Inter-Agency Task Team on HIV and Young People

GUIDANCE BRIEF

HIV Interventions for Most-at-Risk Young People
**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. 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 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. 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.

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.

**PURPOSE**

This Brief has been developed by the Inter-Agency Task Team (IATT) on HIV and Young People to assist United Nations Country Teams (UNCT) and UN Theme Groups on HIV/AIDS in providing guidance to their staffs, governments, development partners, civil society and other implementing partners on HIV interventions for most-at-risk young people. 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.

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4 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.

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

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

7 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.

8 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 old who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.


11 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.

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.43

“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.44 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 self/exchange sex because they do not have other means of earning money.44 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 street children to be HIV-positive with the highest levels among those street children who inject drugs.45

**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,47 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 unprotected48 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.49 50 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.

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**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.24

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,49 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 and criminal gangs. Global research on girls and young women involved in sex work shows that many of them have suffered some form of 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. 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. 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. 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.

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. These include the following five interventions irrespective of the stage of the epidemic:

- information on HIV prevention and treatment (in a form they can understand);
- condoms;
- harm-reduction services (if injecting drugs);
- 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 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, 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.

- 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 epidemics, 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, with the result that data for 10 to 14 years are often missing.
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 CRC43 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. 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.

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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.
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.
Peer education is an effective mechanism for increasing most-at-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 educators50 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 organizations53 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 youth-friendly 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, 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 populations62 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 costing national HIV and AIDS Strategy and Plan of Action and mobilise resources as part of the UN Joint Implementation Support Plan.64

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48 ibid
50 See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on Community-based HIV Interventions for Young People.
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
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
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
Key resources:


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.


Useful web pages:

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

Global Youth Network

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

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

World Health Organization
http://www.who.int/bis/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 UNDP is the lead agency for the prevention of HIV transmission in men
who have sex with men. The main partners in this effort are: UNESCO, UNFPA,
UNICEF, UNODC, the WHO and the UNAIDS Secretariat.
http://www.undp.org

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, WHO, and UNHCR.

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, UNICEF, WFP, UNODC, and WHO.

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

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