have succeeded in catalysing change by helping communities reflect on traditions, norms and values that jeopardize their health and survival.[28]

Community involvement has been demonstrated to play an important role in HIV prevention, treatment, care and support interventions for young people through:[29 30 31]

- Providing access to young people in the community through adult gatekeepers
- Creating a supportive community environment that enables individual behaviour change
- Mitigating the impact of HIV-related stigma and discrimination on young people
- Facilitating changes in gender norms that affect young people's risk of HIV infection
- Increasing community awareness of available HIV services, generating youth demand for such services and increasing access to and use of services through referral systems and support.[32] Any community mobilisation of young people to use HIV prevention and treatment services should be accompanied by improvements in such services and their adaptation to the needs of young people-creating, for example, youth-friendly health services.[33]
- Supporting young people in successful use of treatment
- Supporting young people in the adoption of preventive behaviours
- Increasing young people's status in the community so they can assume leadership roles in reading HIV information and education in their communities
- Promoting sustainability and a sense of community ownership of programmes

Community-based HIV interventions for young people can include the following: behaviour-change communication, such as youth peer education[34] and advocacy programmes to alter risk-taking behaviour;[35] outreach through community organizations to young people most at risk for HIV (i.e. young people who are involved in sex work and/or inject drugs,[36] young men who have sex

18 Centres for Disease Control (2003) *HIV Prevention Community Planning Guide*. CDC, Washington DC.
19 UNAIDS (1997) *Community Mobilisation and AIDS*. Technical update, UNAIDS, Geneva.
20 Butterfoss, F. (2006) "Process Evaluation for Community Participation." *Annual Review of Public Health*, 27: 323-340.
21 Howard-Grabman, L. and Sneto, G. (2003) *How to Mobilise Communities for Health and Social Change*. Health Communication Partnership/USAID, Washington DC. http://www.jhuccp.org/mmc/index.stm
22 International HIV/AIDS Alliance (2005) *Tools Together Now! Participatory Tools to Facilitate Mobilising Communities for HIV/AIDS*. IHAA, Brighton.
23 Donahue, J. and Williamson, J. (1999) *Community Mobilisation to Mitigate the Impact of HIV/AIDS. USAID,* Washington, DC.
24 Shah, M., Zambezi, R. and Simasiku, M. (1999) *Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents.* FOCUS on Young Adults Programme, Washington DC. http://www.pathfind.org/pf/pubs/focus/RPPS-Papers/pla1.pdf
25 Zambezi, R. and Hernandez, J.J. (2006). *Engaging communities in youth reproductive health and HIV projects: A guide to participatory assessments.* Family Health International, Arlington, VA. http://www.fhi.org
26 UNAIDS Definition on Social Change Communication. http://data.unaids.org/pub/Report/2007/jc1404- socchangecomm_en.pdf
27 Franklin, B., Flanagan, and Mahler, H. "Evaluating Behaviour change communication interventions," in Rehle, T. et al (2003) *Evaluating Programmes for HIV/ AIDS Prevention and Care in Developing Countries.* Family Health International, Arlington, VA.
28 Rehle, T., Saidel, T., Mills, S. and Magnani, R. (Eds) (2003) *Evaluating Programmes for HIV/ AIDS Prevention and Care in Developing Countries*. Family Health International, Arlington, VA.
29 Family Health International (2006) *The Role of Community Involvement in Improving Reproductive Health and Preventing HIV among Young People Report of a Technical Consultation.* November 8-9, 2005, FHI, Arlington, VA.
30 Maclean, A. (2006) *Community Involvement in Youth Reproductive Health: A Two-Part Review and Analysis of the Literature*. Family Health International/YouthNet, Washington DC.
31 International HIV/AIDS Alliance (2007) *Community engagement for universal access.* http://www. aidsalliance.org
32 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.*
33 ibid
34 UNFPA and Youth Peer Education Network (Y-PEER) and Family Health International/YouthNet (2005) *Youth Peer Education Toolkit.* UNFPA, New York.
35 Wellborn, A. (1995) *Stepping Stones: A training package in HIV/AIDS, communication and relationship skills,* Strategies for Hope, UK.
36 WHO (2004) Evidence for Action: Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. WHO, Geneva.

with other males and young people in conflict with the law); activities to inform and change norms in relation to gender and sexuality,[37] condom distribution, delivery of clinical care,[38] medication and referrals to providers of care, support and prevention services. The media can also be used to mobilise, inform and promote change in the community.[39] However, HIV programmes need to move from an intervention or service paradigm to one of community engagement based on human rights. This would ensure that segmented and tailored information and skill-building for individuals are coupled with mass media attention, social mobilisation, advocacy and leadership to change policies and social norms and to invest in reducing the vulnerability of disadvantaged and marginalised populations.[40]

Young community members living with HIV can be powerful educators, serving as role models and reducing stigma surrounding HIV and AIDS. However, their involvement must be carried out in a planned, sensitive and responsible manner to avoid becoming tokens or being exposed to further stigma and discrimination. The Internet is being increasingly used by groups of young people to educate others about HIV-related issues; however, its effectiveness has not yet been properly evaluated.

A systematic review of HIV interventions for young people, delivered in geographically bounded communities in developing countries, classified the interventions into four categories and found the following degrees of success:[41]

1. ***Interventions targeting adolescents and youth and delivered through existing organizations or centres*** were most likely to be sustainable and yield positive results. These types of social change-communication interventions produced the greatest effect in changing knowledge, communication skills and sexual behaviours among young people.
2. ***Community-wide interventions delivered through existing kinship networks*** have the capacity to cover a wide range of issues once the system for delivering the intervention has been established.
3. ***Community-wide interventions delivered through activities such as faith-based organizations and festivals*** were found to have the widest reach and to be the most successful in addressing community norms and producing community-wide responses.
4. ***Interventions targeting adolescents and youth by creating new systems and structures*** were not likely to be sustainable.

National AIDS Responses

Community-based interventions include adult gate-keepers in providing access to services for young people.

Young people are the main target group for a Reproductive Health Initiative for Youth in Asia (RHIYA) programme (including HIV). However, to establish a more comprehensive and integrated approach, influential stakeholders-community elders, parents, school teachers, religious leaders, health service providers and volunteers-are the indirect beneficiaries of the project. The involvement of religious leaders has been critical to gain community acceptance of education on reproductive health and HIV and for the creation of Youth-Friendly Centres (YFCs), both for girls and boys.[42]

Community-based HIV interventions are delivered by young people.

In Zambia, young people are involved in care and support of people living with HIV. They were trained as caregivers, and local stakeholders promoted active collaboration between them and local institutions, including health centres, adult home-based care teams, community leaders and NGOs. Adults trained in providing home-based care by the Catholic Diocese of Mansa worked closely with youth, providing them with on-site supervision, skills training, psychosocial support and mentoring. The first referrals to the programme came from the youth club members themselves, based on their knowledge of relatives and neighbours with chronic illness (a commonly used euphemism for suspected HIV or AIDS). Over time, youth caregivers became more trusted, and more community members began to refer other people living with HIV to the programme.[43]

37 International HIV/AIDS Alliance (2007) *Keep the best, change the rest: Participatory tools for working with communities on gender and sexuality.* IHAA, Brighton.
38 http://hivinsite.ucsf.edu/InSite?page=li-07-12
39 Pinkerton, S. D., Kahn, J. and Outbrave, D. R. (2002). "Cost-effectiveness of community-level approaches to HIV prevention: A review." *Journal of Primary Prevention*, 23, 175-198.
40 UNAIDS (2007) *Expert Consultation on Behaviour Change in the Prevention of Sexual Transmission of HIV: highlights and recommendations.* UNAIDS, Geneva.
41 Maticka-Tyndalea, E. and Brouillard-Coyle, C. (2006) "The effectiveness of community interventions targeting HIV and AIDS prevention at young people in developing countries" in *Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries.* Eds. Ross, D. et al., WHO and UNAIDS Interagency Task Team on Young People, Geneva.
42 http://sachet.org.pk/home/programs/rhiya.asp
43 Esu-Williams, E. et al (2004) "Involving Young People in the Care and Support of People Living with HIV and AIDS in Zambia: Final Report of an Operations Research Study in Luapula and Northern Provinces," *Population Council,* Washington, DC. http://www.popcouncil.org/pdfs/horizons/zmbcsythfnl.pdf

Community-based interventions reduce discrimination against marginalised young people.

The Frontiers Prevention Project in Ecuador worked with many groups that were marginalised and discriminated against. Among them, young transgendered people were at higher risk of exposure to HIV. During the project, they designed their own programme to mobilise their peers to address HIV and AIDS. They later went on to form Ecuador's first transgender NGO to demand access to health services and other fundamental human rights. Mobilising discriminated communities such as young transgendered people not only reduces HIV incidence among this particular community, but also prevents HIV infection from spreading to the wider community.[44]

Challenges

Despite the emerging evidence that community interventions do work, there are several challenges that need to be borne in mind:

- ***Diversity*** Communities are not homogeneous, and community members are not all equal; young people themselves are diverse. Social relationships and power dynamics will influence who is most able to participate. Leaders from government, religion and other areas can help or hinder the ability of young people to obtain information and make safe choices regarding their sexual health[45] and substance use.
- ***Gender*** Male and female gender roles and power differences between young men and women and between older men and young women influence their ability to participate in interventions; to access HIV prevention, treatment and care;[46] and to protect themselves from gender-based violence.
- ***Age*** Young people and adults in a community often have different perspectives. Involving only adults or young people in HIV programmes can create an unsafe environment for young people.[47]
- ***Social and cultural norms*** In many countries, husbands and mothers-in-law make the final decision about whether, when and what kind of sexual and reproductive health care young married women can seek.[48] Key life and health decisions for young people are frequently made by family members and dictated by community norms.[49]
- ***Sustainability*** Community-based interventions are often resource intensive and may be difficult to sustain because of changes in the community; for example, it may be difficult to retain young peer educators and outreach workers from at-risk populations. Moreover, consistent sources of funding are often difficult to identify.
- ***Monitoring and evaluation*** Community HIV interventions often pose many challenges for monitoring and evaluation (see later).

Partnerships and Multi-sectoral Approaches

Both adults and young people need to be involved as partners in initiating HIV prevention, treatment, care and support efforts.[50] Scaling-up community HIV interventions for young people requires establishing new partnerships with a range of other organizations. In some countries (such as Cambodia), a commune or municipal system is already in place whereby local Councillors develop a multi-sectoral, five-year development plan and a one-year rolling investment plan. The empowerment and involvement of young people in such local planning processes allow them to identify problems affecting them within their communities and recommend ways and means to address the issues. Furthermore, better understanding of HIV and AIDS by local authorities would facilitate advocacy for integration of HIV interventions for young people into local planning processes.

Such initiatives require capacity building and resource mobilisation to ensure that all relevant groups of young people, as well as key community leaders and local stakeholders, are included.[51]

Monitoring and Evaluation

A systematic review of community-based HIV prevention interventions for young people found many challenges in measuring their effectiveness.[52] Interventions that involve

44 International AIDS Alliance (2005) *Tools Together Now! Participatory Tools to Facilitate Mobilising Communities for HIV/AIDS*. IHAA, Brighton.
45 Family Health International (2006) *The Role of Community Involvement in Improving Reproductive Health and Preventing HIV among Young People Report of a Technical Consultation*. November 8-9, 2005, FHI, Arlington VA.
46 International Community of Women Living with HIV/AIDS (2004) *HIV Positive Young Women*. ICW Vision Paper No 1, London.
47 Family Health International (2006) *The Role of Community Involvement in Improving Reproductive Health and Preventing HIV among Young People* Report of a Technical Consultation. November 8-9, 2005, FHI, Arlington VA.
48 Barua, A. and Kurz, K.M. (2001) "Reproductive Health-seeking by Married Adolescent Girls in Maharashtra, India." *Reproductive Health Matters,* 9(17).
49 Family Health International (2006) *The Role of Community Involvement in Improving Reproductive Health and Preventing HIV among Young People* Report of a Technical Consultation. November 8-9, 2005, FHI, Arlington VA.
50 ibid
51 International AIDS Alliance (2005) *Tools Together Now! Participatory Tools to Facilitate Mobilising Communities for HIV/AIDS*. IHAA, Brighton.

communities are often complex; the availability of documentation varies widely, making comparisons difficult; and the evolutionary nature of community involvement compounds the inherent challenges of evaluation.[53]

- ***Attributing results to community involvement is difficult.*** Many evaluators question what should be evaluated-health outcomes, participation levels, improved capacities, or some combination of all of these?[54] The contribution of community involvement to HIV outcomes among young people is also not clearly documented.[55 56]
- ***Standard indicators of community involvement do not exist.[57]*** Therefore, it is difficult to compare results from different studies. Evaluators must decide whether to focus on community involvement as a means to influence young people's behaviours, to build a stronger community, or both.[58]

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- Advocate for the establishment of mechanisms to allow young people (including HIV-positive young people) to participate in:
  - Identifying their unfulfilled rights in relation to HIV prevention, treatment and care
  - Community-based solutions to HIV-related stigma and discrimination
  - Research on the effectiveness of community-based HIV interventions
- Implementing solutions, monitoring, evaluating and reporting on community-based HIV prevention and treatment interventions
- Advocate for programmes to address cultural norms, beliefs and practices, recognising both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission through 1) stigma and discrimination towards young people living with HIV, 2) engaging in HIV risk behaviour and 3) limiting access to and use of HIV prevention and treatment services.
- Support social change communication programmes and community-based responses to scale-up access of young people to a continuum of interventions for HIV prevention, treatment, care and support services.[59]
- Advocate for a system to monitor young people's participation in community-based HIV interventions (broken down by age, sex, diversity, HIV status and risk behaviour).

52 Maticka-Tyndalea, E. and Brouillard-Coyle, C. (2006) "The effectiveness of community interventions targeting HIV and AIDS prevention at young people in developing countries" in *Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries*. Eds. Ross, D. et al., WHO and Inter-Agency Task Team on HIV and Young People, Geneva.

53 Family Health International (2006) The Role of Community Involvement in Improving Reproductive Health and Preventing HIV among Young People Report of a Technical Consultation. November 8-9, 2005, FHI, Arlington VA.

54 ibid

55 Laverack, G. and Labonte, R. (2000) "A planning framework for community empowerment goals within health promotion." Health Policy and Planning, Vol. 15(3):255-62.

56 Gibbon, M., Labonte, R. and Laverack, G. (2002) "Evaluating community capacity." Health and Social Care in the Community, Vol. 10(6):485-91.

57 UNAIDS has recently recommended a general indicator for community involvement: percentage of community gatherings (e.g. local government, tribal, faith-based) that provide the opportunity for dialogue and planning on the prevention and management of HIV. See UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS, Geneva.

58 Building a stronger community may not have better short-term results for young people's behaviours, but it may help sustain an intervention and build long-term investment in better health outcomes.

59 Adapted from one of the Essential Policy Actions for HIV Prevention - UNAIDS (2006) UNAIDS action plan on intensifying HIV prevention 2006 to 2007. UNAIDS, Geneva.

Key resources:

Family Health International (2006) *The Role of Community Involvement in Improving Reproductive Health and Preventing HIV among Young People* Report of a Technical Consultation. November 8-9, 2005, FHI, Arlington. *http://www.fhi.org*

International Community of Women Living with HIV/AIDS (2004) *HIV Positive Young Women.* ICW Vision Paper No 1, London. This document clearly identifies some of the problems faced by HIV positive women in taking forward HIV interventions in their respective communities. *http://www.icw.org*

International Council of AIDS Service Organizations, the African Council of AIDS Service Organizations, and the International HIV/AIDS Alliance (2007) *Guidelines on the Involvement of the Community Sector in the Coordination of National AIDS Responses Background to Involving Communities.* IHAA, Brighton. *http://www.aidsalliance.org*

International HIV/AIDS Alliance (2005) *Tools Together Now! Participatory Tools to Facilitate Mobilising Communities for HIV/AIDS.* IHAA, Brighton. *http://www.aidsalliance.org/graphics/secretariat/publications/All_Together_Now.pdf*

International HIV/AIDS Alliance (2007) *Keep the best, change the rest: Participatory tools for working with communities on gender and sexuality.* IHAA, Brighton. *http://www.aidsalliance.org/graphics/secretariat/publications/Gender_sexuality_toolkit_P1.pdf*

Maticka-Tyndalea, E. and Brouillard-Coyle, C. (2006) "The effectiveness of community interventions targeting HIV and AIDS prevention at young people in developing countries" in *Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries*. Eds. Ross, D. et al., WHO and Inter-Agency Task Team on HIV and Young People, WHO, Geneva. *http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf*

Maclean, A. (2006) *Community Involvement in Youth Reproductive Health: A Two-Part Review and Analysis of the Literature.* Family Health International/ YouthNet, Washington DC.

Rehle, T., Saidel, T., Mills, S. and Magnani, R. (Eds) (2003) *Evaluating Programmes for HIV/ AIDS Prevention and Care in Developing Countries*. Family Health International, Arlington, VA.

UNAIDS (2007) *Expert Consultation on Behaviour Change in the Prevention of Sexual Transmission of HIV: Highlights and recommendations.* UNAIDS, Geneva.

UNFPA and Youth Peer Education Network (Y-PEER) and Family Health International/ YouthNet (2005) *Youth Peer Education Toolkit.* UNFPA, New York. *http://www.fhi.org/en/Youth/YouthNet/Publications/peeredtoolkit/index.htm*

Engaging Faith-based Organizations in HIV Prevention: A Training Manual for Programme Managers, UNFPA, 2007 *http://www.unfpa.org/upload/lib_pub_file/705_filename_HIVTraining%20Manual%20eng%20.pdf*

Welbourn, A. (1995) *Stepping Stones: A training package in HIV/AIDS,* communication and relationship skills. Strategies for Hope, UK.

Useful web pages:

Youth community networks include:

Global Youth Coalition on HIV/AIDS
http://www.youthaidscoalition.org

Global Youth Network
http://www.unodc.org/youthnet/en/youthnet_action.html

International Youth Harm Reduction Network
http://projects.takingITglobal.org/harmreduction

Living Positively
http://www.youthaidscoalition.org/living.html

Further information and responsible agencies under UNAIDS Technical Support Division of Labour on HIV and Young People

Prevention of HIV through the media and in community sectors is cross-cutting and the responsibility of all co-sponsors: **ILO, UNAIDS Secretariat, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC**, the **World Bank, WFP**, and **WHO**.

There is as yet insufficient evidence of the effectiveness of some of the interventions outlined in the Briefs and for the use of some of the interventions outlined for certain target populations. Similarly, many of the studies of effectiveness do not disaggregate the research findings by sex. Where there is insufficient evidence, the interventions that are described are based on good practice, and it is recommended that in addition to monitoring coverage and quality, such interventions be evaluated and the results of their effectiveness fed back into the global evidence base.

For more information on the Inter-Agency Task Team on HIV and Young People visit: http://www.unfpa.org/hiv/iatt

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Global Guidance Brief

HIV Interventions for Young People in the Workplace

Purpose

This Brief 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 effective HIV interventions for young people[3] in workplace settings. It is part of a series of seven global Guidance Briefs that focus on HIV prevention, treatment, care and support interventions for young people that can be delivered through different settings for a range of target groups.

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.

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 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.

Introduction

The majority of people living with HIV are engaged in some sort of productive activity.[6] Certain types of work are known to increase vulnerability to HIV,[7] but exposure to risk may arise from a broad range of working conditions, including mobility, isolation, stress, single-sex living arrangements and gender inequalities at the workplace.[8] Other workplace issues include discrimination and stigma on the basis of real or perceived HIV status, and the fear of both.

The workplace provides an opportunity to extend access to HIV prevention, treatment, care and support services through education and training programmes, health and safety policies, support for treatment adherence, skills development and income support, and occupational health services. In addition, workplace policies set standards for the protection of workers' rights, including nondiscrimination related to HIV status.[9]

Young people, work and HIV

Since four out of ten of all new HIV infections are among youth 15 to 24[10] years of age, this has serious implications for productivity today and the workforce of tomorrow. High levels of youth poverty[11] and unemployment[12] contribute to HIV vulnerability, and when income is needed, young people may undertake work that is marginal, dangerous or illegal. The absence of decent work[13] opportunities and poverty may lead to a lack of a sense of purpose and social exclusion. As a result, young people may become homeless or be coerced into sex work. Both situations are associated with higher levels of HIV-risk behaviours.[14]

The loss of parents due to AIDS[15] and/or the need of HIV-affected households for additional income may also expose young people to the worst forms of child labour.[16 17] According to the Global Report on Child Labour, there are an estimated 218 million child labourers below the age of 18 in the world.[18] A rapid assessment study by the ILO in Zambia in 2002 estimated that HIV/AIDS increased the child labour force between 23 and 30 per cent. A survey in Uganda in 2004 found that more than 95 per cent of children living in AIDS-affected households were engaged in some type of work. Sixteen per cent of the working children — mostly girls — worked both day and night.[19]

Gender

Girls are more likely overall than boys to stay at home and look after ill parents or younger siblings, thereby foregoing education.[20] The effects of not attending school are greater for girls than for boys, and their impact transfers to the next generation. Whether educated or not, girls are more vulnerable than boys to sexual abuse, exploitation, trafficking and domestic labour,[21] putting them at serious risk of HIV.[22]

Various types of work may oblige young people to spend time away from home, and this often has a gender dimension. Military personnel (who are predominantly young and male) may face above-average risk for STIs, including

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6 ILO (2006) *HIV/AIDS and Work: Global estimates, impact on children and youth,* and response. ILO, Geneva.
7 ILO and WHO (2005) *Joint ILO-WHO guidelines on health services and HIV/AIDS.* ILO, Geneva.
8 ILO (2002) *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work*: An education and training manual. ILO, Geneva.
9 ILO (2001) *The ILO Code of Practice on HIV/AIDS and the World of Work*. ILO, Geneva.
10 UNAIDS (2007) AIDS Epidemic Update: Briefing Booklet. UNAIDS, Geneva. Data are not disaggregated for those age 10 to 14.
11 Youth are over-represented among the world's poor (ILO, 2006) *HIV/AIDS and Work: Global estimates, impact on children and youth, and response.* ILO, Geneva.
12 Young people are two to three times more likely to be unemployed than adults, with significantly higher levels of poverty and unemployment among young women (ILO, 2006) *HIV/AIDS and Work: Global estimates, impact on children and youth, and response.* ILO, Geneva.
13 Decent work is fairly paid, in reasonable working conditions, respecting the rights of workers and equal opportunities for women and men. http://www.ilo.org/public/english/decent.htm
14 Republic of Armenia, National Centre for AIDS Prevention (2006) *Results of behavioural and biological HIV surveillance in the Republic of Armenia: 2002/2005* found that in 2004, 73% of first injecting drug use in Armenia was in men over 30 years, whereas 48.5% of first injecting drug experience outside Armenia occurred in younger men age 20 to 29 years.
15 In 2007, it was estimated that 15 million children had lost one or both parents to HIV. Millions more have experienced deepening poverty, school dropout and discrimination as a result of the epidemic - UNICEF, UNAIDS and WHO (2008) *Children and AIDS: Second stocktaking report.* UNICEF, Unite for Children, Unite against AIDS, New York.
16 Not all forms of work undertaken by children are considered child labour under ILO standards. Light work that does not interfere with education is permitted from the age of 12 years, as is work by children 15 years and above that is not classified as hazardous. See the website of the ILO Programme to End Child Labour (IPEC) http://www.ilo.org/ipec
17 Two important documents identify the worst forms of labour for children: the United Nations (1989) *Convention on the Rights of the Child,* UN, New York and the ILO (1999) *Worst Forms of Child Labour Convention*, ILO, Geneva.
18 Of these about 166 million are age 5-14, and approximately 52 million are between 15 -17 years of age; 126 million child labourers work in hazardous conditions. In sub-Saharan Africa, the country with the deepest and most extensive AIDS pandemic, there are almost 50 million child labourers age 14 or under. This is 26.4% of the under-15 population. There are also an estimated 122 million child labourers under 15 in the Asia and Pacific Region and 5.7 million in Latin America. There are a further 13.4 million in other regions. - see ILO (2006) Global Report on Child Labour. ILO Programme to End Child Labour (IPEC), Geneva.
19 Rau, B. (2002) *Combating child labour and HIV/AIDS in sub-Saharan Africa: A review of policies, programmes, and projects in South Africa, the United Republic of Tanzania and Zambia to identify good practices.* ILO IPEC Working Paper no 1, Geneva.Rau, B. (2002) Intersecting Risks: HIV/AIDS and Child Labour. ILO IPEC Working Paper no 8, Geneva.
20 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV Interventions for Young People in the Education Sector.*
21 Fyfe, A. (2007) *The Worldwide Movement Against Child Labour: Progress and Future Directions.* ILO, Geneva.
22 The Global Task Force on Child Labour and Education for All (2007) *Reaching the unreached - our common challenge*. ILO, Geneva.

HIV.[23 24] Underage and child soldiers (predominantly boys) are a particular concern.[25 26] Truck drivers and their mates in Africa and India are often young males who may have girlfriends, including sex workers, at a number of truck stops.

Children orphaned by AIDS suffer in a variety of ways. Not only do they lose their parents, but with them essential life skills and traditional knowledge (such as farming skills).[27] Without access to assets, and often left with the responsibility for their households and younger siblings, many children are forced into work, becoming especially vulnerable to exploitation and harassment.[28]

The estimated 50 million children orphaned as a result of AIDS over the next two decades will enter the workforce with many disadvantages: gaps in education, psychological problems associated with the trauma of a lost parent or parents, lack of social structure to guide effective decision making, and the stigma and discrimination surrounding people affected by HIV/AIDS. They will not be the first choice of formal-sector employers unless they have completed their schooling.[29]

Without guardians, social support or income, young people may also be forced onto the streets. UNAIDS estimates that more than 120 million children worldwide live (and scrape out a living) on the streets.[30] High levels of sexually transmitted infections,[31] including HIV, have been reported among these children, [32] making it critical that HIV interventions are targeted to them. [33]

The majority of young people are forced to find or make opportunities to earn their livelihoods in the informal economy, where underemployment, poor working conditions and the lack of labour protection are endemic. These young workers need targeted interventions at both policy and workplace levels. [34]

In some countries the lack of work opportunities leads to the migration of young people in search of employment, including to countries with higher HIV prevalence. Young migrant workers away from their usual home environments, social norms and community structures may be under great pressure to have sex that is often unprotected. For example, young factory workers in Nepal, who had migrated from rural areas for work, reported experiencing sexual intercourse (one in five boys and one in eight unmarried girls), despite religious and cultural restrictions. Half of international migrants, about 95 million, are women and girls. They make substantial contributions to their families at home and communities abroad, but their needs continue to be overlooked, [35] including their disproportionate vulnerability to trafficking, exploitation and abuse. [36]

Effectiveness of Workplace-Based HIV Interventions

Young people who are at the centre of concentrated epidemics urgently require interventions based on good practice.[37] There is a significant body of evidence[38] that demonstrates the effectiveness of HIV interventions in the prevention and treatment of HIV among young people. The world of work is a vital channel for reaching young workers, the young unemployed and young people in vocational training. The challenge is to extend these evidence-informed interventions to young people involved in the informal economy, child labourers and those who have been trafficked for employment and sexual exploitation.

23 Boyer, C. et al (2001) "Prevention of sexually transmitted diseases and HIV in young military men" *Sexually Transmitted Diseases*, 28(6): 349-355. June.
24 Scalway, T. (2001) *Young men and HIV: Culture, poverty, and sexual risk*. UNAIDS, PANOS, London.
25 The UN lists 12 countries in which an estimated total of 250,000 children are found in military service, among them Sri Lanka, Uganda, Nepal, and Philippines. There may be as many as 70,000 child soldiers engaged in government and rebel armies in Burma. These countries are now under pressure to sign the "Optional Protocol" to the CRC which would compel new laws and reintegration of child solders into normal life. The International Criminal Court already considers the recruitment of children under age 15 for military purposes to be a war crime.
26 http://www.aidsandemergencies.org/overview2.html
27 Agriculture accounts for 70 per cent of child labour worldwide. http://www.fao.org/newsroom/en/ news/2006/1000394/index.html
28 http://www.fao.org/newsroom/en/news/2006/1000394/index.html
29 Rau, B. (2002) *Combating child labour and HIV/AIDS in sub-Saharan Africa: A review of policies, programmes, and projects in South Africa, the United Republic of Tanzania and Zambia to identify good practices.* ILO IPEC Working Paper no 1, ILO, Geneva.
30 UNAIDS (2002) *HIV/AIDS stigma and discrimination.* UNAIDS Best Practice Collection, Geneva.
31 In Jakarta, Indonesia, one in every seven street children had a history of STIs, Monitoring the AIDS Pandemic (MAP) Network (2001) *The status and trends of HIV/AIDS/ STI epidemics in Asia and the Pacific.* Melbourne. http://ww.aids.org/hivaidsinfo/statistics/map/MAP2001.doc
32 Saint Petersburg, 37.4% of 313 street children in were found to be HIV positive. Kissin, D. M. et al (2007) "HIV seroprevalence in street youth, St Petersburg, Russia," AIDS, 21(17): 2333-2340, November.
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 more information on the interventions and the most appropriate methods for delivering them in different contexts.
34 ILO (2005) *Youth Employment: Pathways to Decent Work.* Report VI, International Labour Conference, ILO, Geneva.
35 UNFPA (2006) *A Passage to Hope: Women and International Migration.* UNFPA, New York.
36 Puri, M. and Cleland, J. (2006) "Sexual behaviour and perceived risk of HIV/AIDS among young migrant factory workers in Nepal," *Journal of Adolescent Health,* 38(3):237-246.
37 Aggleton, P. and Rivers, K. (1999) "Interventions for adolescents" in: Gibney, L., DiClemente, D. and Vermund, S. eds. *Preventing HIV in developing countries: Biomedical and behavioral approaches.* New York, Plenum Publications: 231-255.
38 WHO, UNFPA, UNODC, UNAIDS, YouthNet (2004) *Protecting Young People from HIV and AIDS: The Role of Health Services.* WHO, Geneva. http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_159247_8.htmWHO, UNFPA, UNAIDS, YouthNet (2003) *Achieving the Global Goals: Access to Services, Technical Report of a Global Consultation on the Health Services Response to the Prevention and Care of HIV/AIDS among Young People.* WHO, Geneva. http://www.who.int/child-adolescent-health/New_Publications/ ADH/ISBN_92_4_159132_3.pdf

National AIDS Responses

The location and nature of workplace interventions will depend on the stage of the epidemic. In low-level and concentrated epidemics, the emphasis should be on prevention and non-discrimination, with a focus on identifying economic sectors and populations with higher than average levels of risk, including child labourers, transport workers, miners and workers in the leisure industry. The formal-sector workplace, which is male-dominated in many countries, also offers opportunities to reach the clients of sex workers. Their health and safety/employee assistance programmes often include interventions on substance abuse, which can be linked to HIV-risk reduction.[39] In generalised or hyperendemic situations, broad-based HIV interventions at the workplace should be core elements of the national AIDS strategy.[40]

Behaviour change communication

Education, training and life skills help prepare a young person for adult life and work. Workplace settings (including apprenticeship and vocational training programmes) are ideal for imparting life skills, providing HIV information and education, and influencing behaviour. Workplaces provide an environment where young people may come together with adults to discuss, interact and learn from each other. In Papua New Guinea, HIV has been incorporated into the curriculum of all vocational training under the direct control of the Ministry of Labour. In Vietnam, job centres that are part of a national network have become social gathering points for young people, and they increasingly convey HIV information as well as job offers.

Peer education is a successful strategy in many settings, especially as part of behaviour change communication.[41] In Ghana, an ILO project linked up with apprentice mechanics and trained a corps of peer educators in small garages in and near the main cities. In Abidjan, Cote d'Ivoire, peer education has been successful in building unity among sex workers to insist on condom use.[42] In Brazil, HIV interventions with young military conscripts have been conducted since the 1990s with remarkable success: there has been a consistent increase in the use of condoms among young conscripts, from 38 per cent in 1997 to 50 per cent in 2000. Since then, new course materials have been developed, including a training guide and a peer-education toolkit specifically adapted to the Brazilian setting.[43]

Examples of the awareness-raising activities that need to be in place when working with young people in both the formal and informal economies have been identified in the manual on Supporting Children's Rights through Education, the Arts and the Media (SCREAM) and include:

- Increasing community awareness about the problem of HIV and child labour
- Educating and empowering young people to give them responsibility for awareness-raising and to participate fully with other young people in finding solutions
- Fighting stigma targeted at individuals infected and affected by HIV in schools, the workplace and society
- Promoting responsible sexual behaviour and faithful relationships; encouraging young people to talk about sex, its dangers and safe practices; and educating men to respect women's rights to "say no to sex"
- Sensitising the community about sexual and reproductive health (including homosexuality), gender-based violence and sexual abuse, and substance use; promoting more awareness and responsibility among men for reproductive health issues
- Identifying and disseminating good practices on HIV and child labour[44 45]

Access to health services[46]

Employers are improving access to health services for young people, both directly and indirectly. Occupational health services are being adapted to provide HIV prevention and care, including treatment of sexually transmitted infections (STIs) and opportunistic infections as well as antiretroviral therapy. These services lend themselves well as support for treatment adherence. Smaller enterprises are pooling resources to share the services of a nurse on a part-time basis. Workplaces promote access to health through health insurance and referral to public services. Evidence from many enterprises shows that uptake of HIV-prevention messages, as well as of opportunities for voluntary HIV testing and treatment, is greater where trust has been built as a result of employment protection,

39 http://www.ilo.org/public/english/protection/safework/
40 http://mirror/public/english/protection/trav/aids/publ/access.pdf
41 ILO/Family Health International (2003) *HIV/AIDS Behaviour Change Communication: A tool kit for the workplace.* ILO, Geneva - provides examples and guidance, including a chapter on peer education.http://www. ilo.org/public/english/protection/trav/aids/publ/bcctoolkit.htm
42 ILO (2002) *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work: An education and training manual.* ILO, Geneva.
43 http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2006/20060227_brazil.asp
44 ILO (2008). *SCREAM Supporting Children's Rights through Education, the Arts and the Media: A special module on HIV, AIDS and child labour.* International Programme on the Elimination of Child Labour (IPEC), ILO, Geneva.
45 ILO (2004) *Youth at risk: The role of skills development in facilitating transition to work.* In Focus Programme on Skills, Knowledge and Employability, ILO, Geneva
46 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on HIV, Young People and Health Sector Interventions* for information on an evidence-informed package of health interventions and the most appropriate methods for delivering it in different contexts.

non-discrimination and employer-worker collaboration.[47] Mechanisms need to be in place to extend these services to young people working informally who may not have health insurance or who need access to prevention and care services without the consent of parents/guardians.

Creation of a safe and supportive environment

The creation of a safe and supportive environment includes nondiscrimination and respect for the rights of young people. This involves listening to the needs of different groups of young people, including those living with HIV, young women, men who have sex with men, young migrants and refugees, and rural youth.

Two sides of the same coin

The ILO, with several UN partners, held a youth consultation on HIV in Kigali, Rwanda, in November 2007. The aim was to listen to young people's own views of their needs and work out joint responses. A key issue was to make sure that AIDS policies and programmes address youth employment issues and vice versa. For young people, opportunities for decent and productive work and HIV prevention are two sides of the same coin. The meeting, which was attended by the Ministries of Youth and Labour as well as the President of the National AIDS Council, adopted the "Kigali Call to Action" and made a number of recommendations. Follow-up will include an integrated package of measures to promote youth employment and prevent HIV.

Workplace programmes based on the 10 key principles of the ILO Code of Practice on HIV/AIDS and the World of Work help protect the health and the rights of young people as well as reducing the social and economic impact of the epidemic.[48] These principles include the recognition of HIV as a workplace issue, confidentiality, gender equality, healthy work environments (including HIV prevention, treatment, care and support interventions), non-discrimination and social dialogue. In addition, the principles state that screening for HIV should not be required of job applicants or persons in employment and that HIV infection is not a cause for termination of appointment. The Code of Practice will be complemented by a new international labour standard on HIV/AIDS, currently under preparation for adoption by the 2010 International Labour Conference.

The world of work also provides structures and mechanisms to address social and economic issues such as: school-to-work transitions that include career planning and vocational/ entrepreneurial skills; job security; access to youth-friendly credit and financial services, social and welfare benefits; referrals to relevant legal services, self-help, youth and other community-based groups.[49]

Trade unions often have programmes to promote the engagement of young people as well as protecting the rights of workers facing HIV-related discrimination. Youth and Unions (UNI Youth) is working with governments, NGOs and community-based organizations[50] to enhance capacity and resources to progressively eliminate child labour, promote "Education for all" by the year 2015 and combat HIV/AIDS.[51]

For young unemployed people and those involved in the informal economy, attention needs to be placed on the development of livelihood skills. Tailored training programmes have been developed for vulnerable groups of young people. Examples include the Food and Agriculture Organization (FAO)-supported Junior Farmer Field and Life Schools in Africa, which provide agricultural training and education to out-of-school youth and young people orphaned by AIDS.[52] In addition, mechanisms need to be in place to:

- Provide vulnerable children affected and infected by HIV with social protection when their parents fall ill, lose their jobs or die; the aim is to prevent these children from becoming child labourers
- Resuscitate community-level social protection strategies so that children can be integrated rather than isolated as a result of HIV
- Provide subsidies to families for child care, food and education support, as well as life skills and vocational training to orphaned children, so that all children are guaranteed a childhood and can grow up to be productive, educated members of society[53]

In the Philippines, the National Union of Workers in the Hotel, Restaurant and Allied Industries (NUWHRAIN) has included a clause about sex tourism in its collective agreements with hotels.

The clause is based on a model agreement developed by the International Union of Food Workers (IUF), which

47 ILO (2001) The *ILO Code of Practice on HIV/AIDS and the World of Work*. ILO, Geneva.
48 ibid
49 ILO (2004) Youth at risk: *The role of skills development in facilitating transition to work*. In Focus Programme on Skills, Knowledge and Employability, ILO, Geneva.
50 For more on community-based HIV interventions see Inter-Agency Task Team (IATT) on HIV and Young People (2008) *Global Guidance Brief on Community-based HIV Interventions for Young People*.
51 Youth and Unions - UNI Youth (2004) World Youth Action Plan. Adopted by the 1st UNI World Youth Conference, 23/24 Oct. 2004, Berlin.http://www.union-network.org/uniyouth.nsf/ 9548462b9349db27c125681100260673/574f66b5650708fcc1256f5100480ed4?OpenDocument
52 http://www.fao.org/tc/tce/pdf/Swaziland_factsheet.pdf
53 ILO (2008). *SCREAM Supporting Children's Rights through Education, the Arts and the Media: A special module on HIV, AIDS and child labour*. International Programme on the Elimination of Child Labour (IPEC), ILO, Geneva.

outlines the rights of employees and responsibility of hospitality facilities (hotels, restaurants and bars) in the fight against sex tourism.[54]

Given the wide variation in sexual risk associated with the workplace, HIV intervention strategies should be tailored to address occupational-related factors as well as prevention more generally. Activities focusing on increasing young workers' ability to identify and avoid potential risk situations, to resist sexual advances and/or to negotiate condom use should be included in work orientation.[55]

Partnerships and Multi-Sectoral Approaches

A wide range of partners in public, private and non-profit sectors are already involved, or have the potential to become involved, in workplace-based HIV interventions with young people. Key actors are the organizations of employers and workers who work with ministries of labour to implement comprehensive programmes in the world of work: from skills and entrepreneurship development to gender equality and standard-setting, youth employment is a high priority. HIV and AIDS are being progressively integrated into these programmes. Some other partners and examples of their work are shown below. For potential partners, capacity may need to be built so they are aware of the range of effective responses and methodologies for delivering the interventions.

The Youth Employment Network (YEN)[56] -a joint initiative of the UN Secretary General, the World Bank and the ILO- provides a framework for action to promote, protect and support young people through employability, equal opportunities, entrepreneurship and employment creation.

The United Nations Foundation and United Nations Fund for International Partnerships (UNFIP) are collaborating with the Ethiopian Government, UNFPA, the Nike Foundation, the Population Council and local and international NGOs. In Addis Ababa and Bahir Dar, the project promotes advocacy and provides services to protect vulnerable migrant girls at risk of exploitation.

Comprehensive Partnership Strategies for HIV/STI Prevention among Young People in the Russian Federation (DFID-UNFIP) [57]

This project involved a number of UN agencies in partnership with government authorities and academic institutions. The ILO component covered:

1. Training staff in the vocational training and employment centres in the Altai territory and the Volgograd region
2. Developing an HIV/STI system ensuring access to information and medical services for vocational students and unemployed young people visiting these centres
3. Developing "Your Health" kit, 12 booklets on health issues for young people
4. Disseminating information about the project to other regions of the Russian Federation and nearby countries

Lessons learned

The best HIV-prevention practice is to integrate prevention education into information, occupational guidance and club activities aimed at older school children, students in vocational training and unemployed young people.

The UNFIP has also been involved with the United Kingdom Department for International Development (DFID) and other agencies in HIV/STI prevention in the Russian Federation (see box).

Monitoring and Evaluation

Mapping is required to track HIV interventions among young people at the workplace in order to extract lessons learned as well as to identify opportunities for HIV mainstreaming. Indicators for monitoring and evaluating workplace-based HIV interventions are included in UNGASS core indicators[58] as part of the National Composite Policy Index and as 1) a percentage of transnational companies in developing countries and that have workplace HIV policies and programmes;[59] and 2) a percentage of international organizations that have workplace HIV policies and programmes.[60] However, none of these

54 ILO (2002) *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work: An education and training manual.* ILO, Geneva. An extract from the model IUF is given as an example.

55 ibid

56 The Youth Employment Network (YEN) promotes youth employment and advises on policies and programmes involving youth. in 2003, a Youth Consultative Group (YCG) was established with YEN partner status, and consists of 13 global or regional youth organizations. www.ilo.org/yen

57 http://europeandcis.undp.org/files/uploads/John/ARN_RF_Bishkek_Nov2004.doc

58 UNAIDS (2007) *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators: 2008 reporting.* UNAIDS, Geneva, UNAIDS/07.12E / JC1318E. http://www.unaids.org

59 The United Nations Conference on Trade and Development (UNCTAD) list of the 100 largest transnational companies plus an additional 10 transnationals in the mining and tourism sectors are asked to state whether they are implementing personnel policies and procedures that cover, as a minimum, all of the following: 1. Prevention of stigmatisation and discrimination on the basis of HIV status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits. 2. Workplace-based HIV prevention activities that cover: (a) basic facts on HIV; (b) specific work-related HIV transmission hazards and safeguards; (c) condom promotion; (d) confidential voluntary counselling and testing; (e) STI diagnosis and treatment; and (f) provisions for AIDS-related drugs.

60 Major international organizations (UN, European Community, bilaterals and other international organizations with global coverage and a development, humanitarian, or emergency mandate) are asked to state whether they are implementing personnel policies and procedures that cover, as a minimum, the same as the UNCTAD requirements and in addition: training for HIV/AIDS control in conflict, emergency and disaster situations.

indicators make specific reference to the need to disaggregate data by age, sex and diversity of the workforce. Monitoring progress towards the Millennium Development Goal (MDG) 8[61] target (in cooperation with developing countries) to develop decent and productive work for youth involves reporting on youth unemployment rates. This, together with monitoring progress towards MDG 6 to halt and begin to reverse the spread of HIV/ AIDS, can shed further light on the role that employment plays in protecting young people against HIV.

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- In generalised and hyperendemic countries, advocate for rights-based, gender-sensitive and evidence-informed workplace HIV interventions for young people; in all countries, include a strategy for workplace interventions in HIV-prevention efforts for young people.
- Advocate that workplace-based HIV programmes disaggregate data by age, sex and diversity so that the specific needs of young men and women can be addressed; advocate that institutions submitting data on the UNGASS workplace indicators provide disaggregated data and routinely report on the HIV situation of young men and women.
- Advocate for communication and consultation with young people at the workplace and through their organizations.
- Advocate for the establishment of workplace-based mechanisms, including grievance procedures, to monitor and address stigma and discrimination experienced by young people living with HIV.
- Advocate that programmes promoting safer sex practices, life-skills- based education and the utilization of sexual health services target young workers in the informal economy and vulnerable young migrants. [62]
- Support training of UN staff in sexual and gender-based violence and HIV at the workplace and advocate for zero tolerance towards violence and harassment against women at work.
- Identify key partners (especially the organizations of employers and workers and their youth branches) to help support the national programme on HIV initiatives involving young people.
- Support research into HIV-risk behaviour among young people at work (including in the informal economy, on the street and in migrant-worker settings) and advocate for interventions to be implemented based on the findings.

61 MDG 8: To develop a global partnership for development.
62 Puri, M. and Cleland, J. (2006) "Sexual behaviour and perceived risk of HIV/AIDS among young migrant factory workers in Nepal," *Journal of Adolescent Health*, 38(3):237-246.

Key resources:

ILO (2002) *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work: An education and training manual.* ILO, Geneva.

ILO/Family Health International (2003) *HIV/AIDS Behaviour Change Communication: A tool kit for the workplace*. ILO, Geneva. *http://www.ilo.org/public/english/protection/trav/aids/publ/bcctoolkit.htm*

ILO and WHO (2005) *Joint ILO-WHO guidelines on health services and HIV/AIDS*. ILO/WHO, Geneva.

ILO (2006) *HIV/AIDS and Work: Global estimates, impact on children and youth, and response*. ILO, Geneva.

ILO (2008) *SCREAM Supporting Children's Rights through Education, the Arts and the Media: A special module on HIV, AIDS and child labour.* International Programme on the Elimination of Child Labour (IPEC), Geneva. *http://www.ilo.org/ipecinfo/product/viewProduct.do?productId=6884*

Rau, B. (2002) *Combating child labour and HIV/AIDS in sub-Saharan Africa: A review of policies, programmes, and projects in South Africa, the United Republic of Tanzania and Zambia to identify good practices.* ILO IPEC Working Paper no 1, Geneva.

UNFPA (2006) A *Passage to Hope: Women and International Migration*. UNFPA, New York.

Useful web pages:

Global March Against Child Labour
http://www.globalmarch.org

ILO Programme to End Child Labour (IPEC)
http://www.ilo.org/ipec
http://www.ilo.org/ipecinfo/product/viewProduct.do?productId=6884

The Youth Employment Network (YEN)
http://www.ilo.org/yen

Youth and Unions - UNI Youth
http://www.union-network.org/uniyouth.nsf

Further information and responsible agencies under UNAIDS Technical Support Division of Labour on HIV and Young People

ILO is the lead agency for HIV/AIDS workplace policies and programmes, and integration of HIV/AIDS in work-related programmes for youth.

The main partners in this effort are: **UNDP, UNESCO** and **UNHCR**.

There is as yet insufficient evidence of the effectiveness of some of the interventions outlined in the Briefs and for the use of some of the interventions outlined for certain target populations. Similarly, many of the studies of effectiveness do not disaggregate the research findings by sex. Where there is insufficient evidence, the interventions that are described are based on good practice, and it is recommended that in addition to monitoring coverage and quality, such interventions be evaluated and the results of their effectiveness fed back into the global evidence base.

For more information on the Inter-Agency Task Team on HIV and Young People visit: http://www.unfpa.org/hiv/iatt

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ABOUT THE IATT

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 relation to young people. The main purpose of the Task Team is to foster a joint accelerated, harmonized and expanded country-level response aimed at increasing young people's access to and utilization of HIV prevention, treatment and care services. UNFPA is the convener of this Task Team, and at the time that these Global Guidance Briefs were developed, membership of the Task Team was limited to the UNAIDS Secretariat and the ten UNAIDS Cosponsoring Organizations. In May 2008, the IATT was expanded to include partners from civil society, academia, youth networks/associations, the private sector and the development partner community.

For further information on the IATT on HIV and Young People, visit: http://www.unfpa.org/hiv/iatt

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