Background and rationale

Young people are at the centre of the global HIV epidemic. It is estimated that 5.4 million youth (15 to 24 years) are living with HIV, 58.5% of them are female and 41.5% male.\(^1\) Out of an estimated 6,800 new infections a day, 34.1% are in youth aged 15 to 24 years.\(^2\) Sub-Saharan Africa is home to almost two thirds (61.8%) of all youth living with HIV/AIDS (3.28 million), 76% of them female. South East Asia and the Pacific have the second highest prevalence, with an estimated 1.27 million youth living with HIV, 70% of whom are male\(^3\). 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 in this region.

The need to focus on HIV among young people has been endorsed by governments in a range of international fora\(^4\) and specific targets have been agreed to:

- Reduce HIV prevalence among young men and women (15-24) by 25% globally by 2010
- By 2010, ensure that 95% of youth aged 15–24 have information, education, services and life-skills that enable them to reduce their vulnerability to HIV infection (UNGASS)

Elements to be considered in the situation analysis

The overall situation analysis should include a breakdown of HIV/AIDS prevalence/incidence by age and sex. For young people, it is important to have disaggregation by 15-19 and 20-24 years, for the general population as well as for populations most at risk of HIV, such as injecting drug users, men who have sex with men, and sex workers. In some countries, information to identify young women who are especially vulnerable may be important, such as those working as domestic servants.

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\(^1\) UNAIDS/UNICEF databases (2007) - data are not available for young people 10 to 24 years.


\(^3\) UNAIDS/UNICEF databases (2007).

\(^4\) 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.
To more fully understand the extent of the epidemic in young people, information on the following is important:

- **Where is the virus:** which young people have the highest HIV prevalence rates (by age, sex), what are the risk behaviours underlying transmission, and where are the settings in which these behaviours occur?
- **Where is the virus going:** which young people are most vulnerable to becoming infected with HIV, as the virus moves from most at risk groups to other population groups (for example young married women or the regular partners of young sex workers)?
- **What are the factors affecting young people’s vulnerability to the virus:** what are the cultural, economic, social and political factors which make young people vulnerable to HIV, or force them into adopting high risk behaviours?

Sufficient evidence exists of the effectiveness of specific interventions to prevent HIV among young people.\(^5\)\(^6\) There are four core areas of action that target both risk and vulnerability reduction among young people, and that are reflected in the global goal of achieving universal access to services for HIV and AIDS prevention, treatment and care:

- information to develop knowledge
- opportunities and support to develop life skills
- appropriate and accessible health services for young people
- the creation of a safe and supportive environment

There is also growing clarity and consensus about the core activities of the health sector in response to HIV among young people:

- Strengthening strategic information for advocacy, policies and programmers;
- Supportive evidence-based policies;
- Service provision, improving quality and increasing utilization;
- Strengthening other sectors: what the health sector can do for others, and what others need to be doing for the health sector.

**This Service Delivery Area focuses on improving young people’s access to appropriate health services for prevention, treatment and care.**

There is a growing body of evidence\(^7\) that demonstrates the effectiveness of interventions delivered through health services for the prevention and treatment of HIV among young people.

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These include:

- **information and counseling** 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** for those young people who are sexually active;

- **harm reduction** for those who inject drugs;

- **diagnosis and treatment for sexually transmitted infections** to decrease HIV infection and identify individuals who require HIV information, condoms and provider initiated HIV testing and counseling because they have had unprotected sex;

- **male circumcision**, particularly in those communities where HIV prevalence is high and male circumcision rates are low: adolescent boys and young men are a key group for male circumcision;

- **voluntary HIV testing and counseling** is an essential HIV prevention opportunity for young people and for those who are HIV-positive, to provide them with prompt referral to HIV treatment, care and support services

- **treatment, care, and support services for young people living with HIV**

A systematic review of HIV prevention interventions among young people from developing countries demonstrates 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 (that they are more "adolescent/youth-friendly")

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8 Sterile injecting equipment and substitution therapy have proved effective amongst adult injecting drug users.


10 See http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf. Male circumcision among adolescent boys should also provide an important entry point for adolescent sexual and reproductive health, see the report from the East and Southern Africa CMMB/WHO FBO consultation (in press)


- Information about the services is provided in the community to generate demand and community support.

**Main activities to consider**

**Health system**

- *Health sector policies and legislation* can be barriers to the provision and use of health services, for example policies that restrict the provision of services and commodities to young people (particularly unmarried adolescents), and those that limit young people's use of services, such as policies relating to informed consent and confidentiality for minors. \(^{16,17}\)

- *Strategies.* While there is no one-size-fits-all approach to the provision of health services for young people, there are some guiding principles, such as: linking prevention and care; linking HIV services to other sexual and reproductive health interventions; and making existing services more responsive to the specific needs of young people. However, different strategies for delivering these services will be required, depending on the health infrastructure and the epidemiological characteristics of the epidemic, with particular attention needed for reaching adolescents and youth most at risk of HIV. Adequate referral systems are needed both within the health sector (from clinics to hospitals, from general practitioners to specialized services), and between the health sector and other sectors \(^{18}\) and organizations.

- *Standards for adolescent/youth-friendly health services* can provide clear vision and guidance on the provision of health 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 monitor the services that are provided. \(^{19,20}\)

**Health facilities**

- *Train service providers:* Standardized training of service providers is important. This can be done by including an HIV-related module into existing training programmes for health workers, \(^{21}\) focusing on the development of specific orientation and skills, \(^{22}\) or by including

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\(^{19}\) WHO (in press) Making Adolescent Friendly Health Services Happen, (check title)

\(^{20}\) See Adolescent and Youth Friendly Health Service Standards from India, Serbia, Tanzania, United Kingdom and Vietnam.


modules on the specific needs of adolescents in on-going in-service training programmes for health workers on HIV/AIDS.  

- **Make changes in the facilities**: Consideration needs to be given to the many factors that may influence young people’s willingness to use facilities, for example ensuring that they are open when young people are able to use them; that they are affordable (through the possible use of voucher schemes); and that privacy and confidentiality are respected when young people consult health care providers.

**Family and community component**

- **Demand Creation**: In addition to improving the quality of HIV-related health services for young people, it is also important to generate demand. Families and communities 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 use them.

- **Generating Community Support**: Adolescents’ use of health services remains a sensitive issue in many communities. It is therefore important to contact, inform and involve a range of gatekeepers, from parents 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 HIV prevention and care health services for young people.

**Defining and quantifying target population**

**Target Populations.** Different groups of young people have specific needs, for example, adolescent boys and girls, younger adolescents and older youth, those already engaging in HIV risk behaviours, rural and urban youth, married and unmarried youth. It is therefore important that services are sensitive to the needs of these different groups, and that health services are accessible not only to the general population of young people, but also to those who are most at risk of HIV (MARA). At the same time, it is important not to over-load programmes with too much heterogeneity.

Two groups need particular attention:

**Young People Most at-risk of HIV**

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24 WHO (2007) *Guidance for Provider Initiated Testing and Counselling*, Geneva; and


The majority of most at-risk adolescents (MARA) and youth do not receive the health services that they require. 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 other population groups most at risk of HIV. In addition they should support the collection and dissemination of strategic information about MARA, including promoting the disaggregation of all data by age and sex; ensure that there is a supportive policy environment, including linking with other sectors, such as criminal justice; and providing overall guidance and support, standards and training materials, for other partners, such as NGOs who are in contact with MARA, to strengthen the capacity to respond to the needs of adolescents and youth.

**Young People Living with HIV**

Strengthening the health sector response to treatment, care, support and prevention for young people living with HIV is a challenge in many countries. Issues that require further development include:

- Health service standards for the provision of services for young people living with HIV
- Minimum and minimum-plus treatment/care packages
- Psychosocial support, particularly important for adherence, disclosure, dealing with stigma/discrimination, and preventing high-risk behaviours
- Orientation and training of health staff to provide appropriate information and services
- Train and support young people living with and affected by HIV to contribute to health sector activities
- Linking with other sectors to strengthen the health sector response

**Costing the activities**

While there are a number of tools available to undertake cost assessments for health service provision, none of these have been designed explicitly to examine the costs of quality services for young people. In recognition of the need for cost data, WHO/CAH has developed tools for estimating costs related to health service provision for young people. A strategic decision was made to focus efforts on assessing costs of existing interventions and programmes. The tools therefore provide information on current resource use, which can be used to assess different delivery strategies and their cost implications.

In order to be relevant to on-going planning for the provision of health services related to the MDGs, the WHO/CAH tools were designed around a set of key interventions addressing sexual and reproductive health and HIV prevention. The five default interventions included in the generic model are:

- information and counseling for sexual and reproductive health,

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27 A young people living with and affected by HIV support group has been established in the Republic of Moldova and other countries.
• provision of contraceptives, including condoms,
• management of sexually transmitted infections,
• counseling and testing for HIV, and
• harm reduction for injecting drug users.

While the tools were designed around this key set of interventions, they can be adapted to assess resource needs for any services for young people that are of specific interest. The tools developed assess total economic costs from the perspective of the health sector provider, and do not explicitly include costs incurred by the patient for accessing services, such as travel costs, waiting time, and the private purchase of drugs.

In 2005-2006, the tools were field tested in selected sites in India, Uganda and Viet Nam\textsuperscript{28}.

**Key indicators**

Indicators have been promoted by UNAIDS\textsuperscript{29} (for HIV programmes in general) and by WHO\textsuperscript{30} (focusing on the health sector response), and these both include a focus on young people and these indicators should form the basis for developing and reporting on projects directed to adolescents and youth. Every effort should be made not to:

- Have a clear structure for thinking about indicators, that differentiate between health outcomes, underlying behaviours, risk and protective factors that affect behaviours, and interventions designed to influence these determinants;\textsuperscript{31}
- Monitor the global goals/targets that relate to young people’s access to health services\textsuperscript{32} and monitor programmes at district level;\textsuperscript{33}
- Disaggregate all data that are collected, by age, including 10-14, 15-19, 20-24 age groups, including data that are collected relating to most at risk populations, and give adequate attention to marital status of adolescents and youth;
- Ensure that adequate attention is given to 10-14 year olds\textsuperscript{34} when data collection systems are developed and reviewed, since this age group are frequently omitted because of the sensitivities surrounding the collection of data from minors (they are not included in most DHS);
- Be aware of the differences between young people and adults that may have implications for the data that are collected, for example they may have less knowledge about HIV and may

\textsuperscript{28} Further information on the tools can be found in *Measuring the Costs of Health Services provided to Young People - Guidance from a Technical Consultation Meeting*, draft report, CAH/WHO.

\textsuperscript{29} UNAIDS Indicators (check reference)

\textsuperscript{30} WHO Indicators (check reference)

\textsuperscript{31} See the structure used in the *UNAIDS M&E Guide to indicators for Prevention Programmes for Young People*

\textsuperscript{32} See *Monitoring young people’s access to health services for HIV prevention and ASRH*, WHO (check reference)

\textsuperscript{33} See ref Draft CAH district level monitoring materials

\textsuperscript{34} See report from UNFPA/Population Council meeting (check reference)
have less experience of using health services, they may not be sexually active, they may have different ideas about the meaning of words, such as “multiple partners”.

**Linkages with other programmes**

HIV presents a unique entry point for adolescent health and development. This is important not only to ensure the sustainability of interventions that are developed within the health system, but also to facilitate the integration and convergence of interventions that are directed to HIV and those that are directed to other components of adolescent sexual and reproductive health.

**Key implementing partners**

Partners to be considered for implementing activities:

- International agencies - for technical assistance, facilitation of work, advocacy and policy development;
- Other governmental sectors such as youth, media and education to ensure linkages with demand creation activities;
- Education institutions, including health professional associations, pre-service and post-graduate education;
- Community-level institutions, to ensure community support;
- Non-governmental organizations serving/representing young people.

*Note: this was prepared by the Department of Child and Adolescent Health and Development, WHO, Geneva, following a format proposed by HIV/WHO, to provide an overview for the purposes of GFATM proposal development. Further information and resources can be provided on request.*

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